NICE National Institute for Health and Care Excellence

NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

PUBLIC BOARD MEETING

Wednesday 18 September 2019 at 1.30pm
in Sheffield Town Hall, Pinstone St, Sheffield S1 2HH

AGENDA

19/077	**Apologies for absence** To receive apologies for absence	(Oral)
19/078	**Declarations of interests** To declare any new interests and consider any conflicts of interest specific to the meeting	(Item 1)
19/079	**Minutes of the last Board meeting** To approve the minutes of the Board meeting held on 17 July 2019	(Item 2)
19/080	**Matters arising** To consider matters arising from the minutes of the last meeting	(Oral)
19/081	**Chief Executive's report** To receive the Chief Executive's report *Andrew Dillon, Chief Executive*	(Item 3)
19/082	**Finance report** To receive the report *Ben Bennett, Director, Business Planning and Resources*	(Item 4)
19/083	**NICE Connect: the case for change and transformation priorities** To approve the proposals *Professor Gillian Leng, Deputy Chief Executive and Director, Health and Social Care Directorate*	(Item 5)
19/084	**Staff survey 2019: report and action plan** To consider the results and action plan *Ben Bennett, Director, Business Planning and Resources*	(Item 6)
19/085	**NICE impact report: maternity and neonatal care** To review the report *Professor Gillian Leng, Deputy Chief Executive and Director, Health and Social Care Directorate*	(Item 7)
19/086	**Annual equality report** To receive the report *Ben Bennett, Director, Business Planning and Resources*	(Item 8)

19/087	**Antimicrobial resistance: developing and testing innovative models for the evaluation and purchase of antimicrobials** To review the report *Dr Nick Crabb, Programme Director, Science Advice and Research*	(Item 9)
19/088	**Standing orders and scheme of reservation** To approve the amendments *Sir David Haslam, Chair*	(Item 10)
19/089	**Directors' reports for consideration** Communications Directorate	(Item 11)
	Directors' reports for information	
19/090	Centre for Guidelines	(Item 12)
19/091	Centre for Health Technology Evaluation	(Item 13)
19/092	Evidence Resources Directorate	(Item 14)
19/093	Health and Social Care	(Item 15)
19/094	**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 Wednesday 20 November 2019 at Great Ormond St Hospital, Great Ormond St, London WC1N 3JH

Interests Register – Board and Senior Management Team

Board Members

Name	Role with NICE	Description of interest	Interest arose	Interest ceased
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). Professor of Health Policy, University of Plymouth	2017 2004	
Angela Coulter	Non-Executive Director	Director, Coulter & Coulter Ltd.	2009	
		Member, Academy of Medical Royal Colleges Choosing Wisely steering group.	2015	

Name	Role with NICE	Description of interest	Interest arose	Interest ceased
		Honorary Fellow, Royal College of General Practitioners.	2007	
		Honorary Professor, Institute of Regional Health Research, University of Southern Denmark.	2007	
		Member, Public Advisory Board of Health Data Research UK.	2019	
Prof Martin R Cowie	Non-Executive Director	Consultancy payments for the membership of Steering committee/DSMBs/Endpoint committees related to Global Clinical Trials or Registries: XATOA, COMPASS, COMMANDER-HF (Bayer); SHIFT, QUALIFY, OPTIMIZE (Servier); RELAX-Region Europe, PARALLAX, VERIFY (Novartis); COAST (Abbott); COAST-AHF (Neurotronik); FIRE1 system (FIRE1); SERVE-HF (ResMed).	2016	
		Associate Editor honoraria from Heart (BMJ Publications) and Journal of the American College of Cardiology.	2016	
		Research grants to Imperial College London to support investigator-led research projects (ResMed; Bayer; Abbott; Boston Scientific; NIHR; British Heart Foundation).	2016	
		Fellowships of the Royal College of Physicians of London and Edinburgh, and of the European Society of Cardiology, the Heart Failure Association of the European Society of Cardiology, and the American College of Cardiology.	2016	
		Chair of the Digital Committee of the European Society of Cardiology, and Member of the Digital Committee of the British Cardiovascular Society.	2016	
		Member of the Advocacy Committee of the European Society of Cardiology.	2016	
		Member of the Medical Advisory Board of the patient charity: the Pumping Marvellous Foundation.	2016	
		Trustee of the Atrial Fibrillation Association (patient charity).	2019	
		Adviser, BMJ Best Practice.	2019	

Name	Role with NICE	Description of interest	Interest arose	Interest ceased
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	2019
		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	
		Non-Executive Director, Styrene Systems Ltd.	2017	2019

Name	Role with NICE	Description of interest	Interest arose	Interest ceased
		Board Member, Pistoia Alliance Advisory Board.	2017	2019
		Non-Executive Director, Pembrokeshire Retreats Ltd.	2006	
		Non-Executive Director, ImaginAb Inc.	2019	
Dr Rima Makarem	Non-Executive Director	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.	2016	
		Non-Executive Director and Audit Committee Chair, House of Commons Commission.	2018	
		Non-Executive Director, The Hillingdon Hospitals NHS Foundation Trust.	2019	2019
		Lay Member, General Pharmaceutical Council.	2019	
Tom Wright CBE	Non-Executive Director	Chief Executive, Guide Dogs.	2017	
		Trustee, Doteveryone charity.	2017	

Senior management team

Name	Role with NICE	Description of interest	Interest arose	Interest ceased
Sir Andrew Dillon	Chief Executive	Trustee, Centre for Mental Health charity.	2011	
		Visiting Professor at Imperial College London.	2016	
Ben Bennett	Director Business Planning and 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	
		Member of the International Advisory Panel for the Agency for Care Effectiveness (ACE) in Singapore.	2019	
Paul Chrisp	Director Centre for Guidelines	Spouse works in medical communications offering services to a range of pharmaceutical companies.	2009	
Jane Gizbert	Director Communications	Non-Executive Director Tavistock and Portman NHS Mental Health Trust.	2014	2019
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	2019
		Chair - Guidelines International Network (GIN).	2016	

Name	Role with NICE	Description of interest	Interest arose	Interest ceased
		Spouse is an Executive Director at Public Health England.	2013	
Alexia Tonnel	Director Evidence Resources	None.		

NICE National Institute for Health and Care Excellence

NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

Public Board Meeting and Annual General Meeting held on 17 July 2019 at Northampton Guildhall, Northampton, NN1 1DE

Unconfirmed

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

Present

Sir David Haslam	Chair
Professor Sheena Asthana	Non-Executive Director
Professor Angela Coulter	Non-Executive Director
Professor Martin Cowie	Non-Executive Director
Elaine Inglesby-Burke	Non-Executive Director
Professor Tim Irish	Non-Executive Director
Dr Rima Makarem	Non-Executive Director
Tom Wright	Non-Executive Director

Executive Directors

Sir Andrew Dillon	Chief Executive
Ben Bennett	Business Planning and Resources Director
Professor Gillian Leng	Health and Social Care Director and Deputy Chief Executive
Alexia Tonnel	Evidence Resources Director

Directors in attendance

Meindert Boysen	Centre for Health Technology Evaluation Director
Paul Chrisp	Centre for Guidelines Director
Jane Gizbert	Communications Director

In attendance

David Coombs	Associate Director – Corporate Office (minutes)

19/057 APOLOGIES FOR ABSENCE

1. None.

19/058 DECLARATIONS OF INTEREST

2. Martin Cowie declared his recent appointment as a trustee of a patient charity, the Atrial Fibrillation Association, which would be added to the register of

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

19/059 MINUTES OF THE LAST MEETING

3. The minutes of the Board meetings held on 22 May 2019 and 19 June 2019 were agreed as correct records.

19/060 MATTERS ARISING

4. The Board reviewed the actions arising from the public Board meeting held on 22 May 2019 and noted that:
    - Meindert Boysen would review the delays in the technology appraisal programme due to the regulatory process and inform the Board of any thematic issues.
    - The reservation of powers to the Board and scheme of delegation had been amended as agreed by the Board.
    - All other actions were in progress.

19/061 CHIEF EXECUTIVE'S REPORT

5. Andrew Dillon presented his report which provided an update on the main programme activities to the end of June 2019 and summarised the financial position at the end of May. He noted that it will be important to closely track the income received from charging for the technology appraisal (TA) and highly specialised technologies (HST) programmes, and welcomed the positive engagement from the companies subject to the new cost recovery arrangements to date. Andrew highlighted the progress with the business plan objectives and performance against the balanced scorecard metrics. He stated that an evaluative commissioning output was delivered to NHS England in the first quarter, so this target should have been marked as green in the report and not red. All targets in the balanced scorecard were therefore either green or amber at the end of the first quarter.

6. The Board received the report.

19/062 ANNUAL REPORT AND ACCOUNTS 2018/19

7. Andrew Dillon presented the annual report and accounts 2018/19 which had been laid before Parliament following approval by the Board on 19 June.

8. The Board received the annual report and accounts and welcomed the year's achievements and the accessible presentation of the report.

9. A member of the audience asked if there are any themes about the implementation of NICE guidance in the impact reports. Gill Leng stated that a

key theme is the variability in implementation within different aspects of a piece of NICE guidance and between different parts of the country. A recurring challenge is the availability of data and therefore NICE is seeking to encourage national data collection in priority areas for improvement.

19/063 FINANCE AND WORKFORCE REPORT

10. Ben Bennett presented the report which outlined the financial position at 31 May 2019 and provided an update on workforce developments. At the end of this period there is a £0.3m underspend. The full-year forecast is an overspend of £0.8m, wholly attributable to an under recovery of technology appraisal (TA) and highly specialised technologies (HST) income in this first year of charging companies for these programmes. Ben reminded the Board that the business plan included a £1.6m deficit due to the delay in introducing these new charging arrangements, which the Department for Health and Social Care have agreed to underwrite. Although currently ahead of plan, future income remains uncertain and information will regularly be presented to the Board on income generated, work in progress and the TA and HST topic pipeline.

11. The Board received the report.

19/064 ANNUAL WORKFORCE REPORT

12. Ben Bennett presented the annual workforce report that outlined the composition of the workforce at 31 March 2019 and key issues of note over the year. He welcomed Grace Marguerie, Associate Director – HR, to the meeting to respond to the Board's questions.

13. The Board reviewed the report and welcomed the level of information provided. Board members raised a number of comments and queries on the report, including the actions taken to retain staff through providing career development opportunities; the completion of appraisals; the gender pay gap; and actions taken to increase the diversity of the workforce and to ensure staff are comfortable disclosing their sexual orientation. In response, it was noted that various initiatives are in place to nurture talent and a significant proportion of appointments are to internal candidates. The Board was advised that the gender pay gap would unlikely be due to differences in the approach to pay negotiation between men and women, as in line with the Agenda for Change pay framework, new starters are appointed at the bottom of the pay band unless clearly defined criteria are met. Grace acknowledged the non-disclosure rate in the sexual orientation data but stated that the staff diversity group have not raised this as an area of concern, and view the bigger challenges to be around ethnicity and disability. She stated that work is underway to seek to further increase the diversity of the workforce, including reviewing the way positions are advertised. Also, the introduction of a new applicant tracking system will provide the opportunity to further analyse data on the conversion rate of applicants from different ethnic backgrounds. It was noted that the move to a new London office and proposed works to the Manchester office provide an opportunity to enhance the accessibility of the working environment.

14. The Board received the report. It was agreed that it would be helpful for next year's report to provide a longer time series for the data where appropriate to track changes in performance, and include data on average length of tenure in each grade to help understand turnover. It was noted that data on the completion of appraisals will be provided to the September Board meeting, once the current appraisal round is complete.

ACTION: Ben Bennett

19/065 ANNUAL REVALIDATION REPORT

15. 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.

16. The Board received the report and approved the 'statement of compliance' which confirms that NICE, as a Designated Body, is compliant with the Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

19/066 NICE IMPACT REPORT: ADULT SOCIAL CARE

17. Gill Leng presented the report on how NICE's guidance contributes to improvements in adult social care, and highlighted that the report has been more challenging to produce than previous reports on other topics due to limited availability of national data given that social care is delivered by thousands of providers. Gill noted that future impact reports will be produced as an HTML webpage rather than a pdf document to ensure they meet accessibility requirements and enable the content to be more easily shared and promoted.

18. The Board noted and welcomed the benefit of working with the Care Quality Commission (CQC) to enhance the impact of NICE guidance. In particular, it was noted that incorporating the guidance into the CQC's key lines of enquiry can be an important mechanism in driving improvements in social care. The reference to NICE's guidance in the CQC's review of oral health care in care homes was welcomed, and it was suggested that it would be helpful if future reviews asked if people had implemented and not just read the guidance. Gill agreed to explore this further with the CQC.

ACTION: Gill Leng

19. Board members expressed disappointment at some of the findings in the report, including the responses to the personal social services adult social care survey about cleanliness and hygiene. It was noted that the drive to integrate health and care services provides the opportunity to improve both outcomes and data collection.

20. The Board received the report.

21. A member of the audience highlighted that linking with the CQC's enforcement regime is key to increasing the impact and implementation of NICE guidance.

19/067 REVIEW OF METHODS FOR THE HEALTH TECHNOLOGY EVALUATION PROGRAMMES

22. Meindert Boysen presented that paper that set out the scope of the methods review for the technology appraisals programme (TA), highly specialised technologies programme (HST), medical technologies evaluation programme (MTEP), and the diagnostics assessment programme (DAP). He outlined the approach to stakeholder engagement through the working party and steering group, and noted there will be a patient working group to get feedback from patient organisations and offer proposals for improved patient involvement. Meindert thanked colleagues for their input to the review to date.

23. In response to a question from the Board, Meindert explained that the review will consider whether to codify the approach taken by committees to apply a modifier when a technology is aimed at children, and also consider whether any changes are required to methods to take account of the high cost and curative potential of gene therapies. He confirmed that the review will look at patient reported outcome measures and the way uncertainty is presented. He agreed that the timescale for undertaking the review is challenging, but stated it is deliverable.

24. The Board approved the scope of the methods review for the health technology evaluation programmes.

19/068 POLICY ON DECLARING AND MANAGING INTERESTS FOR ADVISORY COMMITTEES

25. Gill Leng presented the proposed amendments to the policy on declaring and managing interests for advisory committees. The policy has been reviewed following its first year of operation and the amendments seek to reinforce the risk based approach to handling interests. They take account of feedback from the guidance teams and conflicts of interest reference panel, and research in the British Medical Journal about funding from the life sciences industry to patient groups participating in NICE's TA programme.

26. A question was raised from the Board about the approach for handling a scenario whereby a committee chair who has not published a clear view on the matters to be considered by the committee before their appointment, subsequently appear to be a strong proponent of a position once appointed. Andrew Dillon stated this extends beyond the remit of the interests policy and relates to the committee recruitment process, which should explore a candidate's willingness to objectively consider the evidence and receptiveness to alternative viewpoints.

27. The Board approved the policy for immediate implementation across the advisory committees, with the policy's next scheduled review in three years.

19/069 PUBLIC INVOLVEMENT PROGRAMME ANNUAL REVIEW

28. Gill Leng presented the report that outlined public involvement activities across NICE in 2018/19, and welcomed Laura Norburn, from the Public Involvement Programme, to the meeting. Laura outlined some points of note in the report including the work on shared decision making, and the activities to involve children, young people, and people with learning difficulties in developing guidance and quality standards. Laura thanked the large number of people who have shared their knowledge and experiences of care to ensure that NICE's guidance fully reflects the needs of patients, people using services, their families, carers and the public.

29. The Board received the report and welcomed the programme's work.

19/070 AUDIT AND RISK COMMITTEE MINUTES

30. Rima Makarem, chair of the Audit and Risk Committee, presented the unconfirmed minutes of the committee's meeting held on 19 June 2019. She highlighted the new requirement to comply with the Cabinet Office's counter fraud functional standards and stated that the committee will review the required submissions in September.

31. The Board received the unconfirmed minutes.

19/071 – 19/075 DIRECTORS' REPORTS FOR INFORMATION

32. The Board received the Directors' Reports.

33. In response to a question from the Board, Paul Chrisp and Gill Leng provided further background to the proposed collaboration with the British Thoracic Society and Scottish Intercollegiate Guidelines Network to develop a single consistent guideline for diagnosis and management of asthma. They noted the specific challenges with the existing multiple guidance and feedback from stakeholders about the benefits of a consistent approach. They highlighted that the proposed work will use NICE's methodology.

19/076 ANY OTHER BUSINESS

34. None.

NEXT MEETING

35. The next public meeting of the Board will be held at 1.30pm on 18 September 2019 at Sheffield Town Hall, Pinstone Street, Sheffield S1 2HH.

National Institute for Health and Care Excellence

Chief Executive's report

This report provides information on the outputs from our main programmes for the 5 months to the end of August and on our financial position for the 4 months to the end of July, together with comment on other matters of interest to the Board.

The Board is asked to note the report.

Andrew Dillon
Chief Executive
September 2019

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 2019 and for income and expenditure to the end of July 2019. This report notes the guidance published since the last public Board meeting in July and refers to business issues not covered elsewhere on the Board agenda.

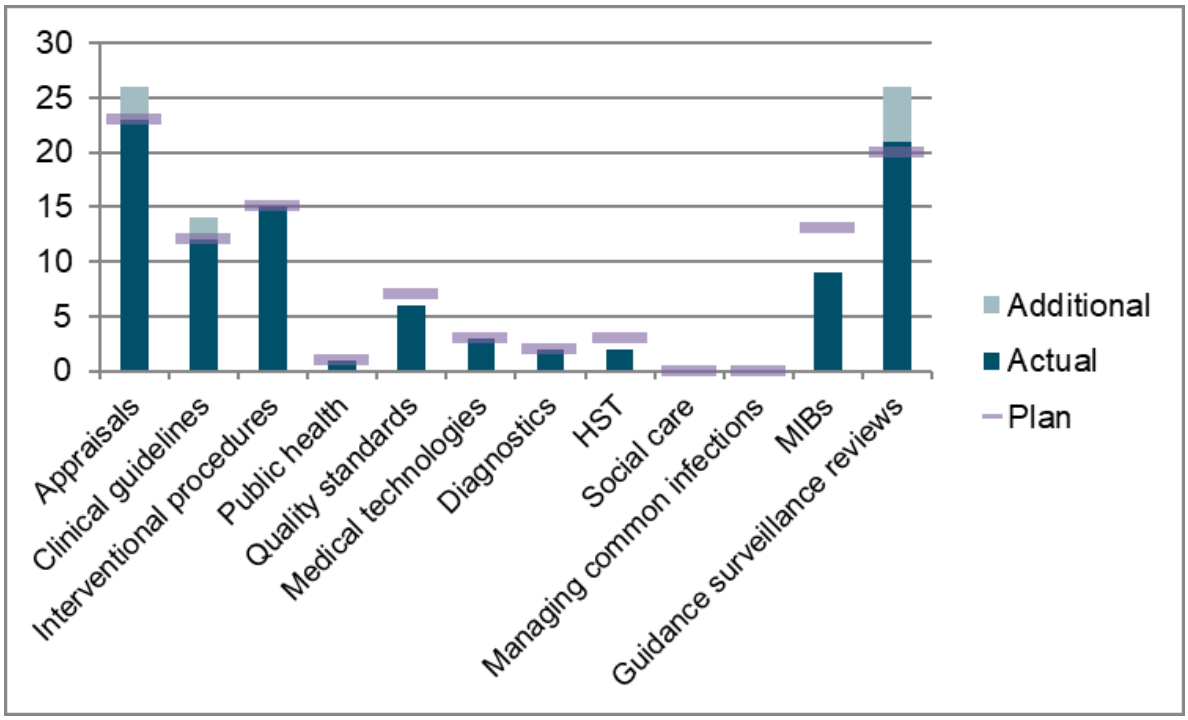
2. The report also contains a report on the performance of the Science, Advice and Research programme in Appendix 5.

Performance

3. The current position against a consolidated list of objectives in our 2019-20 business plan 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 2019 is set out in Chart 1.

Chart 1: Main programme outputs: April to August 2019



download the data set for this chart

Notes to Chart 1:

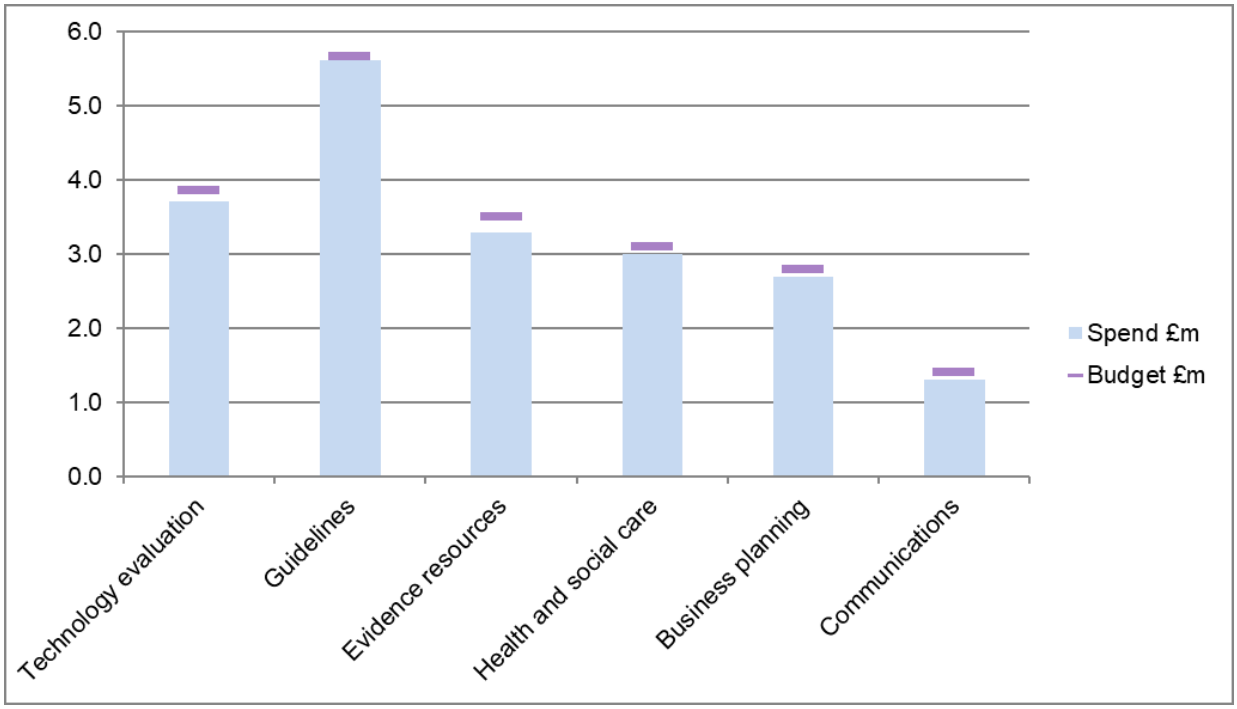
a) HST refers to the highly specialised technologies programme (drugs for very rare conditions)
b) MIBs (medtech innovation briefings) are reviews of new medical devices
c) Guidance surveillance reviews provide the basis for decisions about whether to update current NICE guidance
d) The variance is the difference between the target output for the reporting period, as set out in the business plan and the actual performance
e) 'Additional' topics are either those which should have published in the previous financial year, or that have been added since the publication of the business plan

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.

Financial position (Month 4)

6. The financial position for the 4 months from April 2019 to the end of July is an under spend of £0.8m (5%), against budget. This consists of under spend of £0.27m on pay and £0.33m on non-pay budgets, balanced by an over-recovery on income. The position of the main budgets is set out in Chart 2. Further information is available in the Business Planning and Resources Director's report, including a detailed report on the recovery of costs for the technology appraisal programmes.

Chart 2: Main programme spend: April to July 2019 (£m)



download the data set for this chart

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 2019-20.

Deliver and support the adoption of accessible, up to date and adaptable advice, fully aligned to the needs of our users	Delivery date	Progress update
• Deliver guidance, standards, indicators and evidence products and services, in accordance with the schedule set out in the business plan and the balanced scorecard, including the planned increases in the technology evaluation programmes	• Ongoing	• Details of the main programmes' performance against plan, including explanations for any variances are set out elsewhere in this report.
• Subject to evaluation of the NICE Connect project pilot, develop a business case and programme plans for the next phase of the project	• End of Q3	• A report has been developed for the Board in September with a business case and detailed plans for the next phase of work.
• Undertake a review of the topic selection arrangements for the HST programme and methods guides for the technology evaluation programmes	• End of Q4	• The programme of work for the review has been launched, with internal and external planning meetings held, and a dedicated page on the NICE website created.
• Review and update the guidelines methods and process manual to determine the optimal development path and timeline for guideline development in the context of the NICE Connect project	• End of Q4	• Work is ongoing with other NICE teams and external guideline developers to identify priority areas for update to the methods and process manual. • Plans are in place to coordinate the update of the diabetes guideline with the prescribing pathways workstream of NICE Connect. This will inform the emerging methods and processes for developing and updating recommendations in the context of NICE Connect.

• Maintain and monitor performance of NICE Evidence Services (CKS, HDAS, BNF microsites, Evidence Search, Medicines Awareness Service), with investment in new features on a strictly needed basis	• Ongoing	• All systems are performing in line with recent trends. Continued strong performance of the BNF microsites and the CKS service.
• Enable access to the new national core content and procure any additional content in line with Health Education England's (HEE) commissioning decisions	• Q1	• Complete.
• Support shared decision making within NICE through delivery of commitments in the action plan of the Shared Decision-Making Collaborative	• Ongoing	• A meeting of the Shared Decision-Making Collaborative was held in June and was well attended. A revised action plan is being developed following on from this meeting.
• Deliver a range of tools and support for the uptake of NICE guidance and standards, including adoption support products, endorsement statements, and shared learning examples	• Ongoing	• Tools and support have been delivered as planned. Further information is available in the Health and Social Care Director's report. The need for adoption support products is being reviewed as part of the NICE Connect project.
• Evaluate the most effective social and multimedia channels currently used to promote NICE's work	• Ongoing	• An evaluation of media channels is underway and will be completed by mid-August. A report will be prepared by mid-September which will be used to inform the Board's consideration of the NICE Connect programme at the October strategy meeting.
• Evaluate the scope to improve the recruitment and retention of advisory committee members	• End of Q2	• New digital platforms have been used to promote opportunities for committee members, and ways of being more proactive about recruitment are being explored in CHTE.

Play an active, influential role in the national stewardship of the health and care system	Delivery date	Progress update
• Work with NHS England and other health and care system partners to support the implementation of the NHS long term plan	• Ongoing	• We have mapped areas of NICE's work to the implementation arrangements for the Long-Term Plan and are working with NHS England to ensure NICE guidance is appropriately reflected.
• Explore with NHS England the options for a digital health technology evaluation workstream, building on the Evidence for Effectiveness standards	• End of Q2	• An internal project team has been established and there is a stakeholder Steering Group, chaired by the Programme Director, Evidence Resources. • An outline process has been developed for the evaluation pilot. • Four apps have been identified as pilot topics.
• Subject to the UK's EU exit arrangements, design and put in place changes to our current technology appraisal process in order to secure consistency with UK regulatory arrangements	• End of Q2	• Planning for EU Exit has resumed, including consideration of adjustments required to the technology appraisal process. The combined impact of EU Exit and impending changes to European device regulations on NICE's guidance recommendations for medical devices and diagnostics is being closely monitored.
• Commission a bi-annual NICE reputation research project to assess our key stakeholders' views of NICE and our work, and conduct specific and targeted audience research on key issues that contribute to meeting corporate business objectives and implementation of NICE guidance	• End of Q2	• The final report on the findings of the research project findings was presented to the Board in August. The survey results will be shared with teams across NICE and plans will be developed to implement suggestions from the NICE Board.
• Deliver a suite of activities to mark NICE's 20th anniversary	• End of Q1	• Complete.

Take advantage of new data sources and digital technologies in developing and delivering our advice	Delivery date	Progress update
• Develop and establish a long term data analytics strategy for NICE together with a framework for the appropriate the use of data analytics across NICE's programmes, and facilitating a national leadership in the field	• End of Q3	• A 'Statement of Intent' has been developed, which sets out how we aim to use data analytics in our future work. This is now the subject of a 3-month consultation and a series of workshops to gain further feedback.
• Identify digital investment priorities, and their sequencing, to align with the NICE Connect project transformation work, reviewing the roadmap quarterly	• Ongoing	• SMT approved a proposal to merge the NICE IT and digital services teams. We are seeking external support to design the target operating model for the integrated team and to refresh our technical strategy. • We agreed a short-term approach to managing the use of Office 365 at NICE and the procurement of additional resources to support immediate implementation and the development of a longer-term strategy. • Work to upgrade the existing Pathways service was also approved over the period. • Support to scope and plan digital work required under NICE Connect continued.
• Manage and maintain the live digital services of NICE utilising user insight and strategic service goals to prioritise use of resource	• Ongoing	• Usual activity of defect resolution and responding to change requests continues.

Generate and manage effectively the resources needed to maintain our offer to the health and care system	Delivery date	Progress update
• Deliver performance against plan for all budgets and achieve or exceed on non-Grant-in-Aid income targets	• End of March 2020	• Projections at the end of quarter 2 show that we expect to remain within the tolerance agreed with DHSC for the transition year to the full cost recovery for technology appraisal and highly specialised technologies. • NICE Scientific Advice has generated a small surplus in income over the first 5 months and is on-track to achieve the 2019/20 income targets, which include a full contribution to NICE's overheads.
• Introduce charging for technology appraisal and highly specialised technologies and recover the target income for 2019/20	• From 1 April 2019	• As above: charging systems are now fully operational. Income was slightly ahead of target for quarter 1, and projections at the end of quarter 2 show that we expect to remain within the tolerance agreed with DHSC for this first year.
• Deliver existing grant funded research projects to plan and timetable and secure a pipeline of new projects for 2020/21	• End of March 2020	• Science Policy and Research income is on target for 2019/20. Several projects extend to future years (some to 2023), with funding for the next 2 years secured at comparable levels to this year. A new project was added to the portfolio in July. Existing projects are being delivered to plan.
• Promote our capacity for knowledge sharing with international organisations interested in NICE's expertise and experience, including the re-use of NICE's published content outside of the UK	• Ongoing	• The SMT approved a strategy for NICE's international activities to be re-launched under the 'NICE International' brand. The team are now working on a communications plan and are preparing internal and external

		promotional content ahead of the launch later this year. The team continues to see considerable interest in NICE's work from international stakeholders and has several projects from a range of different countries in the pipeline. • Revenue generated from content re-use (of published NICE guidance) services at the end of August was approximately £54,000, which is ahead of target for the year.
Support the UK's ambition to enhance its position as a global life sciences destination	**Delivery date**	**Progress update**
• Make preparations to implement the commitments of the 2019 Voluntary Scheme for Branded Medicines Pricing and Access related to NICE so that (i) all new active substances and drugs with significant licence extensions will be appraised, except where there is a clear rationale not to do so, by April 2020; (ii) NICE is able to publish recommendations on non-cancer drugs within 90 days of licensing to match the timescales for cancer drugs (ongoing)	• End of Q4/on-going	• Planning meetings have been held with NHS England and NHS Improvement, and with the Department of Health and Social Care, to consider the timing of the expansion of the technology appraisal programme, and the ability to publish guidance for non-oncology drugs against the same 90 day target as oncology drugs.
• Deliver the actions set out for NICE in the Government's Life Sciences Sector Deals and significantly increase the number of evaluations of these health tech products conducted, giving greater scope for considering different types of innovation, including digital products.	• Ongoing	• Work is ongoing with NHS England and NHS Improvement on the development of a new Medtech funding mandate, with NICE as a key partner. • Discussions are ongoing with NHS England and NHS Improvement about the timing of a potential expansion of the Medtech programmes, and with the Department of Health and Social Care on how the expansion could be funded. The expansion of NICE's Medtech and diagnostics guidance capacity is signalled in the NHS

		Long Term Plan, and the source of funding for this is currently under discussion with DHSC Finance team.
• Prepare a final case for establishing a not for profit organisation delivering fee for service advisory and educational programmes, aligned to NICE's public task	• End of Q3	• The Board agreed in June that the original proposal was not viable and to stand down planning for the proposed entity.
Maintain a motivated, well-led and adaptable workforce	**Delivery date**	**Progress update**
• Ensure that all staff have clear objectives supported by personal development plans	• End of Q1	• Each directorate has an individual business plan and that is cascaded into individual objectives which links to the annual appraisal and informs personal development plans.
• Actively manage staff engagement and morale with the objective of ensuring that the global job satisfaction index in the annual staff survey is maintained or improved from its 2018 level	• End of Q1	• The annual staff survey achieved our highest-ever completion rate of 85%. The results are used to form organisational and directorate action plans, supported by HR. The results and organisational action plan will be presented to the Board at its September meeting.
• Implement the actions set out in the workforce strategy, including mapping out career paths for key roles, including increasing opportunities for apprenticeships, and defining the behaviours expected of a manager at NICE	• End of Q2	• We have introduced leadership and management apprenticeships at levels 3, 5 and 7 (MBA level) and are developing graduate opportunities in a range of areas. • We will be introducing organisational values and behaviours for managers in the coming months.
• Work with the Department of Health and Social Care to secure the future London office accommodation, and begin planning for the move to take place in the summer of 2020	• End of Q3	• Planning for the move to Stratford in Summer 2020 is progressing, with key

		decisions on contractual issues considered by SMT. • Engagement with the leaseholder and other tenants on space configuration are well-advanced.
• Develop and implement a programme of improvements for the Manchester office to ensure best use of the space available	• End of Q2	• A paper was presented to SMT in August detailing proposed improvements. External advice on office space planning is now being commissioned.

Appendix 2: Extracts from the Directors' reports

Director	Featured section	Section/ reference
Health and social care	NICE supported the NHSE's Chief Allied Health Professions Officer's Awards in July 2019 for the second time through a NICE Into Action award category. This encouraged allied health professionals to showcase how they have used NICE guidance or quality standards to improve the quality of care and how services use resources. Twelve nominations were received, and the 3 finalists were: • Royal Devon and Exeter NHS Foundation Trust (winner) who redesigned their approach to bed based intermediate care delivered with their community hospital teams based on NICE's guidance on intermediate care. This resulted in reduced length of hospital stays and an increase in patients returning home directly. • Dudley Falls Prevention Service, an integrated multi-agency service, combining NHS, CCG, Local Authority and Public Health services provides multifactorial assessment and intervention to prevent falls, based on the relevant NICE guideline and quality standard. • Midlands Partnership Foundation Trust for the OASIS project, which created a high quality and efficient treatment pathway based on the care and management of osteoarthritis.	Para 23
Guidelines	A potential collaboration with the World Health Organization (WHO) to provide evidence-based recommendations on antibiotic choice for its Essential Medicines List (EML) is being developed. The proposal is to reuse the evidence reviews that underpin NICE antimicrobial prescribing guidelines. The product would be co-badged, in line with NICE's policy on co-production.	Para 14
Health technology evaluation	The 2019/20 business plan indicates that NICE would publish 78 technology appraisals and highly specialised technologies. At the time of writing the report, 28 have published so far and it is currently anticipated that a final number of 72 pieces of guidance will publish for the 2019/20 business year. This number is lower than anticipated as a number	Para 28

	of topics have been suspended or delayed during the business year for a variety of reasons such as licencing changes, on-going discussions with NHS England regarding commercial opportunities, and at company request for delay (resulting in publication in the 2020/21 business year). However, the programmes are working on 84 (75 TA and 9 HST) 'live' topics that are currently between the formal invitation to participate and final guidance publication stages. Another 22 topics are scheduled to start between the September and November NICE Board meetings.	
Evidence resources	One of our main objectives is to deploy our digital expertise to deliver business-led strategic projects, including •The Evidence Management platform (delivering web tools for searching evidence, systematic review needs and building an evidence surveillance capability): we held meetings with our collaborating centres to understand their remaining needs and agree a plan for feature development and onboarding of these centres in the first half of 2020; •Ongoing work to support configuration of a new identity management solution to replace our current in-house 'NICE Accounts' solution; •Operational Productivity: we have consolidated activity focusing on replacing the legacy Contact Database and Planning Tools into the NICE Connect programme and established a multi-disciplinary team focused on Operational Productivity. This early work will look across data, process and tooling to support operational activity in the context of our transformation.	Para 9
Communications	During July and August we responded to 1,589 enquiries which included 23 MP letters, 16 Freedom of Information (FOI) requests, and 19 parliamentary questions (PQ). The majority of PQs related to the review of methods in our technology appraisal programme. We also continued to receive PQs on the appraisal of nusinersen for the treatment of Spinal Muscular Atrophy. Topics covered by MP letters were varied but a number related to our appraisal of cerliponase alfa for the treatment of Batten disease. The development of guidance on cannabis-derived products for medicinal use continues to attract public enquiries. Following the publication of the draft guideline we received correspondence	Paras 21 to 23

	from people who were very disappointed with the draft recommendations. We have also received a number of enquiries asking NICE to prioritise the development of guidance on pernicious anaemia and requests to reconsider draft recommendations on metreleptin for treating lipodystrophy.	
Finance and workforce	The Technology Appraisal (TA) and Highly Specialised Technologies (HST) charging regime has now been running for 4 complete months. At 31 July 2019, 23 topics had started (that is, had their invitation to participate (ITP) notice) and are subject to charging; of these 19 were Single Technology Appraisals and 4 were Cancer Drugs Fund reviews. The planning assumption is that 78 topics will commence in each financial year. This is equivalent to an average of 6-7 topics starting per month. Therefore, the number of topics expected to have started is 26. The actual number of topics started is 23, slightly lower than predicted however the income recognised to date is higher than forecast due to the timing and phasing of those invoices, with a higher than expected number of topics starting in April and May. It is expected that there will be peaks and troughs like this throughout the year but this will be mitigated by the fact the income is recognised over the life of the appraisal (10-11 months) rather than when the invoice is raised.	Paras 22 and 23

Appendix 3: Guidance development: variation against plan April - August 2019

Programme	Delayed Topic	Reason for variation
Clinical Guidelines	No variation against plan 2019-20	-
	2 additional topics published in 2019-20, that were not planned for this financial year	Surgical site infections: prevention and treatment: Originally planned for 2018-19. Published April 2019 (Q1 2019-20). Suspected neurological conditions: Originally planned for 2018-19. Published May 2019 (Q1 2019-20).
Interventional procedures	No variation against plan 2019-20	-
Medical technologies	No variation against plan 2019-20	-
Public Health	No variation against plan 2019-20	-
Quality Standards	1 topic delayed	School based interventions: Publication now anticipated by end of Q2 2019-20.
Diagnostics	No variation against plan 2019-20	-
Technology Appraisals	No variation against plan 2019-20	-
	3 additional topics published in 2019-20, that were not planned for this financial year	Cabozantinib for previously treated advanced hepatocellular carcinoma: Published as a terminated appraisal in May 2019 (Q1 2019-20). Bosutinib for untreated chronic myeloid leukaemia: Published as a terminated appraisal in April 2019 (Q1 2019-20). Brentuximab vedotin for untreated advanced Hodgkin lymphoma: Published as a terminated appraisal in August 2019 (Q2 2019-20).
Highly Specialised Technologies (HST)	1 topic delayed	Cerliponase alfa for treating neuronal ceroid lipofuscinosis type 2: Timelines are to be confirmed.

Programme	Delayed Topic	Reason for variation
Social Care	No variation against plan 2019-20	-
Managing Common Infections	No variation against plan 2019-20	-

Appendix 4: Guidance published since the last Board meeting in July 2019

Programme	Topic	Recommendation
Clinical Guidelines	Hypertension in adults: diagnosis and management	General guidance
	Preterm labour and birth	General guidance
Interventional procedures	Ultrasound-guided high-intensity transcutaneous focused ultrasound for symptomatic uterine fibroids	Special arrangements
	Transurethral laser ablation for recurrent non-muscle-invasive bladder cancer	Special arrangements
	Low-energy contact X-ray brachytherapy (the Papillon technique) for locally advanced rectal cancer	Research only
	Endovascular insertion of an intrasaccular wire-mesh blood-flow disruption device for intracranial aneurysms	Standard arrangements
Medical technologies	No publications planned	
Diagnostics	Therapeutic monitoring of TNF-alpha inhibitors in rheumatoid arthritis	None of the 6 technologies assessed in this guidance, were recommended for routine adoption due to insufficient evidence. All technologies received recommendations for further research on clinical effectiveness. The guidance also recommends that laboratories currently using the tests should do so as part of research or further data collection. The technologies included in the assessment were: Promonitor,

Programme	Topic	Recommendation
		IDKmonitor, LISA-TRACKER, RIDASCREEN, MabTrack and Sanquin Diagnostic Services ELISA tests.
Public Health	Alcohol interventions in secondary and further education	General guidance
Managing Common Infections	No publications	
Social care	No publications	
Quality Standards	Hearing loss in adults	Sentinal markers of good practice
	Lyme disease	Sentinal markers of good practice
	Learning disability: care and support of people growing older	Sentinal markers of good practice
	Coexisting severe mental illness and substance misuse	Sentinal markers of good practice
Technology Appraisals	Nusinersen for treating spinal muscular atrophy	Optimised
	Blinatumomab for treating acute lymphoblastic leukaemia in remission with minimal residual disease activity	Optimised
	Fluocinolone acetonide intravitreal implant for treating recurrent non-infectious uveitis	Recommended
	Letermovir for preventing cytomegalovirus disease after a stem cell transplant	Recommended
	Cemiplimab for treating metastatic or locally advanced cutaneous squamous cell carcinoma	CDF
	Ribociclib with fulvestrant for treating hormone receptor-positive, HER2-negative, advanced breast cancer	CDF
	Brentuximab vedotin for untreated advanced Hodgkin lymphoma	Terminated appraisal
	Dacomitinib for untreated EGFR mutation-positive non-small-cell lung cancer	Recommended

Programme	Topic	Recommendation
	Olaparib for maintenance treatment of BRCA mutation-positive advanced ovarian, fallopian tube or peritoneal cancer after response to first-line platinum-based chemotherapy	CDF
	Risankizumab for treating moderate to severe plaque psoriasis	Optimised
	Dapagliflozin with insulin for treating type 1 diabetes	Optimised
Highly Specialised Technologies (HST)	Patisiran for treating hereditary transthyretin amyloidosis	Recommended
Medtech Innovation Briefings (MIB)	HemaClear for bloodless surgical field during limb surgery	Summary of best available evidence
	Endo-SPONGE for colorectal anastomotic leakage	Summary of best available evidence
Guidance Surveillance Reviews	CG115 Alcohol-use disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence	No update required
	PH24 Alcohol-use disorders: prevention	Partial update
	NG6 Excess winter deaths and illness and the health risks associated with cold homes	No update required
	CG95 Chest pain of recent onset: assessment and diagnosis	No update required
	CG146 Osteoporosis: assessing the risk of fragility fracture	Full update

Programme	Topic	Recommendation
	NG9 Bronchiolitis in children: diagnosis and management	Partial update

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. Positive recommendations are subject to a legal funding requirement.

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

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

Appendix 5: Science, Advice and Research Programme progress report

NICE Scientific Advice

1. During July and August 2019, NICE Scientific Advice has initiated 10 individual advisory projects. This includes 5 projects where companies have sought advice from NICE directly (including two projects offering a concurrent advice service alongside the EMA's advice process), 1 PRIMA project, 3 projects where NICE has given advice through the European Network for HTA (EUNetHTA) Early Dialogue procedure and 1 META Tool consultation. A further 3 advisory projects have been confirmed with contracts in the process of being signed as well as a further 33 ongoing enquiries for projects starting later in the year.

2. The International team received 14 new enquiries, and delivered 2 international engagements, including a 4 week training programme for a resident pharmacist from Saudi Arabia. A further 21 enquiries are currently in progress and are yet to be confirmed. A number of meetings have been held to help secure a multi-country visit (provisionally scheduled for October) to deliver a number of HTA workshops organised by the Department for International Trade in Latin America to Ministries of Health in Brazil, Uruguay, Colombia, and Peru. The team took a strategy paper to SMT in August which was well-received and supported plans to re-launch the service under the 'NICE International' name. The team are now working on a communications plan and are preparing internal and external promotional content ahead of the launch in Q3 this year.

3. After a strong first quarter, the team have continued to build on this success by focussing on project work and driving business development activity, participating in 5 different business development events over the two month period. On top of our core advisory services, the team has made valuable contributions to the Antimicrobials Evaluation and Purchasing Models project with NHS England and have started work on the Innovate UK Digital Health Technology Catalyst and the Executive MSc in collaboration with the London School of Economics. In addition, the team has made progress in a stakeholder mapping project which will help inform future business development strategy and facilitate the transition to a bespoke Customer Relationship Management (CRM) system later in the year.

Science Policy and Research

Research recommendations

4. The National Institute for Health Research (NIHR) have been screening the NICE research recommendations database for over 15 years to identify topics suitable for commissioning through its research commissioning programmes.

The SP&R team leads activity with NICE's guidance producing teams to promote their research recommendations to three of the NIHR programmes managed at the NIHR Evaluation,Trials and Studies Coordinating Centre (NETSCC): Health Technology Assessment, Public Health Research and Health Services and Delivery Research. NICE's research recommendations aim to resolve important uncertainties in the evidence base and inform future updates to our guidance.

5. In the 2018/2019 financial year, NETSCC funded 12 new research projects linked to NICE guidance and committed £16 million of funding. NETSCC's total spend on NICE research recommendations to date is over £100 million. This includes research to address 7 out of NICE's 10 'key priority' research recommendations. The key priority status, which allows a fast track route through NIHR's processes, was introduced in 2015 to resolve important uncertainties as rapidly as possible.

6. Through regular engagement with NETSCC and NICE's guidance producing teams, SP&R ensure that our research recommendation process is robust and maximises the opportunities for timely research, ensuring that our guidance is based on the best available evidence.

EUnetHTA

7. The NICE team have been planning the content of the final deliverable from the NICE led work package. The report will evaluate changes in implementation between previous and the current EUnetHTA joint actions, define key structures that HTA agencies, EUnetHTA and stakeholders will need to put in place to maximise use of EUnetHTA joint assessments and make recommendations for ongoing implementation support in a future model of European HTA cooperation.

September 2019

National Institute for Health and Care Excellence

Finance report

This report gives details of the financial position as at 31 July 2019 and the current forecast outturn for 2019/20. The report also includes information on Technology Appraisal (TA) and Highly Specialised Technologies (HST) income generated through cost recovery charging.

The Board is asked to review the report.

Ben Bennett

Director, Business Planning and Resources

September 2019

Financial position as at 31 July 2019

Summary

1. Table 1 summarises the financial position as at 31 July 2019 and gives an estimated outturn for 31 March 2020. There is a full analysis in Appendix A.

Table 1 Financial position at 31 July 2019

Area	Year to date budget £m	Year to date expenditure £m	Year to date income £m	Year to date variance £m	Estimated outturn (March 2020) Budget £m	Estimated outturn (March 2020) Expenditure £m	Estimated outturn (March 2020) Income £m	Estimated outturn (March 2020) Variance £m
Guidance & Advice Centres	16.1	16.1	(0.4)	(0.4)	49.2	49.6	(1.0)	(0.7)
Corporate Functions	4.5	4.6	(0.3)	(0.2)	13.8	15.0	(0.9)	0.3
Science Advice & Research	0.0	0.8	(0.9)	(0.1)	0.0	2.6	(2.7)	0.0
Other Income	(3.9)	0.0	(4.0)	(0.1)	(14.4)	0.0	(14.0)	0.4
Grand Total	**16.7**	**21.5**	**(5.7)**	**(0.8)**	**48.6**	**67.2**	**(18.6)**	**0.0**

2. The table above shows a total underspend against budget of £0.8m (5%) at the end of July 2019.

3. The full-year forecast is a break-even position, as a result of cost pressures expected later in the year relating to the organisational transformation project known as NICE Connect, Manchester office improvements and preparations for relocating to a new office in London.

Financial position as at 31 July 2019

4. Table 2 summarises the year to date financial position as at 31 July 2019 split between pay, non-pay and income.

Table 2 Year to date financial position (July 2019)

Type of cost	Budget £000	Expenditure £000	Variance £000
Pay	12,738	12,471	(267)
Non-pay	9,386	9,060	(326)
Income	(5,451)	(5,688)	(237)
Grand Total	**16,673**	**15,844**	**(829)**

5. Table 2 above shows total net expenditure to 31 July 2019 was £15.8m against a budget of £16.7m, giving an underspend of £0.8m (5%). The underspend comprised of:

   - £267,000 pay underspend due to vacancies and staff turnover across the organisation.
   - £326,000 non-pay underspend relating to depreciation charges, external contracts in the MedTech Evaluation programme where the full budget has not been utilised during the first 4 months of 2019/20 and lower than planned spend on Digital Services non-pay budget set aside for development projects.
   - £237,000 income target surplus due to TA and HST charging income being ahead of plan and increased intellectual property and copyright license income generated within the Evidence Resources Directorate.

6. Appendix A 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 the senior management team receive a finance report detailing the summary position and any issues on a bi-monthly basis.

Pay and resourcing

7. Pay expenditure to 31 July 2019 was £12.47m against an adjusted budget of £12.74m, resulting in an underspend of £267,000. The distribution across the centres is shown in table 3:

Table 3 Year to date pay figures by centre

Centre / Directorate	Budget £000	Expenditure £000	Variance £000	*Variance %*
Centre for Guidelines	2,192	2,137	(55)	*(2%)*
Centre for Health Technology Evaluation	3,020	2,997	(23)	*(1%)*
Health & Social Care	2,811	2,768	(44)	*(2%)*
Evidence Resources	1,732	1,669	(62)	*(4%)*
Science Advice and Research	748	721	(27)	*(4%)*
Business Planning & Resources	1,014	1,027	13	*1%*
Communications	1,221	1,152	(69)	*(6%)*
Grand Total	**12,738**	**12,471**	**(267)**	**(2%)**

8. The full year pay budget has been adjusted by transferring £0.8m of expected budget slippage associated with vacant posts into reserves at the start of the financial year (known as the part-year effect adjustment). This was used to offset the unfunded pay award and pension increases notified as set out in the 2019/20 business plan. A further £0.25m was removed in May for new vacancy slippages, this was transferred into the NICE Connect budget for 2019/20.

9. During July the total number of vacancies was 35 wte (a 5.2% vacancy rate). This has reduced from the 10% consistent vacancy rate in 2018/19 and the 7.2% rate in May, the part year effect budgets have been removed for these posts as referred to above. Current vacancies are mainly due to the timing delay between leavers and new starters.

10. There are currently 5 wte agency staff employed across the organisation with a total spend up to July 2019 of £132,000 (1% of total pay costs), this is similar to the position during the same period last year.

Non-pay

11. Non-pay budget under spends have contributed £326,000 to the current year to date underspend, this is mainly due to the following areas of under spend.

    - Depreciation of £47,000. The depreciation underspend is expected to grow in the short-term but will reduce in the latter part of the year as we commit expenditure on capital purchases such as IT hardware and improvements to the Manchester office. Depreciation is a non cash allocation and therefore under spends on this budget cannot be allocated to expenditure elsewhere.

    - MedTech External Assessment Centre contracts of £95,000. This is due to lower than expected numbers of topics being run by the Observational Data Unit. This under spending is expected to continue for the rest of the financial year, and it is unlikely that the variable element of the MedTech external assessment centre budget (£0.35m) will be utilised during 2019/20. This accumulated underspend will be used to offset the potential cost pressures and NICE Connect resource requirements mentioned in the forecast below.

    - A planned year to date underspend of £82,000 in the Digital Services non-pay budget. This will be used to fund digital development work in the latter part of the year to support customer relationship management, Microsoft Office 365 rollout and commitments relating to the NICE Connect project.

Income

12. Income at 31 July is £237,000 more than planned. Technology Appraisal and Highly Specialised Technologies charges, intellectual property and copyright license income, and the NICE Scientific Advice are all ahead of plan and have exceeded their targets in the first 4 months of the year.

13. It is still too early to predict with any certainty what the final income figure for Technology Appraisal and Highly Specialised Technologies charges will be in 2019/20. A forecast income figure of £4.4m (which would result in a deficit of £0.4m to be underwritten by DHSC) is the best estimate at this stage based on the topics in the pipeline for the rest of the financial year, but there is the potential for a wide margin of error. We are keeping DHSC informed about the position.

14. Further details about Technology Appraisal income is included later in this report.

Forecast outturn

15. The current full year forecast is a break-even position. Non-recurrent underspends relating to vacancy savings and non-pay reductions are being used to offset the forecast deficits on Technology Appraisal income (as noted above), the NICE Connect transformation programme and potential cost pressures including improvements to the Manchester office and potential preparation costs arising from the London office move due to take place in 2020. Should we be unable to fully cover the TA income shortfall the DHSC as agreed to underwrite this.

16. The original business planning assumption was that TA and HST charging would incur a shortfall in this first year of up to £1.6m due to the delays in getting final approval to go ahead from DHSC. DHSC agreed that it would underwrite the deficit up to this amount if required. Currently income is running ahead of plan and we are now forecasting a deficit of only £0.4m. At the current time it seems likely that we will be able to absorb this deficit within the overall budget and therefore will not need DHSC to provide the funds required to underwrite it.

17. The summary financial position analysed by directorate is shown in Appendix A. In addition to the £0.4m adverse variance relating to TA and HST income, there are other significant variances shown. The first is shown against Centre for Health Technology Evaluation (CHTE), where the total forecast underspend is £0.32m wholly attributable to the flexible element of the MedTech External Assessment Centre contract as mentioned above. Other non-recurrent pay underspends are being used to offset the likely increased pay costs within CHTE in the latter part of the year relating to Technology Appraisal expansion plans funded by cost recovery income.

18. Evidence Resources is showing a £0.13m forecast underspend against budget. Vacancy underspends across the directorate will be used to offset planned non-pay relating to CRM implementation and Office 365 and SharePoint configuration and support later in the financial year.

19. The resources required to support the NICE Connect transformation programme have been estimated at £0.56m for the current financial year, which will be funded by £0.43m budget and the projected overspend offset by other directorate underspend transfers this year.

20. The final significant variation shown in Appendix A relates to potential cost pressures (£0.365m) which may materialise during the year. These include:

    - Improvements to the Manchester office are planned for later in the year, including increasing the meeting room capacity, and updating the rear

reception area. Although most of the expenditure will come from the £0.5m capital budget, there may be some revenue costs associated with the works that have not been budgeted for.

- Investment is required to update the IT infrastructure and other technology, including implementing recommendations made by external consultants in relation to data management and storage.
- A need to make provisions in the accounts towards the end of the financial year for potential costs and liabilities arising from the London office move.

21. There are currently no reserves in place to fund the above potential cost pressures if they materialise. However, the current forecast assumes that a number of non-recurrent underspends in teams (including the forecast underspend in CHTE noted above) will be sufficient to offset this potential cost, therefore leading to an overall breakeven position.

Technology Appraisals and Highly Specialised Technologies charging

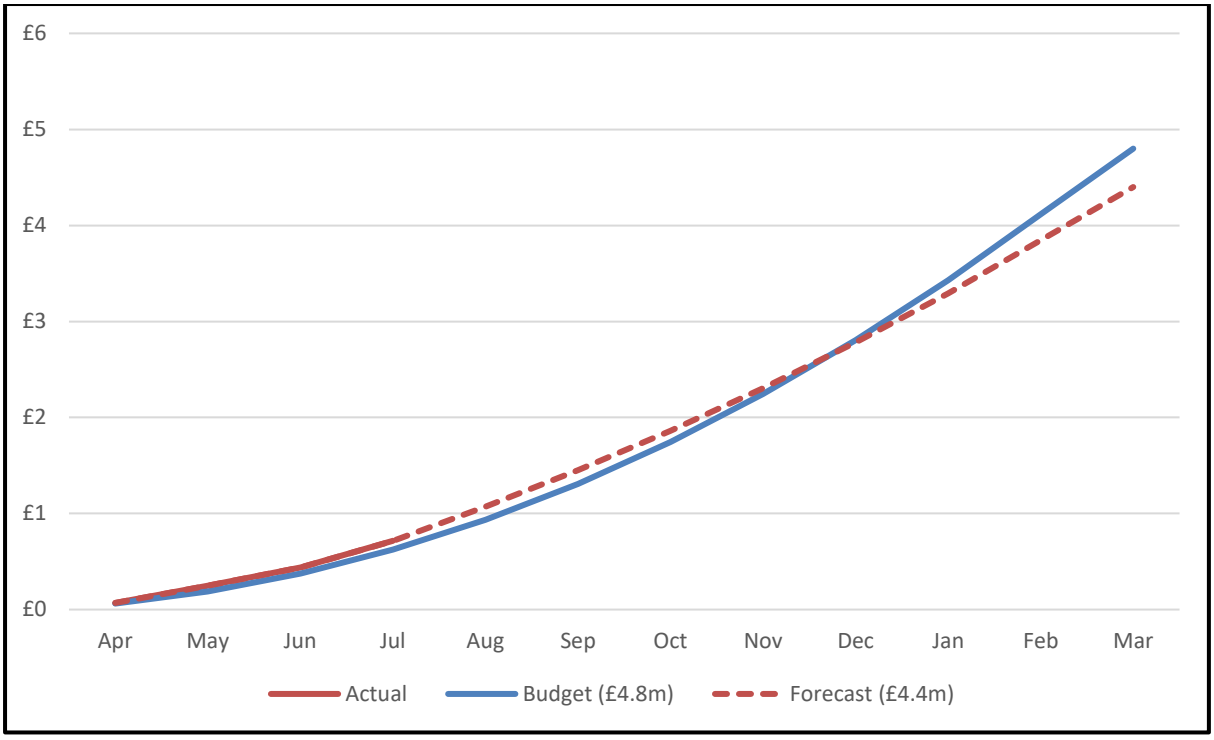
22. This report covers the position to 31 July 2019 which is the first 4 months of the cost recovery charging regime for Technology Appraisal (TA) and Highly Specialised Technologies (HST). At 31 July 2019, 23 topics had started (that is, had their invitation to participate (ITP) notice) and are subject to charging; of these 19 were Single Technology Appraisals and 4 were Cancer Drugs Fund reviews.

23. The planning assumption is that 78 topics will commence in each financial year. This is equivalent to an average of 6-7 topics starting per month. Therefore, the number of topics expected to have started is 26. The actual number of topics started is 23, slightly lower than predicted however the income recognised to date is higher than forecast due to the timing and phasing of those invoices, with a higher than expected number of topics starting in April and May. It is expected that there will be peaks and troughs like this throughout the year but this will be mitigated by the fact the income is recognised over the life of the appraisal (10-11 months) rather than when the invoice is raised.

24. The TA and HST income target for 2019/20 is £4.8m. The year to date income target is £0.6m and £0.7m of income has been recognised for the 23 topics that have started. These topics are expected to achieve £2.6m of income for 2019/20.

25. Chart 1 below shows that we are currently £0.1m ahead of target and the income recognised exceeds the forecast amount in each individual month so far. However, as topics do not start in linear fashion across the year the current full year forecast is £4.4m.

Chart 1: Cumulative income to date and full-year forecast compared to 2019-20 budget (£m)



Download the data set for this chart

26. At any point in time there are TA and HST topics in the 'pipeline', some of which are in the scoping phase, some have been referred by DHSC but not yet had their ITP and others have started the appraisal process. At 31 July 2019, 84 topics had started the appraisal process and 23 of those are subject to charging (32%), with the balance of 61 relating to appraisals that began before 1 April 2019. As we move through 2019/20 the number and proportion of topics that have started and have been charged for will increase and conversely the number of topics that are residually funded by GIA will decrease.

27. It was agreed that small companies (as defined by the companies' act) will receive a 75% discount and have the option of paying in instalments. Our initial estimate was that around 10% of topics would be from a small company based on previous technology appraisals. Thus far none of the 23 TA and HST topics that have started this year have been from a small company. However, three small companies have been invoiced so far for topics starting in September and October.

28. During this launch phase, the CHTE topic selection and finance teams have continued to maintain good communication with companies regarding charging and payment has usually been received promptly. Debt management procedures and consideration of pausing topics have not been required.

Appendix A: Summary of Financial Position

The table below is a summary of the financial position per centre and directorate as at 31 July 2019 and gives an estimated outturn to March 2020.

Centre / Directorate	Year to date budget £000's	Year to date actual £000's	Year to date variance £000's	*Year to date variance %*	Estimated outturn (March 2020) Budget £000's	Estimated outturn (March 2020) Outturn £000's	Estimated outturn (March 2020) Variance £000's	Estimated outturn (March 2020) *Variance %*
Income from other ALBS, Devolved Administrations and other miscellaneous income	(3,293)	(3,301)	(8)	*0%*	(9,570)	(9,578)	(8)	*0%*
Income from TA and HST cost recovery	(621)	(716)	(95)	*32%*	(4,800)	(4,400)	400	*(8%)*
Centre for Guidelines	5,674	5,625	(49)	*0%*	17,353	17,252	(100)	*(1%)*
Centre for Health Technology Evaluation	3,859	3,716	(143)	*(4%)*	11,830	11,510	(320)	*(3%)*
Health & Social Care	3,077	3,032	(45)	*1%*	9,286	9,172	(114)	*(1%)*
Evidence Resources	3,512	3,314	(197)	*(3%)*	10,757	10,626	(131)	*(1%)*
Science Advice and Research	(30)	(83)	(52)	*(31%)*	22	(27)	(49)	*(226%)*
Business Planning & Resources	2,812	2,742	(70)	*(2%)*	8,570	8,564	(5)	*(0%)*
Communications	1,376	1,278	(98)	*(2%)*	4,120	3,919	(201)	*(5%)*
NICE Connect	92	67	(25)	*(23%)*	431	562	131	*30%*
Potential cost pressures	-	-	-		0	365	365	*n/a*
Depreciation	217	170	(47)	*(22%)*	650	639	(11)	*(2%)*
Grand total	**16,673**	**15,844**	**(829)**	***(3%)***	**48,648**	**48,605**	**(43)**	***(0%)***

September 2019

National Institute for Health and Care Excellence

NICE Connect - The Case for change and transformation priorities

This report gives details of the drivers for change and sets out how we plan to address the challenges through NICE Connect.

The Board is asked to:

- approve the purpose of the transformation and structure of the programme
- note the plan to explore the funding and management of the programme in more detail at the October Board strategy meeting.

Professor Gillian Leng

Deputy Chief Executive

September 2019

Executive Summary

1. After 20 years of operation, NICE has acquired an international reputation for developing evidence-based advice and guidance, with a particular focus on cost effectiveness. We have published almost 400 guidelines to drive best practice across the health and care system and identified those new medical technologies that represent value for money to support investment decisions and improve care for people with lived experience.

2. Our success in developing a portfolio of over 2500 separate pieces of advice has also created several challenges, both for NICE and for the users of our products. The NICE Connect transformation programme aims to address these challenges and enable NICE and the users of our evidence-based advice to take advantage of new digital technologies for the future.

The case for transformation

3. There are several compelling reasons why we need to change both the way that NICE works and the way we present our advice and guidance. While doing this we must retain our gold standard assessment of the evidence and economic analysis, to ensure our guidance has maximum impact on outcomes, and we must continue to respond to strategic drivers within the external environment. The three main underpinning drivers for change are:

    - Feedback from our users and system partners. We hear that our advice can be challenging to find and difficult to relate to a care pathway. There can often be a number of products in the same topic area on different parts of our website, as well as different ways for users to engage with us and comment on our draft recommendations. This means information about the role of new technologies can be difficult to find, and uptake may be lower than expected.

    - The range and volume of our guidance and advice. This generates the issues described by users in finding our guidance, but also presents significant internal challenges including keeping our advice up to date, aligning our work programmes and data management, as well as the efficient analysis and presentation of complex information.

    - The need to make better use of new digital technologies and artificial intelligence (AI). We need to do more to embed NICE guidance in those technologies used by front line practitioners and healthcare systems. This includes the potential to use voice activation, and to integrate with new learning health systems. We also need to take advantage of technology to improve internal data sharing and, in future, to use AI to facilitate rapid updating of recommendations.

The future vision for NICE

4. Our vision for the future builds on NICE's place as an international leader in evidence synthesis, guideline development and technology evaluation. We will build and enhance this reputation with an improved offer that integrates our advice along care pathways, accessible to users whenever and wherever they need it, which is always up to date. To achieve this, we will make effective use of digital technologies and artificial intelligence, with the aim of improving care and facilitating the use of new, cost effective technologies. This will not only improve the service for users of NICE guidance, but make the process quicker and more efficient.

5. To achieve this vision, we expect our future offer to contain the elements listed below. The details of any final outputs will be tested with relevant user groups and tailored to their requirements. Any resultant changes to our methods and processes will be subject to the usual consultation with stakeholders.

    - Advice and guidance integrated in a care pathway format, aimed at frontline practitioners. This will have short, focussed recommendations framed within questions that are important for practitioners and the public. Further detail will be accessible through layers of information, including evidence summaries to support shared decision making. Medicines and new technologies will be positioned in the pathway shortly after guidance is published, to facilitate their use. It will be designed to be adopted into third party digital systems as appropriate, to increase its accessibility.

    - On-line, citeable publication of systematic reviews and technical reports. This will represent an important, resource for researchers and academics, as well as for those interested in the detail underpinning our recommendations. This may require establishing an arrangement with a third-party publisher.

    - Easy to access listings on decisions about new technologies, aimed primarily at commissioners and the life science industry. This will particularly help those with a responsibility for funding our recommendations.

    - A dedicated stakeholder platform to enable stakeholders to register once, for all aspects of NICE's work. It will bring together all planned and ongoing consultations and will provide a single portal for responses.

Delivering the transformation

6. Achieving our vision for the future represents a multi-year programme of work. Initial priorities will be to develop a new way of integrating all our advice, as well as putting in place important internal operational efficiencies. We will aim, where possible, to make incremental changes to our online presentation.

7. These changes will require dedicated staff to support and govern the changes, with additional input from existing staff plus external expertise where required. Clear governance mechanisms will be established to oversee and monitor progress and we will work carefully with staff to inspire their support and involvement.

8. Digital developments will be crucial to enable this change. It will support more efficient internal day to day working, provide a framework for our new integrated pathways, and ensure we can deliver what our users need to provide and commission care for people with lived experience, their carers and the public. To take advantage of the potential offered by artificial intelligence for updating recommendations, we will have to work with experts in the field and embed changes to our routine ways of working.

Resourcing the transformation

9. NICE Connect will require a multi-million pound investment over 3-5 years. Additional funding would ensure the transformation can go ahead with minimal impact on NICE's outputs. Several options are being explored to support this work, but no definite funding commitments have yet been made. After several years of significant reduction in grant in aid funding, NICE does not have the resources available to deliver the full range of immediate priorities alongside maintenance of existing outputs.

Background

10. Since our establishment in 1999, we have developed a wide range of evidence-based guidance and information to enable people working in health and social care to make better decisions about the services they provide. We have established an international reputation for our rigorous approaches to evaluating the evidence, to carrying out economic assessments, and for being robust and independent.

11. As we celebrate our 20th birthday, we are conscious of the need to reflect not only on our success, but on how we can build on this to create an organisation providing services that are fit for purpose for the next twenty years. Much has changed since 1999, particularly the development of technologies that now provide us with rapidly accessible portable information, with interactive screens, videos and voice activation. NICE guidance was first developed on the assumption that people would receive paper copies through the post.

12. We have been systematically gathering stakeholder feedback for a number of years. Sources of information include: surveys, both large and small, qualitative and quantitative; field team reports that have captured rich qualitative data from all of NICE's major stakeholder groups; results from user testing by the digital services team; and questions and concerns received by our enquiries team.

13. This feedback tells us that our work is highly valued by the majority of people and that our guidance is seen by many as the gold standard. However, there are a number of common and interrelated themes across stakeholder groups that indicate we can do better in certain areas. We know that our products need to be easier to find and presented and structured in a way that makes them easier to use in a modern digital environment.

14. NICE's success in developing dedicated outputs for specific needs has been largely the result of establishing separate business units for product development. While this equips individual teams with the flexibility to innovate process, methods and technical solutions, this approach has come at a cost. It can result in duplication and inefficiency as teams undertake similar activities, and loses productivity gains that greater standardisation can bring. Our end-products are conceived, developed, presented and maintained in the separate units, in part causing the lack of integration in the outputs that our users experience.

15. These user insights and internal drivers for change are explored in more detail below. Collectively they present a strong case for change, to ensure NICE remains fit for purpose in future and operates in the most efficient way. There is a risk that if we fail to respond to these challenges, the value of our work will be

eroded over time as users look to other organisations that can respond more quickly.

16. NICE Connect has been created over the last year as a programme to address these challenges in a significant organisation-wide transformation. A vision and ambition for NICE are articulated below that provide a framework for taking forward the work required. This has been enabled by a number of strands of exploratory work undertaken over the last year. Together with other insights, the findings from these areas of work enable us to plan a range of priority next steps to take the transformation forward.

17. NICE's staff have already experienced a series of organisational changes, driven in recent years by the need to make efficiency savings to manage reduction in our grant in aid funding. This significant transformation is designed for a different purpose and will only succeed if we bring staff with us on the journey. We are working with staff to understand how they feel about the prospect of change, and want to retain their enthusiasm for the concepts and ideas as these become the future reality.

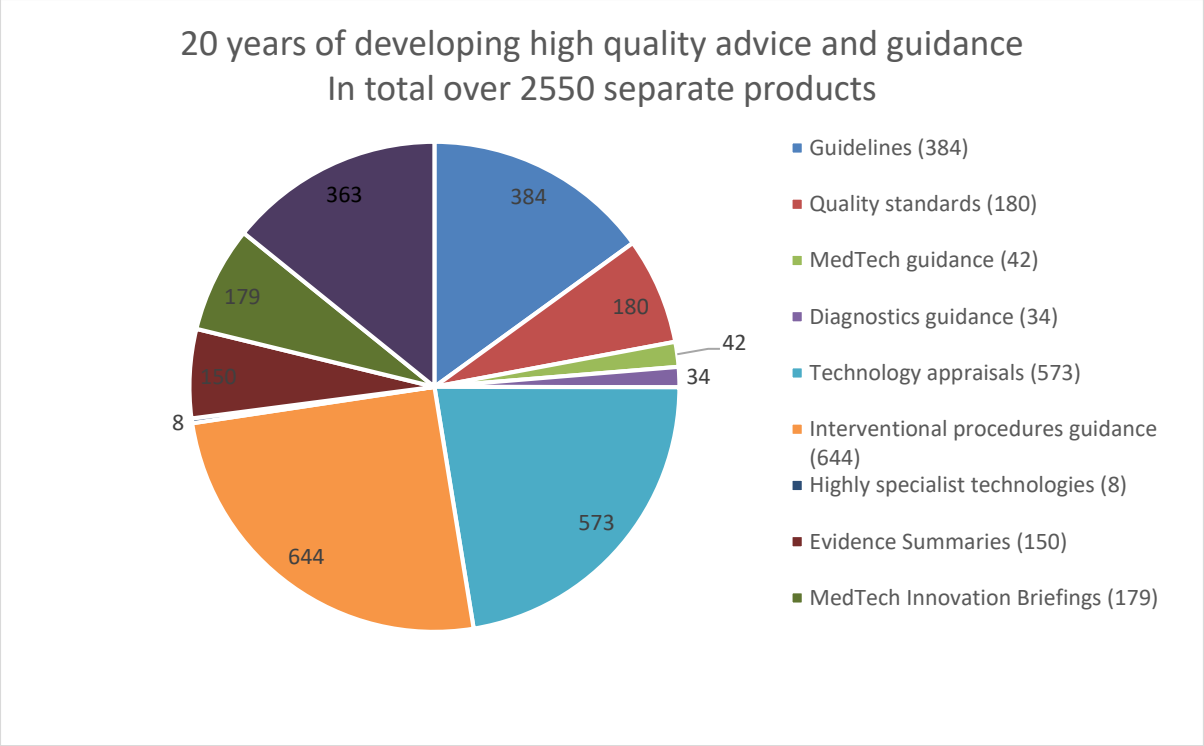
18. In addition to changes to the individual roles that staff play, we need to be mindful of their identity within the organisation as it changes and the fact that different people will respond in different ways. The final section of this paper highlights engagement activity with staff to date, and plans for the future. A summary is also provided of our external engagement activity and plans, covering our stakeholders and funders.

The case for change

19. After 20 years of successfully developing advice and guidance for the health and care system, there are now a number of reasons why we need to change the way we present and produce our work. These are partly related to developments in the wider environment and the availability of new technologies.

Finding NICE guidance

20. Difficulty in finding guidance and other products on the website is a recurring theme coming up in nearly every engagement we have with our users. Many people tell us that as the volume of guidance grows, their success in finding what they need diminishes. Stakeholders often say the guidance documents themselves are long, complex and difficult to navigate.



Download the data set for this chart

21. The extensive number of products offered by NICE is a theme often reported by the Field Team's various external engagements. The number of different products (guidelines, quality standards, evidence summaries) all on the same topic can leave people unsure how the products relate to each other and what they should do with each one. As a consequence, the implementation of our recommendations is affected, and the impact of our work potentially diminished.

22. We also know that many clinicians use online decision support systems, often linked to electronic patient records, which use decision algorithms based on guideline recommendations. These algorithms are developed by third parties and may not accurately reflect NICE guidance. Ideally, we would produce information that can be pulled into clinical systems by system providers with no or minimal translation, thus retaining accurate links to the original text.

Structure and presentation of guidance and advice products

23. Many stakeholders tell us that our recommendations would be more easily understood if presented in multiple layers of interactive material, rather than through traditional linear blocks of text. They would like to be able to drill down into increasing levels of detail, as required, and to link across to other relevant information. We also receive many enquiries about how our guidance connects together. We have numerous examples of questions around how technology appraisals fit together, and how they are used in different clinical situations.

24. Users generally like the concept of NICE pathways and the ability to click through to gain further information where required, however, they still sometimes find the recommendations too long and wordy when they reach the information they need. They also say that they get frustrated if there are too many clicks required to find the information they want.

25. Stakeholders frequently tell us that they would like summary versions of our guidance with the use of graphics and visuals. New products such as the Social Care Quick Guides, visual summaries in the antimicrobial guidelines, and the web-based Quality Improvement Resource have been popular with users.

26. Summaries and visual representations are regularly mentioned by respondents as useful to help them get to the recommendations they need. Stakeholders sometimes develop their own visual versions of NICE guidelines because they find the guidelines too difficult to follow and need to simplify them for local use.

Range and volume of NICE guidance

27. In addition to the feedback from users about the design and presentation of our advice and guidance, we are also aware that we have insufficient capacity to maintain the currency of our recommendations. We run an ongoing surveillance programme to examine new evidence relevant to guidelines, but the capacity required to actually update recommendations is limited. We need an ongoing mechanism to enable us to rapidly act on new data and evidence, and demonstrate to users what has changed.

Making better use of new technologies

28. Increasing operational efficiency at NICE will enable us to do more with the resources that we have and increase staff satisfaction and retention. Targeted investments (see appendix 1 for details) have been made over the last few years to address key points of inefficiency. However, an external review of our data management practices has highlighted further aspects that would benefit from transformation, for example establishment of principles, standards and technology to support activities such as data sharing and reporting.

29. Working practices are evolving and the range of digital tools now available to support new and efficient working practices across key capabilities is increasing, including in relation to records management, collaborative working, planning, stakeholder management. Our upgrade to Microsoft Office 365 creates opportunities to invest in new tools for staff, and we want to pro-actively invest in growing these capabilities.

30. We know that there is much more we can do. Technology advances are driving user expectation and opening new channels and sources of information that will compete with our offer. To keep our advice up to date and available to users in

an integrated way, we will need to embrace the opportunities that investment in new technology, such as artificial intelligence or new content management tools, can bring to ensure we get the most from our available resources.

31. However, transformation is not just about technology. A move from working in separate units to more integrated, collaborative development of decisions and recommendations to feed NICE's future services will impact on all aspects of the organisation and its culture. We have undertaken a range of activities over the last year to explore some of these areas in detail, and developed a vision and ambition for NICE Connect that sets out the complexity of the challenge.

Key concepts for the future

What do we mean by products, channels, services, user needs and content?

32. NICE currently publishes separate products that strongly reflect the way in which the recommendations, decisions and evidence are developed within distinct business units. We use our website as a channel, or delivery mechanism, to provide our guidance, advice and standards to our users as a service that helps them make better decisions.

33. In future we want to provide more flexible, versatile services to our users – helping them to do different things – through delivery mechanisms that work for them. Examples of different channels include our own web site, voice-activated search, and systems provided by others (third-parties that integrate our guidance with other functionality at the point of care).

34. We want to respond to the needs of our users and create and re-create different products from one source of information that can be used flexibly (but, crucially, retains important links between relevant information). Examples might include pathways of care that integrate everything NICE says on a particular topic, collections of approved technologies, collections of information relevant to particular users – personalised by what we know about their needs from the details they provide us, summary versions and access to more detailed information, and answers to key questions.

35. The key to providing these intelligent, flexible services in the future lies in our content, coupled with our understanding of user needs. Our content is the building blocks of the products of the future – it's the words (e.g. our recommendations, decisions, evidence, considerations), the relationship between these elements, and other media such as graphics, video and audio that are developed to represent knowledge.

36. At present our content is locked in our static products: to provide the information they contain in a different way we manually copy the information in chunks, for example to create NICE pathways, or our social care quick guides. In future, we will develop, store and manage it in ways that enable us to achieve our vision of developing intelligent services and flexible products that meet the needs of our users. Our users won't see the complex content models and concepts that lie behind the transformation – but they will see a revolution in how to find and access our work as a result.

NICE Connect - what have we learned so far?

37. Over the last year we have undertaken a range of exploratory work to help us better understand and plan for our transformation. These projects are detailed here with a summary of what we have learned. This work has helped us to understand the complex nature of the changes we need to make, and their interdependencies, and has shaped how we plan to approach the transformation. A range of ideas has also been generated about how we might work in future, and some of these are highlighted below. These will be further explored, expanded and iterated in conjunction with staff and external users before any final solutions are confirmed.

Learning from exploration of our diabetes content

38. In November 2018 we established a NICE Connect diabetes pathways committee to advise NICE on how to present content in a more accessible and simpler format, with a focus on type 2 diabetes. The committee looked at various parts of a pathway, including diabetes in pregnancy, prevention in an at-risk population, medicines sequencing, multimorbidity and social care, as well as digital needs and functionality. They also advised on other aspects of NICE content such as specific content, language and structure, covering topic areas that will contribute to our future content model, and medicines sequencing work.

39. We gained significant learning from the work, and ideas for the future, including:

    - Insights into our future model, including the need to map information at decision points, the importance of linking content, the use of layered information, and factors that influence implementation

    - The complexity of the task we have ahead is in reengineering our advice. Diabetes is a complex topic area with many interrelated published NICE products. We learnt that it is not possible to redesign this content in Committee, although their expertise is vital to validation. Separate teams will need to do initial work such as simplifying recommendations,

removing any duplication, and aligning into themes rather than individual guidelines. This will be a significant amount of work, and there will be elements that cannot be populated from our existing advice. These gaps will need to be identified and addressed as we transition to our future model.

- The importance of involving a range of people within NICE to generate ideas and help inform future ways of working is paramount. This continued staff engagement will be important as the transformation progresses, and we will explore different ways of working to encompass multidisciplinary skills and experiences.

- The need to ensure appropriate resourcing for transformation work, ensuring that staff have protected time to take forward transformation away from their business as usual responsibilities is key to successful delivery.

- The challenge of creating a transformation environment within a highly successful and efficient process-driven organisation like NICE. For transformation we will need to be adaptable, agile and responsive to changing needs and requirements.

Learning about our approach to content management

40. Our current approach to developing and managing content was reviewed by a firm of external consultants (see appendix 2 for an executive summary from their report).

41. The aim of the work was to assess our current content and processes, and our overall readiness for producing and managing content that would be structurally more versatile, more granular, generally easier to manipulate and re-use. The work considered the functions and products of technology appraisals, interventional procedures, quality standards and guidelines, so was not completely comprehensive in its coverage of NICE's work.

42. The review helped us to recognise our current strengths in managing content. These included our strict adherence to product templates and development workflows, examples of recent moves to more granular content, in-house skills and expertise, regular collation of user feedback, and use of responsive design.

43. The recommendations from the review focused on the need for NICE to develop a formal content strategy and design principles, supported by governance and centralised ownership. This would enable the implementation of common information architecture and metadata. It also suggested that we could do more to share the results of our user experience activities across teams.

44. The review also observed there was no existing enterprise tool to manage the data resulting in much manual effort to develop and re-use content. As such, the review also included a high-level options appraisal of market tools (such as XML authoring tools and componentised content management systems) that could meet NICE's needs. Options for future structured content models and standards required to support structured content management were also considered and will be taken into account as we plan our content transformation.

45. The work outlined the complexity of a content transformation journey that will encompass content strategy, digital tools, workflow and people elements. It told us this transformation will require resource, targeted external expertise, senior sponsorship and support for change management.

Learning about our approach to data management

46. An expert assessment of our data management processes and capabilities was undertaken by external consultants to benchmark our data management practice against industry standards. Our level of maturity was contrasted with our transformation ambitions to create a prioritised list of issues, risks and opportunities and a set of recommendations for change.

47. Data flows considered in scope of this review were wide-ranging and included the following types of information: stakeholder contacts and interests; planning data; user feedback; insight and enquiries data; scientific and evidence data that underpin decisions; our guidance uptake data; our own glossaries and own content metadata; and our formal document records.

48. The review assessed the maturity of our data management practices as generally low. It highlighted a significant degree of manual manipulation of data required in day to day tasks. It explained that the tools currently in place, which are built around individual team processes, are driving and reinforcing a culture of siloed working. This in turns creates a significant overhead when trying to achieve a corporate view of NICE data. The review also challenged the lack of an integrated digital and IT strategy to align technology, data and process efficiency ambitions.

49. The review recommended that NICE should prioritise a number of activities as part of our on-going transformation:

    - Developing an integrated digital & IT strategy to provide a clear roadmap for aligned data and technology development.
    - Implementing a single view of contacts and planning data to address inefficiencies related to manual manipulation of data, to enable effective and timely reporting, and to support compliance requirements.

- Implementing a record management solution so that NICE's records are managed automatically in line with approved retention schedules.
- Building a data architecture capability. This means that the business, system and data landscapes are modelled in order to understand how data flows through NICE. These accurate models provide the foundations for future NICE solutions which can then be developed in a coordinated approach.
- Mapping and redesigning business processes so that existing operational business processes are understood and can be redesigned to directly support NICE goals and reduce costs.
- Planning for a collaborative working platform. This means enabling all employees to work in a common cloud delivered solution where data is accessible to all with permissions implemented to limit access where required. Awareness of NICE activity is visible across the Institute with opportunities for knowledge sharing and collaborative approaches to problem solving.

50. As a result of this work we have a clear understanding of current strengths and development opportunities to enable our future business strategy and objectives. The conclusions from this review are shaping the agenda for NICE Connect, and will have a significant impact on our Operational Productivity and Content projects.

Learning about how our content will need to be shared in future

51. Use of intelligent technology and computer support tools is rising across health and care. In future health and care professionals will expect advice from NICE to be embedded in the technology they use at the point of care. Ensuring NICE guidance can be consumed and understood by systems and algorithms – as well as understood by people – will become increasingly important. Enabling information to be shared in this way between systems is often referred to as interoperability.

52. We undertook research and engaged with stakeholders to develop a greater understanding of Clinical Decision Support (CDS) requirements within the wider system. As a result, we know more both about how we need to share our content, including terminology and standards, and the emerging longer-term ambitions of the system. For example, we know that decision support vendors want to be able to link to specific sections within our products, ideally pulling these directly into their systems without copying and pasting. They also want to be able to identify specific elements of our guidance using standard terms and definitions. Our engagement continues, and will be vital to ensuring the place of NICE's content in future systems.

53. As part of the wider concept of a Learning Health System a movement called '[Mobilising Computable Biomedical Knowledge']', is growing in the USA and is also an active area of academic research within the UK. There is interest from many UK groups including NHS bodies in exploring this area to understand its importance in delivering against the 10 year plan for the NHS. NICE is helping to organise the first event in October 2019 in the UK designed to create alignment and momentum in this area. We will continue to pay active attention to developments in this space so that we can engage appropriately once we have clarity on alignment with the ambitions of NICE Connect.

Overview of learning to date

54. The above activities have been undertaken by teams of staff across NICE, the majority absorbing work on top of existing roles which are already very pressured. Significant learning has been generated, and this has enabled us to plan our future vision and ambition with greater confidence. We are grateful to all staff for their input and enthusiasm. However, the most significant learning from this phase is that our transformation is complex and will only succeed if we plan and direct dedicated resource to undertake the work required. This learning has influenced our approach to resource planning and will better enable our work to succeed with pace and agility in future. We are also aware of the opportunity cost of activity that has been displaced by NICE Connect, and will monitor and plan for this as part of future business planning and ongoing NICE Connect activities.

Core elements of our future ambition

NICE's vision

55. Our vision for the future builds on NICE's place as an international leader in evidence synthesis, guideline development and technology evaluation. We will build and enhance this reputation with an improved offer that integrates our advice along care pathways, accessible to users whenever and wherever they need it, which is always up to date. To achieve this, we will make effective use of digital technologies and artificial intelligence, with the aim of improving care and facilitating the use of new, cost effective technologies. This will not only improve the service for users of NICE guidance, but make the process quicker and more efficient.

56. Developing this vision has been driven by the activities outlined above, and by our user insights and internal knowledge. It retains NICE's core purpose of helping to improve the quality, sustainability and productivity of health and social care. NICE does this by producing guidance and information on effective

practice and public health interventions, which enable people working in health and social care to make better decisions with and for those for whom they are providing services.

NICE's future offer

57. Taking into account what we already know, we expect our future offer to contain the elements listed below. The details of any final outputs will be tested with relevant user groups and tailored to their requirements. Any resultant changes to our methods and processes will be subject to the usual consultation with stakeholders.

    - Advice and guidance integrated in a care pathway format, aimed at frontline practitioners. This will have short, focussed recommendations framed within questions that are important for practitioners and the public. Further detail will be accessible through layers of information, including evidence summaries to support shared decision making. Medicines and new technologies will be positioned in the pathway shortly after guidance is published, to facilitate their use. It will be designed to be adopted into third party digital systems as appropriate, to increase its accessibility.
    - On-line, citeable publication of systematic reviews and technical reports. This will represent an important, resource for researchers and academics, as well as for those interested in the detail underpinning our recommendations. This may require establishing an arrangement with a third-party publisher.
    - Easy to access listings on decisions about new technologies, aimed primarily at commissioners and the life science industry. This will particularly help those with a responsibility for funding our recommendations.
    - A dedicated stakeholder platform to enable stakeholders to register once, for any area of NICE’s work. It will bring together all planned and ongoing consultations, and will provide a single portal for responses.

A transformation programme for the future

Elements of the transformation

58. To achieve the changes in NICE’s offer as described above, and to meet the internal challenges outlined earlier, a significant transformation will be required across all elements of NICE’s work.

Our front-facing online service

59. Our front-facing service is the way in which our content is delivered directly to our users. Key elements of this new service are described above. Our ambition is to deliver a cutting-edge product that meets the needs of our users, available through multiple channels using third parties to reach certain user groups.

60. To develop these new services, we will encourage and support stakeholder input to content development and provide systems to support this that are designed to meet their needs. We will use external expertise where required to provide efficient and effective service development.

Our content - what it is, how it interrelates and how it is managed

61. The key to transformation and the future of NICE lies in our outputs, which in turn will support the achievement of the outcomes articulated within the NHS Long Term Plan. To achieve the new outputs, we need to re-imagine our work as an integrated body of knowledge that is designed, structured, labelled and governed as a flexible resource.

62. This new content will be relevant to users, of high quality, and written in plain, accessible language designed to support decision making. It will be consistently structured, use semantic standards, and be granular to enable flexible use and re-use including across multiple 3rd party channels.

Our processes and methods

63. NICE's success has been grounded in the development of gold standard methodology that is operationalised through strict adherence to process. Building on this success in future to support our integrated content, and grounded in our core principles, our processes and methods will be consistent where possible, but not homogeneous. This will simplify our engagement externally, and processes will be designed for efficiency.

Our management of data to achieve operational excellence

64. The data strand of our future organisation is far-reaching, requiring revolution in the way we define, manage and share the data that we use in the course of our work. In future we will understand, manage and utilise all our data (including our user, operational and evidence data) in more efficient ways to add value to our work and for our users.

Our digital technology and infrastructure

65. Digital technology will be at the heart of our transformation. This includes the equipment we use, the applications we have access to, the standards and design principles we follow and the system infrastructure that we build upon. These will all be designed and re-aligned as part of an integrated IT and digital function. Our approach will evolve to meet the challenges of the external

environment, the changing IT demands of our workforce, and the needs of our organisation as we transform at scale.

Our people and organisation

66. As a wide-ranging transformation programme, NICE Connect will impact on all our staff, and the people with whom we work, in a range of ways. Our ambition therefore has elements relating to our culture, skills and structure.

67. Our future workforce will have the professional, technical, data, digital and content management skills required to support our transformation, and these will be deployed flexibly across the organisation to meet demand. Our culture will support collaborative working and our structures will allow the right people to be brought together at the right time and provide appropriate accountability. We will strive to build a culture that empowers continuous change and improvement through the use of Agile and Lean approaches

68. The functions likely to be required by the future organisation will build on what we have now. The organisation will need to be less siloed, with more cross-cutting functions to achieve greater efficiency and alignment across our work.

Initial transformation projects

69. Identification of the next, and longer term, steps we need to take to transform NICE naturally fall out of our ambition framework, as we compare where we are now with where we want to be. There is a lot to do, and with limited resources we need to prioritise.

70. The drivers for change articulated earlier in this paper, and the significant learning from the first phase of NICE Connect, have supported our choice of initial projects, which are articulated in more detail below. These are:

    - Transformation of our content to enable us to respond to the challenges users have with finding our guidance

    - Improvements to our operational productivity to enable us to do more in future with the resources that we have.

71. Subject to board approval, work on these initial priorities will be operational from April 2020. Some work may start before then, subject to resource availability.

Content transformation

72. We need to develop and iteratively test with users an innovative, integrated new content model that brings together all of NICE's work in a single design. This model will enable our content to be used flexibly by NICE to create different products and services to address the needs of core users in the context of users that have been prioritised, and by third-parties. We will also need to invest in

standards and search to ensure our future content supports flexible use across multiple third-party channels. Other elements of content transformation include:

- Developing methods and processes for drug sequencing, and for presenting these pathways
- Considering how best to link information in a care pathway
- Working to standardise the way our products are structured and worded, including the reflection of the underpinning evidence base. This includes a comprehensive review of related products, including quality standards and implementation support.
- Investigating how technical reports and systematic reviews can be published as separate outputs in future
- exploring technology options and identifying, through an external procurement exercise, a suite of digital tools that will house and enable us to manage the new integrated content model.

Operational productivity

73. We need to improve our operational productivity to enable us to do more with the resources that we have, and to increase staff satisfaction and retention. Our current internal processes have evolved naturally and separately over time, now involving a lot of manual manipulation that can be inefficient. Initial priorities will be:

- work on our contacts database and planning tools
- operational process improvement including consideration of declaration of interests
- data management improvements
- efficiencies through the strategic deployment of Microsoft Office 365.

74. Initially our focus will be on the activities that are required to safely replace our existing contacts database and planning tools. This will consider the core capabilities of managing contact information, and the creation, editing and visibility of timeline information. These tools support the production of much of the content we produce.

75. Across all our operational processes we will seek opportunities for standardisation and alignment and we will consider if our current delivery of operational processes can be improved. Foundational work will be undertaken to build a catalogue of existing business and data processes, which will enable us to do this and to support workflow configuration for any new system. In the initial stages we will also test the theory of standardising a core process using our Declaration of Interest (DOI) process and will consider the information

governance implications for our data. The DOI process is a good candidate for early transformation as it represents a complex, important policy applied across all teams, where consistency of application is important.

76. Improved operational processes will allow us to manage data better. We will seek to implement other data management improvement opportunities, and prioritised process efficiencies through the strategic deployment of Microsoft Office 365. This will include roll out of newly available tools to support teams, alongside consideration of the organisational records management and information governance that is required for this.

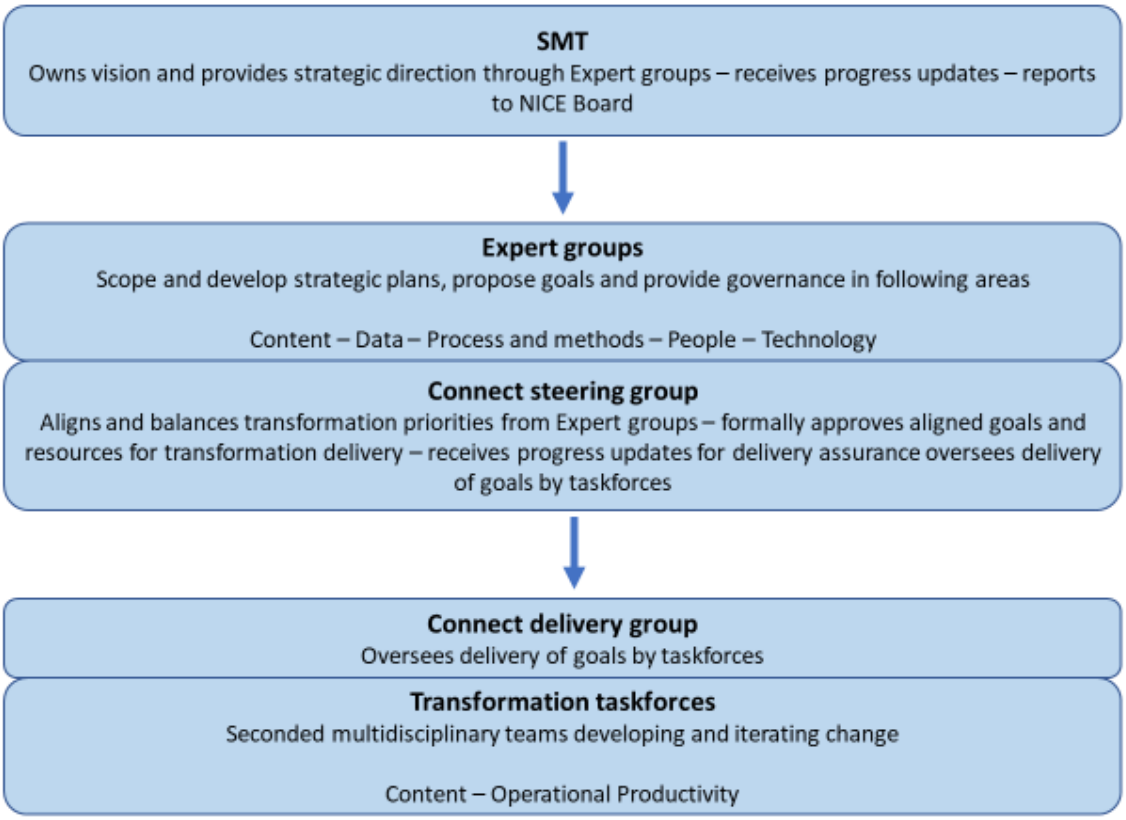
77. As our transformation delivers change, our operational processes will be impacted and we will need to continue to review and redesign ways of working across the organisation.

78. At present we are continuing development of a comment collection tool to improve the stakeholder experience during consultation and improve internal efficiency. A future transformation taskforce would review the full capability of external stakeholder engagement and interactions in the context of the future products and portfolio of NICE and the internal processes that we have developed in earlier taskforces.

Governance and operational standards for the programme

79. Our learning over the past year has highlighted the importance of consistency and streamlined accountability. To support our transformation, we therefore need to formalise standards and governance structures for activities that will be owned, and in some cases managed, centrally. Individual Centres, Directorates and teams have in the past shown individual leadership on these issues, and will continue to do so, but in future we will also have more centralised oversight. The governance and delivery model set out below is designed to provide structures to ensure the success of NICE Connect and provide a firm foundation for future operations.

Key groups involved in NICE's transformation



80. The Senior Management Team (SMT) will continue to have overall responsibility for the work of NICE Connect, supported by a Steering Group to provide strategic oversight of the transformation. SMT members will be central to the steering group, as well as leading expert groups in core areas, as set out below. Delivery of the work will be carried out by taskforces, which will provide the capacity to focus on detailed areas of work. Day to day liaison with the taskforces, to respond to operational issues and ensure alignment, is provided by the Delivery Group.

81. The transformation work will also be supported by a dedicated transformation unit to manage the operation of taskforces and coordinate the delivery of transformation activity. It will provide standard programme management office functions to support day to day working, such as programme planning, monitoring of progress, development of routine reports, plus risk and issue management.

Steering group

82. The cross-cutting steering group is already in place. It is overseeing the planning of transformation activities and developing strategic direction for discussion with SMT and the NICE Board. It will have close links with the detailed work of the expert groups, to ensure that their objectives are aligned

and address the overall strategy. For example, content transformation goals also need to relate to work taking place in data management, and process and methods.

Expert groups

83. Expert groups will be established across the five strategic areas of the ambition framework: content; process and methods; data management; people; and technology. The content and data expert groups have already started to meet to drive forward the work required in these areas. Other expert groups will be convened from October 2019.

84. Each group will be relatively small, led by a Director, with appropriate membership from key individuals across NICE. They may also have external expertise if required in areas where we don't have the required knowledge internally. Groups will agree action plans in their areas, prioritise and set objectives for the related task forces, and establish and run governance processes to oversee progress. They will report to the steering group and SMT, as required.

85. It is anticipated that the expert groups will become a permanent feature of the future organisation, with responsibility for ensuring our approach and plans in the relevant area remain up to date, and that we continue to change in response to the dynamic environment in which we operate.

Taskforces

86. Taskforces will take forward the detailed work required for the transformation priorities, as set out by the Expert Groups. They will initially focus on agreed priorities relating to content transformation and operational productivity, and more than one is likely to be needed in each of these areas.

87. They will be made up of dedicated teams of staff, brought together from across existing NICE programmes. New roles will be created where required to bring in new expertise and skills. Protecting these teams from the pressures of business as usual activity will be vital to the success of the programme.

Delivery group

88. Transformation activity in the taskforces will be overseen by an operational delivery group to ensure alignment between areas of work, and to respond to day to day issues. It will provide reports on progress to the Expert Groups. The group will meet regularly to provide the agility required for assurance.

Building in external challenge

89. NICE has a strong, evidence-based culture and, although this has driven our past success, it has the potential to limit our future transformation if we take a fixed approach to the challenges we face.

90. We therefore plan to have a “red team” as part of the transformation structure. This will be an independent group that challenges the organisation to improve its effectiveness by assuming the role of a critical friend. It is particularly effective in organisations with strong cultures and fixed ways of approaching problems.

91. To bring this approach into NICE Connect we will engage a consultancy to provide constructive challenge at key points as the transformation progresses. The resources required for this activity are included in the overall costings for the transformation.

Communication and engagement during the transformation

Internal communications

92. Communication and engagement with our staff is key to taking forward the NICE Connect transformation. We have used a variety of mechanisms over the course of the exploratory phase to keep staff informed of our plans and engage them in a conversation to surface their ideas and help them understand what the transformation might mean for them. Engagement activity has included:

    - establishing and maintaining a NICE space page on NICE Connect
    - using the staff weekly newsletter, blogs, monthly all staff meetings, and the quarterly NICE Times newsletter to communicate key messages and updates
    - discussing and iterating the vision and ambition for NICE Connect with Associate and Programme Directors in interactive meetings
    - running interactive lunch and learn sessions to engage with staff in more detail and hear their views.

93. Through these activities we have created a sense of urgency regarding the need to transform, and the engagement sessions have helped us to understand what NICE staff view as priorities. We know from our recent staff survey that there is more that we can do, and engagement activities will continue as the transformation unfolds. We are committed to finding new mechanisms to bring staff with us on the journey.

External engagement

94. A vital part of our external engagement activity is to maintain an open dialogue with our funders to ensure they understand the scale of the transformation ahead and keep them abreast of our plans. In addition to discussing NICE Connect as part of established meetings, we have set up an external engagement group to bring together our funders and other Arm’s Length Bodies to enable us to discuss the transformation from a whole systems perspective. The group met in February and April 2019 and are scheduled to meet again in late September.

95. In this early phase of NICE Connect we have not undertaken significant external engagement activity with our stakeholders as we recognise that it will take a number of years to deliver the vision. A key note presentation at the NICE Conference in May reflected on the drivers for change and our vision, and a dedicated page on the NICE website gives a high level introduction to the programme.

96. We will continue to review our engagement strategy with our stakeholders as the transformation progresses. A video is currently in development that will highlight the drivers for change, and the vision and ambition for our future organisation and product. This will provide a valuable resource in future as we engage with our stakeholders and staff on our aims and approach.

Resource requirements

97. NICE Connect will require a multi-million pound investment over a 3-5 year period. Whilst the financial implications in 2019-20 can be reasonably reliably estimated (£1.4m), the requirements for the subsequent years are less certain. However, it is clear that additional funding will be required to ensure that the transformation can go ahead with minimal impact on NICE's outputs. Several options are being explored to support this work, but no definite funding commitments have yet been made.

98. If additional funding is not made available, we will need to stop other NICE activity to free up resources. After several years of significant reduction in grant in aid funding, NICE does not have the resources available to deliver the full range of immediate priorities while maintaining outputs. The detail will be discussed with the Board in October and will then need to be confirmed with our funders.

99. As the transformation progresses, it is possible that further or different resource requirements will be identified, and the Board will be kept informed of any material additional requirements or changes to the planned expenditure.

Risks

100. The NICE Connect transformation programme is significant, and generates risks that have been captured on the NICE risk register as follows, and are being actively managed:

- The NICE Connect project does not progress as planned due to insufficient resources, lack of clarity on the future model, failure to gain any necessary external approvals, or lack of enabling digital technology.
- The transformation associated with the NICE Connect project raises concerns for staff, leading to a decrease in performance and an increase in staff turnover.
- The outputs implemented by the NICE Connect project do not successfully deliver the anticipated tangible improvements from users' perspectives.
- The effort, complexity, and cultural & organisational change impact resulting from the new approaches results in a drop-in performance of NICE's ongoing business as usual activity through the change period, impacting on the quality and quantity of delivery of guidelines and advice

Board action required and next steps

101. The Board is asked to review the report and:

- approve the purpose of the transformation and structure of the programme
- note the plan to explore the funding and management of the programme in more detail at the October Board strategy meeting.

September 2019

Appendix 1

Investment activities to date to support operational productivity at NICE

- Development of NICE docs, a secure document share tool (live since 2012)
- Creation of bespoke publishing tools to standardise and streamline publishing processes (egap converter 2011; NICE Publications 2013; NICE In Dev 2013)
- Development of a tool to automatically source freely available bibliographic content (live since 2016), freeing up analyst and information specialist time
- Adoption of EPPI-reviewer as a bespoke tool to support systematic reviewing (live since 2016), and developing this tool further to support our specific needs (in progress)
- Development of a comment collection tool to improve the user experience of NICE consultations and reduce the administrative burden on staff (available to NICE teams from late 2018 with continued development in 2019)
- Implementation of a new identity management system to ensure appropriate access to NICE's digital services, improve efficiency, and improve the user experience (in progress)
- Discovery work that will lead to the replacement of our systems for stakeholder management and planning, improving user experience and providing significant opportunities for efficiency
- Exploration of ways to create and manage structured content to reduce operational inefficiency, and increase the flexibility and accessibility of our content through personalisation and multi-channel delivery
- Development work with the Office for National Statistics DataScience Campus to create a machine learning tool that will link related NICE recommendations.

Appendix 2

NICE Content strategy review discovery report

NICE is highly respected as a provider of high-quality clinical guidance, but knows that its current content management practices are both inefficient and inadequate to meeting its users' information needs.

Content transformation is therefore a key enabler for meeting NICE's strategic goals, and a necessary building block to allow NICE to operate effectively in a changing environment.

Current content management issues at NICE include:

- working in a siloed way
- not putting users' needs explicitly at the centre of the entire content lifecycle, including commissioning and drafting as well as publication
- a lack of essential content management capabilities including content strategy, design principles and information architecture
- an absence of enterprise content tools.

Mekon recommends that NICE should:

- Put users' needs at the heart of the entire content lifecycle, including topic selection and commissioning stages as well as drafting and publication. A good content strategy is not just concerned with making the end publishing stages more efficient; instead, it creates an end-to-end process to ensure that you can efficiently deliver content which your users find valuable and usable.
- Move to "intelligent content", i.e. content that is modular, structured, semantic, and granular.
- Invest in your content management capabilities, using the capabilities model we outline below to ensure you address all enablers.
- Invest in enterprise tools including one or more structured authoring tools, a Component Content Management System (CCMS), and a taxonomy management tool.
- Review your approach to user research and the actionable insights it generates.

- Re-consider your organisation design and workflows in order to ensure you can work in a joined-up way across the organisation.

NICE should structure the content transformation as an extended programme, building on the exploratory work that NICE Connect is already undertaking. The programme should explicitly be set up to deliver intelligent content and all the enablers that are required to work effectively with content. In our experience, you can expect the programme to take 2-3 years and cost in the low millions. NICE may wish to position the content transformation as part of a wider digital transformation programme, which includes re-defining products and use of data.

This report includes more information about each of these recommendations, as well as supporting information about content management and transformation activities. We have also included case studies from organizations who have undergone a similar transformation in order to illustrate the transformation journey.

Mekon 2019

National Institute for Health and Care Excellence

Staff survey 2019: report and action plan

This report gives details of the results of NICE's 2019 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

Business Planning and Resources Director

September 2019

Introduction

1. The 2019 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 2019 survey. An update on the progress against last year's action plan (appendix B) and proposed action plan for the coming year is also included (appendix C).

Background

2. NICE commissioned Survey Solutions to undertake our fourteenth annual staff survey. Overall, the findings paint a positive picture of the culture and working environment at NICE.

3. Colleagues in HR, Facilities, Communications, UNISON and the Health and Wellbeing Strategy Group developed an action plan for 2019-20 (appendix C). The plan targets our lowest-scoring areas and is intended to ensure the continuous improvement of NICE as a place to work.

4. The 2018-19 action plan has been updated to show the activities and progress against last year's action plan.

5. This paper highlights key themes and achievements of this year's report, and proposes how the staff survey feedback will be used in a range of ways.

2019 staff survey results

6. NICE's employee engagement index was 79/100, which is measured on five questions:

    - I am proud to work for NICE
    - I would recommend NICE as an employer
    - I am committed to doing my very best for NICE
    - I intend to be working for NICE in 12 months' time
    - Overall, I am satisfied working for NICE

7. When ranked against Survey Solutions' benchmark database, NICE has the 9th highest engagement index score, out of 62 organisations. Survey Solutions' database consist of a range of different public and private sector organisations.

8. Most questions record excellent to very good scores; some areas present opportunities for improvement. Of the 49 questions which asked for staff levels of agreement or satisfaction on a 5-point Likert scale, the responses were:

    - 21 questions with excellent scores: mean score is 4.00 or above
    - 10 questions with very good scores: mean score is 3.80 - 3.99
    - 11 questions with average scores: mean score is 3.50 - 3.79
    - 5 questions with lukewarm scores: mean score is 3.00-3.49
    - 1 question scoring 2.99 or below: more negative than positive responses

9. Most results are broadly unchanged since 2018, with only a handful of results showing significant differences:

Higher scoring questions than 2018 survey:

	2019	2018	% Change
Q8: I feel that the future of my job is secure	3.5	3.3	5.8
Q4: NICE is committed to being environmentally and socially responsible	4.0	3.8	4.9
Q65: NICE takes effective action if staff are harassed and/or bullied for any reason	3.4	3.3	4.3
Q34: The salary and benefits I receive	3.9	3.7	4.1
Q20: I feel I am supported through emotionally demanding times	3.9	3.8	2.1

Lower scoring questions than 2018 survey:

	2019	2018	% Change
Q45: My manager can be counted on to help me with a difficult task at work	4.1	4.2	-3.4
Q49: My manager makes sure I am clear about what my job is	3.9	4.0	-3.0
Q2: I am familiar with NICE's business plan	3.6	3.7	-2.7
Q26: When there are important changes, they are communicated clearly	3.5	3.6	-2.1
Q24: I have the right equipment to do my job	4.1	4.1	-1.7

External benchmarking

10. 22 results can be directly compared with Survey Solutions' all sectors database. 11 of these results are at least 5% above the benchmark (shown below).

	NICE's mean score	Benchmark mean score	Difference
Q6: I would recommend NICE as an employer	4.3	3.9	0.4
Q24: I have the right equipment to do my job	4.1	3.7	0.4
Q50: My manager encourages staff to suggest new ideas for improving services	4.1	3.7	0.4
Q5: I am proud to work for NICE	4.4	4.0	0.4
Q3: I am confident in the way NICE is led	4.0	3.7	0.3
Q2: I have a comfortable work space	4.1	3.7	0.4
Q11: Overall, I am satisfied working for NICE	4.1	3.9	0.2
Q46: My manager gives me clear feedback on my work	3.9	3.6	0.3
Q13: My job allows me to have an adequate work-life balance	4.0	3.8	0.2
Q19: There is someone at NICE who I feel confident in approaching if I am worried or concerned about anything	4.1	3.9	0.2
Q7: I am committed to doing my very best for NICE	4.6	4.4	0.2

11. Two questions score below average against the benchmark (shown below).

	NICE's mean score	Benchmark mean score	Difference
Q29: I have clear, planned goals and objectives for my job	3.9	4.2	-0.3
Q2: I am familiar with NICE's business plan	3.6	3.9	-0.3

Free text comments

12. Staff had the opportunity to provide free text comments saying what they enjoyed most about working at NICE, and suggesting an important change which would help improve satisfaction with working for NICE.

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

Main themes: flexibility, work-life balance, working for a world-class, reputable organisation which makes a difference to healthcare, the people

*"The work that my team produces is renowned around the world as the best in its field. My team is hard-working and dedicated and this **hard work and dedication** is what maintains this **reputation for excellence** in our outputs.."*

*"My **manager is super**, the best that one can have. I love the homeworking/**flexible working**, and generally the **NICE colleagues**.."*

"Knowing that the work is meaningful and has a direct impact on people's health and care services."

"Being a member of an organisation whose work is really important for delivering effective healthcare."

*"It's hard to just name one factor, I like being a part of an **organisation that has a direct impact on healthcare**. I like working for an organisation that **treats its employees well**, you don't just feel like a number here.."*

*"NICE is an **amazingly supportive** place to work. The nature of my job at NICE is very stressful and requires period where overtime is necessary and I am supported to deliver"*

*"Benefits of **being able to work from home**, **flexibility** with doctor appointments, **work-life balance, decent salary** although is higher in private sector."*

NB. Comments have been lightly edited for grammar and spelling
481 responses given in total

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

Main themes: career development/progression, communication, management, training, workload

*"More **opportunities to progress** within the current role and get the appropriate recognition and pay for the role. At the moment, it seems that to progress, you need to get a promotion to the next level and not everyone would like to have line management responsibilities etc."*

*"Within my team, the workload can be extremely high, and a lot of demands can be placed on our time. This can sometimes lead to a **stressful working environment**. It would be helpful if more consideration could be given to the high workload that is required for the role."*

*"**Clear, honest communication** being transmitted to teams about their future roles in the organisation. Hard to work positively with so much uncertainty and no clear communication coming through from senior managers."*

*"It is possible to be proud of NICE as an organisation and to be doing your best, while also feeling disengaged and frustrated to day to day ability to do job. NICE is **too siloed, too hierarchical** and some areas of expertise are not recognised in the same way as others.*

*"**Involving staff** rather than just trade union representatives on proposals to policy changes. As a line manager I was surprised to hear last year that the sickness absence policy had changed and a lot more responsibility was being put on the manager. I do not disagree with this approach, and as a line manager I am comfortable with this. However. I am uncomfortable with the ambiguity and inconsistency in approach by line managers this causes. (…)"*

NB. Comments have been lightly edited for grammar and spelling
449 responses given in total

Next steps

13. The HR and Comms teams will work together to promote the staff survey results and organisation-wide action plan.

14. Directorate-level breakdowns will be shared with senior leaders, so that areas of good practice can be highlighted, and local action plans can be developed to address any areas of concern.

Conclusion

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

September 2019

Appendix A – NICE staff survey results 2019

Staff Survey 2019
Survey Results

June 2019

1. Introduction

1.1 Background

NICE commissioned Survey Solutions to conduct their 2019 Staff Survey. The survey was live between Tuesday 7th May and Tuesday 28th May 2019.

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.

The project was carried out in compliance with, and to the Quality Standards required under:

- The Data Protection Act and GDPR
- ISO 9001:2015 (for Quality Management Systems)
- The MRS (Market Research Society) Code of Conduct
- The MRS Company Partner Quality Commitment

1.2 Methodology

The questionnaire was based on the 2018 NICE staff survey and included 73 questions (62 single answer, 5 multi option and 6 open comment questions). There were also 19 classification (demographic) questions. The questions were grouped under the following 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
- About Me

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. 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 551 responses were received, representing an **85%** response rate overall, which is an excellent return and ensures that the findings are representative of the workforce as a whole.

The responses breakdown by Directorate and Location are as follows:

	Total number of respondents	Total number of respondents	%
Directorate:			
Business, Planning and Resources Directorate	58	53	91%
Centre for Guidelines	103	83	81%
Centre for Health Technology Evaluation	190	158	83%
Communications Directorate	65	62	95%
Evidence Resources	90	79	88%
Health and Social Care Directorate	145	116	80%
Location:			
London Office	140	108	77%
Manchester Office	464	401	86%
Home-based	47	42	89%
Overall response	**651**	**551**	**85%**

The highest response rate is noted amongst home-based staff, with 89% completions, followed by Manchester staff. The response rate for the London office is 77%, which is lower than the rest of the organisation but higher than that achieved in 2018 (66%).

1.3 Reporting Guidelines

Respondent Confidentiality

Throughout all online and PDF reporting provided to NICE, detailed results are shown only for individual questions which have at least 8 respondents, in order to ensure respondent confidentiality. Mean scores are shown for groups with at least 5, but less than 8 respondents. Verbatim comments are shown for employee groups where there are least 20 employees.

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 with ratings 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).

Comparisons to Historical Scores

The survey results tables in this report provide a comparison with the 2018 results, shown as a literal positive or negative difference next to the mean score. Green or red arrows highlight results that are statistically significant differences compared to the 2018 survey, denoting scores outside of the 95% confidence interval.

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% or 99%. Similarly, the mean scores are rounded to 1 decimal places for display purposes although within the database they are calculated to 4 decimal places.

Colour Coding

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 at the end of each question results bar to reflect the mean score result, according to the above thresholds.

It is important to note that there is no colour coding assigned to 'Yes/No' questions, or questions that do not typically use the 'Agree' scale. The colour coding for negatively phrased questions is reversed, so that the 'Agree' options are shown in red.

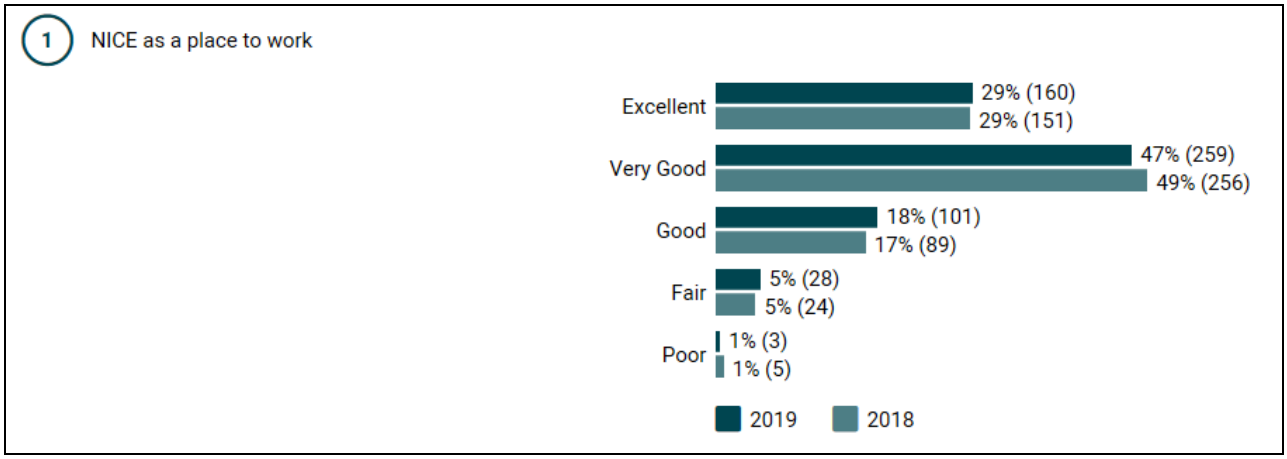
Respondent Base

The number of respondents who responded to a question is shown in the 'Response' 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.

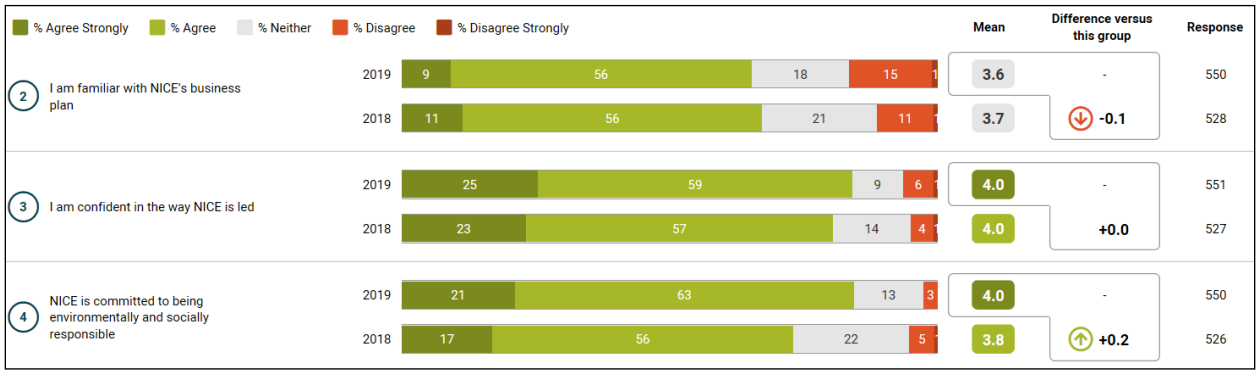
2. Survey Questions Results

2.1. Your Organisation



You can download the data set for this chart

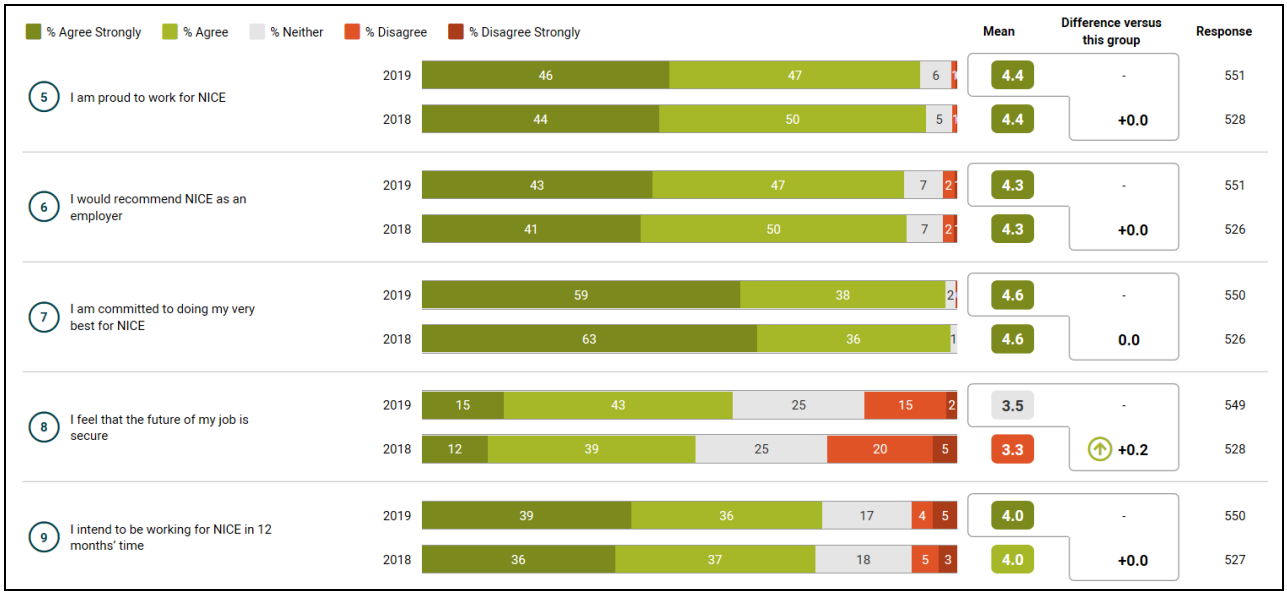
The perception of NICE as a place to work has not changed significantly since the 2018 survey. The proportion of respondents who rated NICE positively this year (by selecting 'Excellent', 'Very Good' and 'Good') is 94% compared to 95% in 2018. Only 1% of the respondents rated NICE as poor (a total of three respondents, compared to five in 2018).



You can download the data set for this chart

Just under two thirds of respondents agree that they are familiar with NICE's business plan (Q2), a lower proportion than in 2018. The level of confidence in the way that NICE is led (Q3), is virtually unchanged from 2018, with a higher proportion of positive responses offset by a higher number of those in disagreement. NICE's commitment to being environmentally and socially

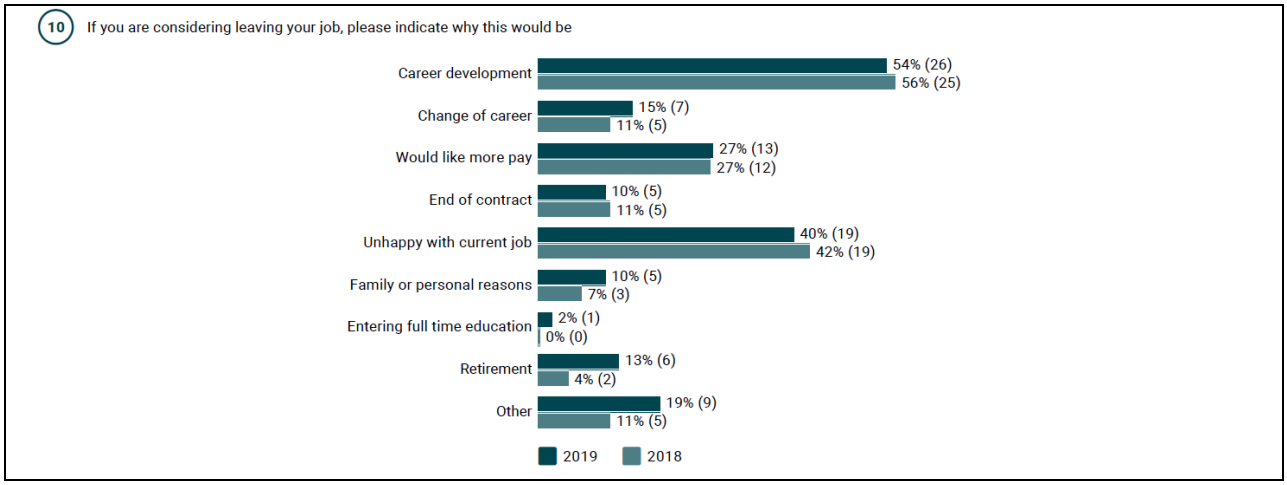
responsible (Q4), is recognised by 84% of respondents, compared with 73% in 2018, a significant increase of 0.2.



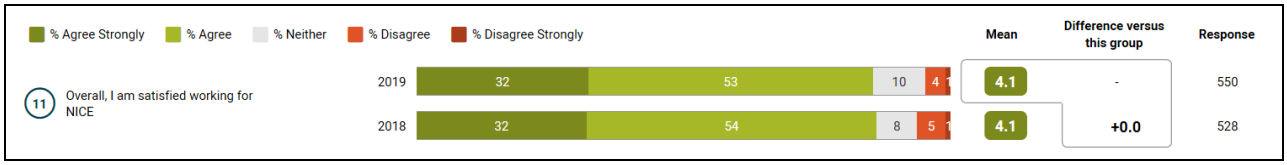
You can [download the data set for this chart]

The results to a range of questions about engagement, namely those about pride (Q5), advocacy (Q6), discretionary effort (Q7) and commitment (Q9), are virtually unchanged since 2018, apart from Q8 - 'I feel that the future of my job is secure', which shows a significant improvement compared to the last survey.

Respondents who answered negatively to Q9 'I intend to be working for NICE in 12 months' time' were asked to state the reasons why. The main reasons cited for considering leaving amongst the 49 respondents who responded negatively to Q9, were career development (54%) followed by being unhappy with their current job (40%). This response pattern is similar to the 2018 survey, although this year's survey notes a higher proportion of respondents thinking of leaving for a change of career, family/personal reasons or due to retirement and other reasons.



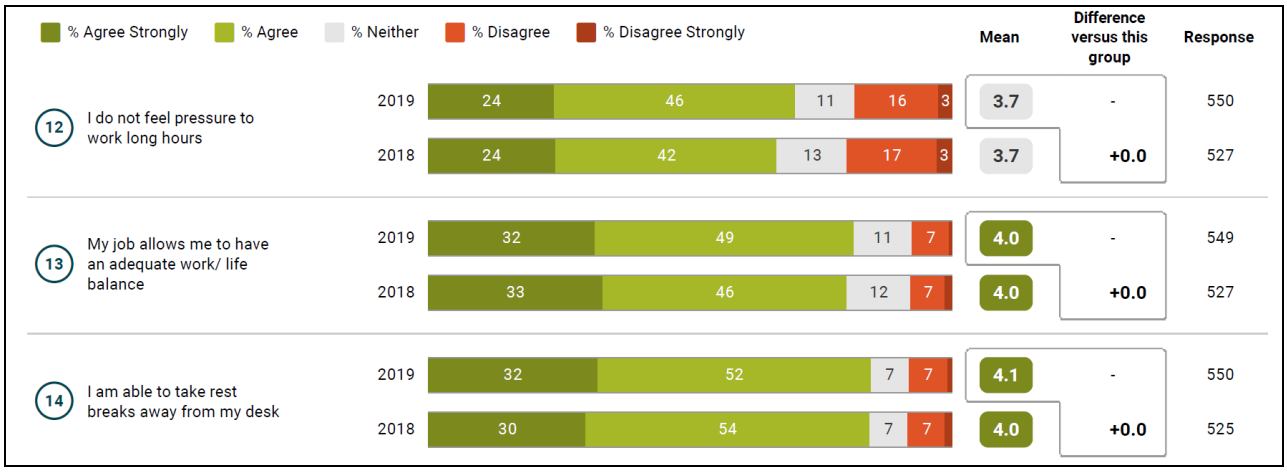
You can download the data set for this chart



You can download the data set for this chart

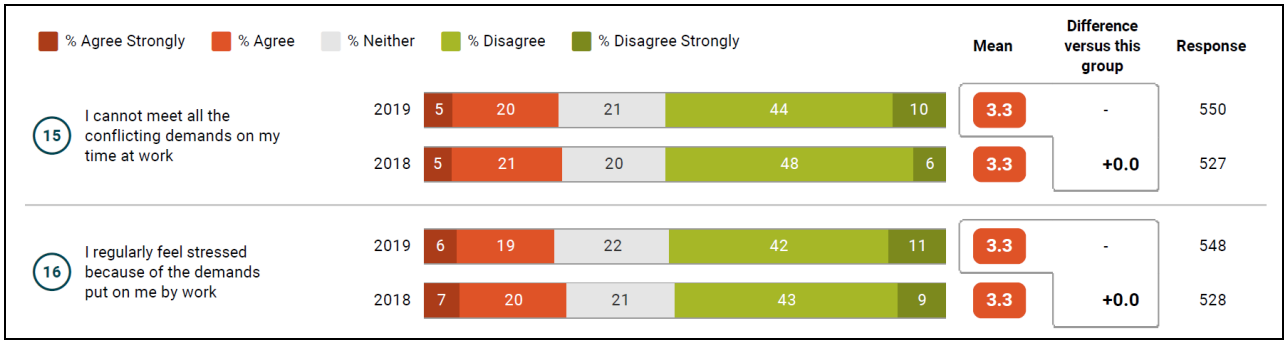
Agreement levels for overall satisfaction (Q11) are very high, with 85% positive. The results are broadly similar to those recorded in the last survey, with slightly fewer negative and positive responses but a few more neutral answers.

2.2 Work-life Balance and Wellbeing



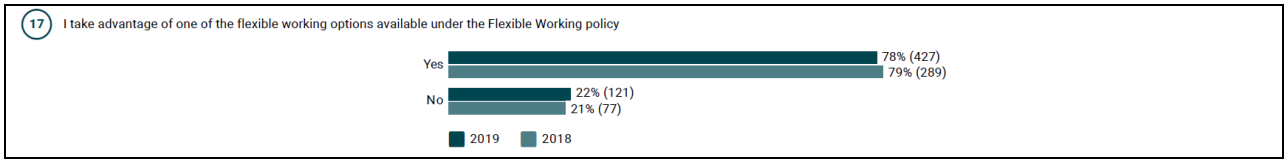
You can download the data set for this chart

The responses to a series of questions about work-life balance and wellbeing show no significant changes compared to the previous survey. Seven in 10 respondents say they do not feel pressure to work long hours (Q12), with nearly one fifth in disagreement. However, over four fifths agree that their job allows them to have an adequate work/life balance (Q13) and that they are able to take rest breaks away from their desk (Q14).



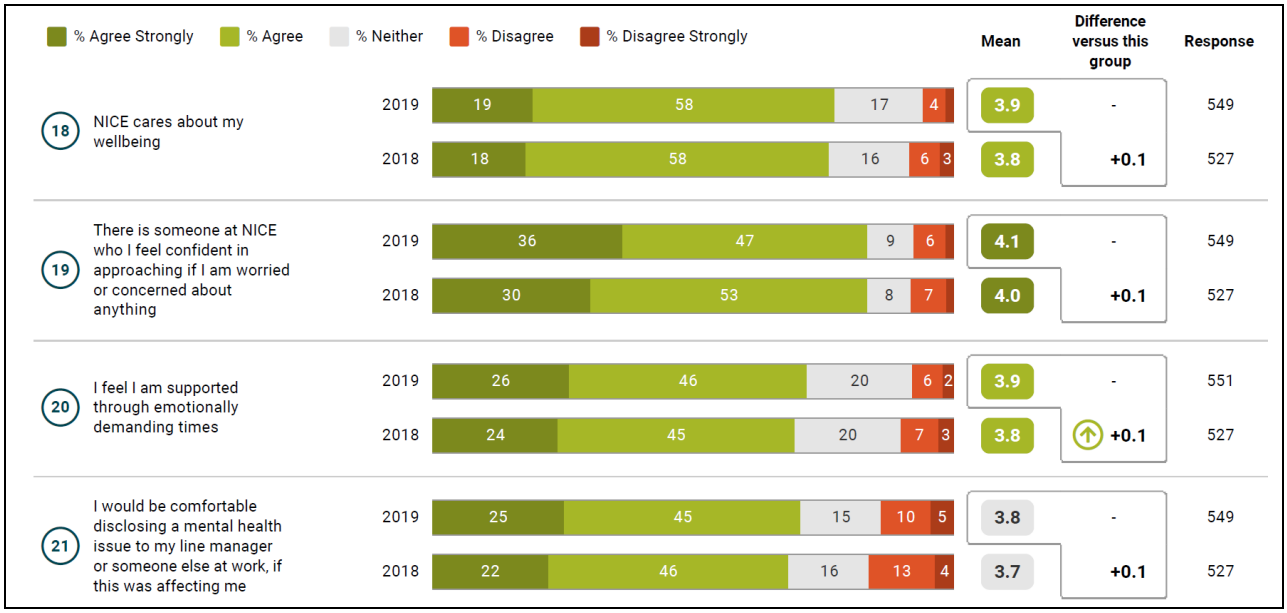
You can download the data set for this chart

The survey also included two negatively phrased questions (Q15 and Q16) around the theme of stress due to work demands; these results have not changed significantly since the previous survey, although there is a slight decrease in those who say they cannot meet all the conflict demands on their time (Q15) and that they regularly feel stressed (Q16).



You can download the data set for this chart

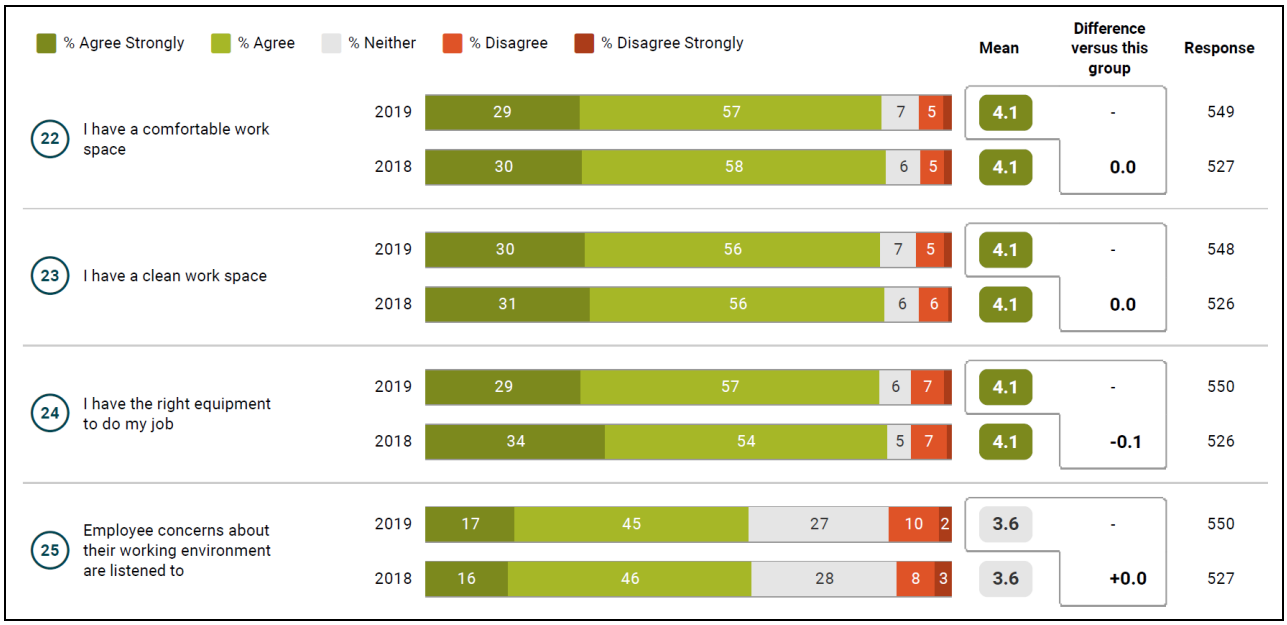
When asked about flexible working, nearly four fifths of the respondents say they take advantage of one of the flexible working options, just under the proportion recorded in 2018.



You can download the data set for this chart

The above questions were new to the 2018 survey, and this year the results show slightly higher agreement levels amongst respondents for NICE caring about their wellbeing (Q18) and there being someone at NICE they would feel confident in approaching if worried or concerned about anything (Q19). Fewer would feel comfortable disclosing a mental health issue to a line manager or someone else at work (Q21), but this result is slightly up since the last survey, as is feeling supported through emotionally demanding times (Q19), which shows a significant increase since 2018.

2.3 Health and Safety

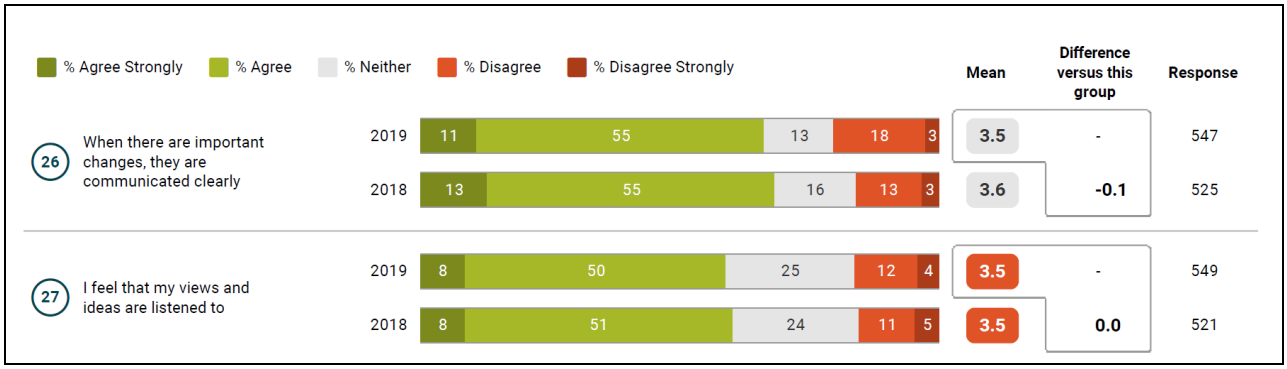


You can download the data set for this chart

Opinions about health and safety and the working environment have remained at similar levels to the last survey. Well over four fifths agree that they have a comfortable (Q22) and a clean (Q23) work space but slightly fewer say that they have the right equipment to do their job (Q24) compared to the last survey. As in 2018, feeling that their concerns about their working environment are listened to records the lowest score in this section, with 62% in agreement.

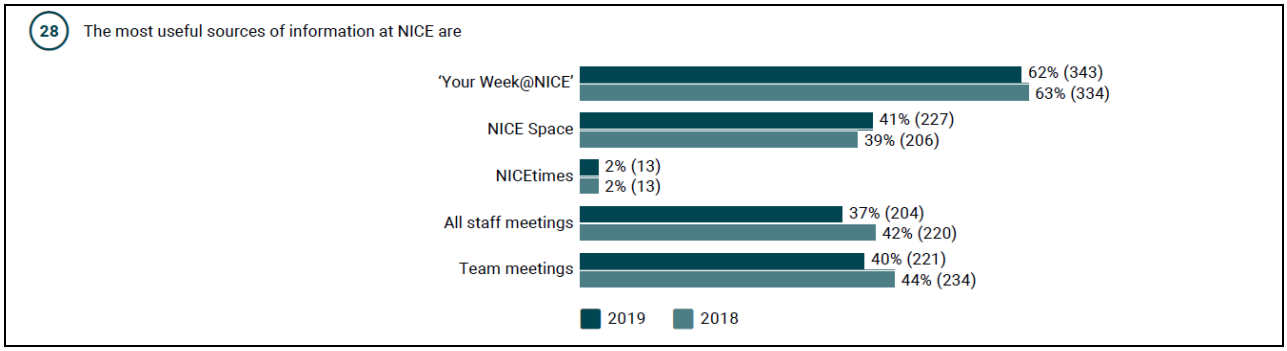
2.4 Communications

The survey found that agreement levels for clear communications around important changes (Q26) have declined slightly since the 2018 survey, with higher proportions of negative responses. Feeling that their views and ideas are listened to (Q27) sees just under three fifths in agreement and has remained broadly unchanged since the last survey.



You can download the data set for this chart

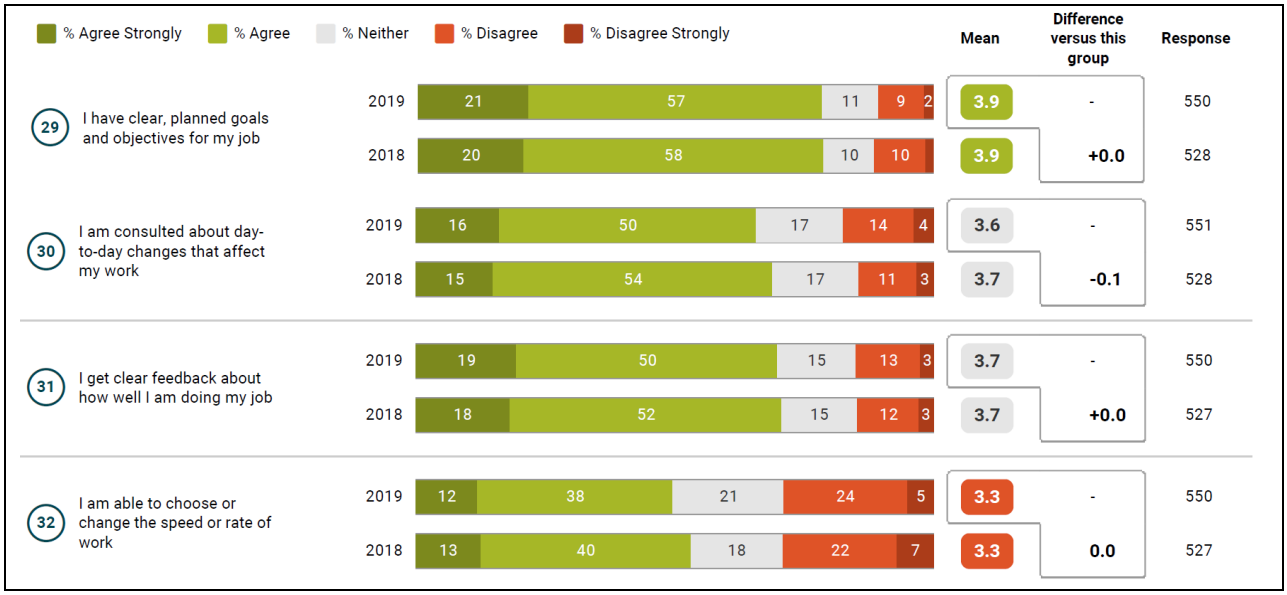
The survey results for sources of information (Q28) show that "Your Week@NICE" is found to be the most useful, followed at a distance by NICE Space, team meetings and all staff meetings; both meeting options, however, received lower scores than in 2018.



You can download the data set for this chart

2.5 Your Job

Most respondents are positive about having clear, planned goals and objectives for their jobs (Q29), a result that has not changed significantly since 2018. The results for being consulted about changes that affect their work (Q30) and getting clear feedback on how well they do their work (Q31) show a slight, but not significant, decline in agreement levels since the previous survey. Being able to choose or change the speed or rate of work (Q32) is the lowest scoring in this set of questions, with weaker agreement levels offset by higher neutral responses, thus leaving the overall score unchanged since 2018.



You can download the data set for this chart

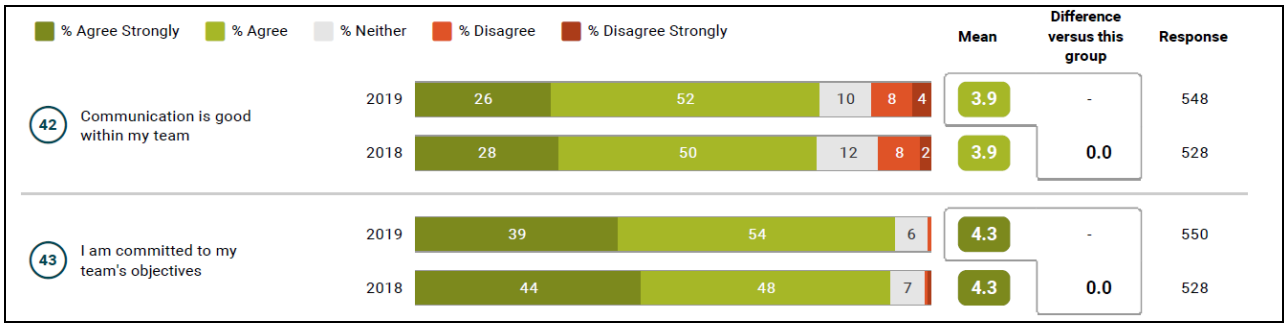
All respondents were asked to state their satisfaction level with a number of areas relating to their jobs. As in 2018, the highest satisfaction scores are seen for the support received from work colleagues (Q36) and immediate manager (Q35). Most respondents are satisfied with the amount of responsibility that they are given (Q37) and the opportunities they have to use their skills (Q38), with no significant changes noted since the 2018 survey. The majority of those who took part in the survey are satisfied with the recognition they get for good work (Q33), a finding largely unchanged since last year. Fewer respondents feel valued for the extent to which NICE values their work (Q39), but positive responses are up from 60% to 63% this year.

Satisfaction levels with salary and benefits (Q34) have increased significantly since 2018, with positive responses nearing 80%.

You can download the data set for this chart

As in the 2018 survey, the lowest scores in the "My Job" section are for career development, with just over one third of respondents satisfied with the career framework (Q40) and the career development opportunities (Q41) – neither results have changed significantly since 2018.

2.6 Your Team



You can download the data set for this chart

Over three quarters of respondents agree that communication is good within their team (Q42), with around one in ten remaining neutral, or disagreeing with this statement. The level of commitment to the team's objectives (Q43) sees over nine in ten in agreement. Both results in this section are broadly unchanged compared to the previous survey.

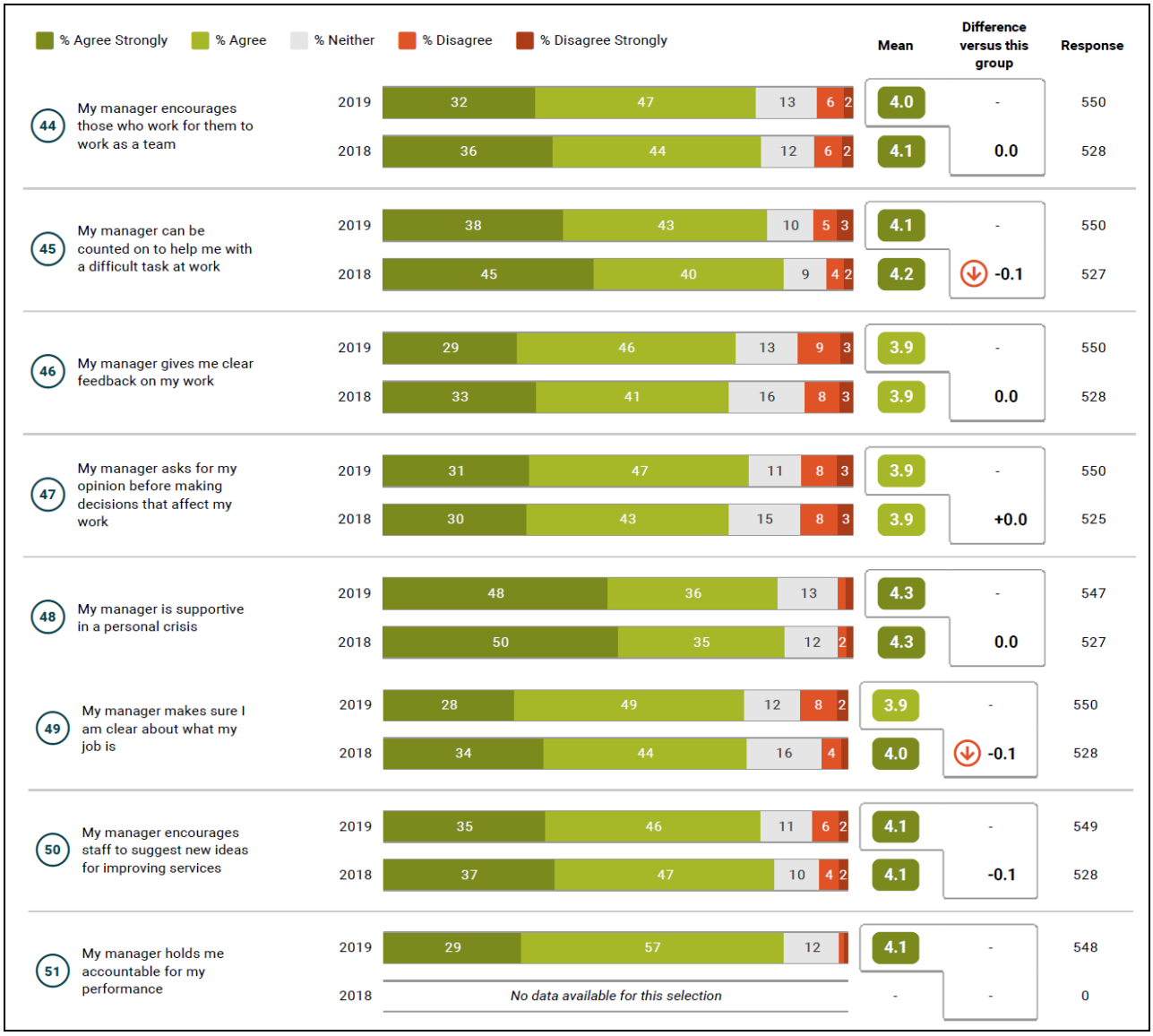
2.7 Management and Leadership

As can be seen from the table overleaf, views of managers remain very positive overall, with high agreement levels in all the areas surveyed. As in the 2018 survey, the most positive views are seen for managers being supportive in a personal crisis (Q48).

Agreement levels for encouraging their direct reports to work as a team (Q44), for being counted on to help with a difficult task at work (Q45), making sure what their job is (Q49) and encouraging staff to suggest ideas for improving services (Q50) remain at good levels, although they have declined since the 2018 survey.

As in 2018, the results for managers giving clear feedback on their work (Q46) and asking for their opinion before making decisions that affect their work (Q47) are good, but not excellent, but show a slight increase in agreement levels.

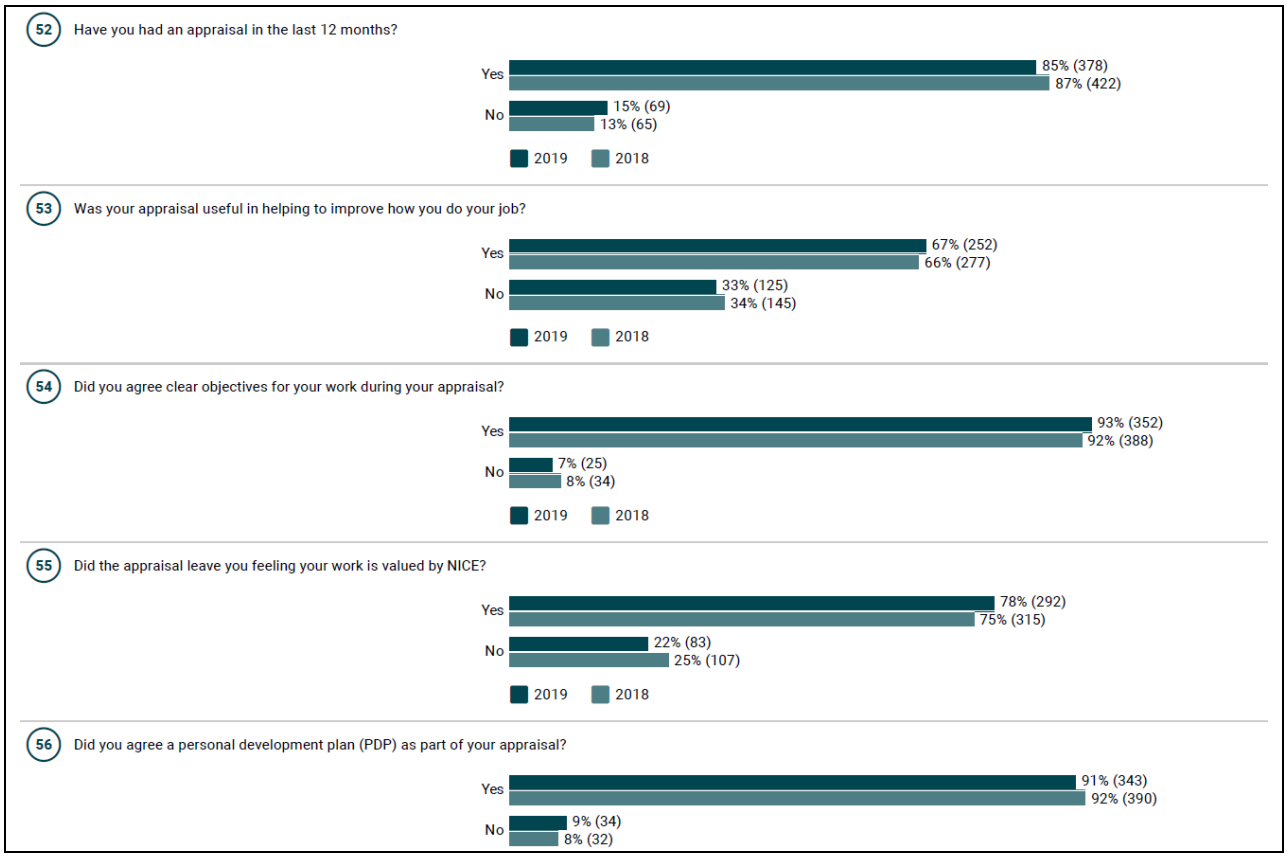
A new question added to the survey this year on the topic of managers holding staff accountable for their performance (Q51), sees agreement levels of 86%, with very minor levels of disagreement.



You can download the data set for this chart

2.8 Appraisal

The survey shows that 85% of respondents that were asked this question have had an appraisal in the last twelve months (Q52), compared with 87% in the 2018 survey.



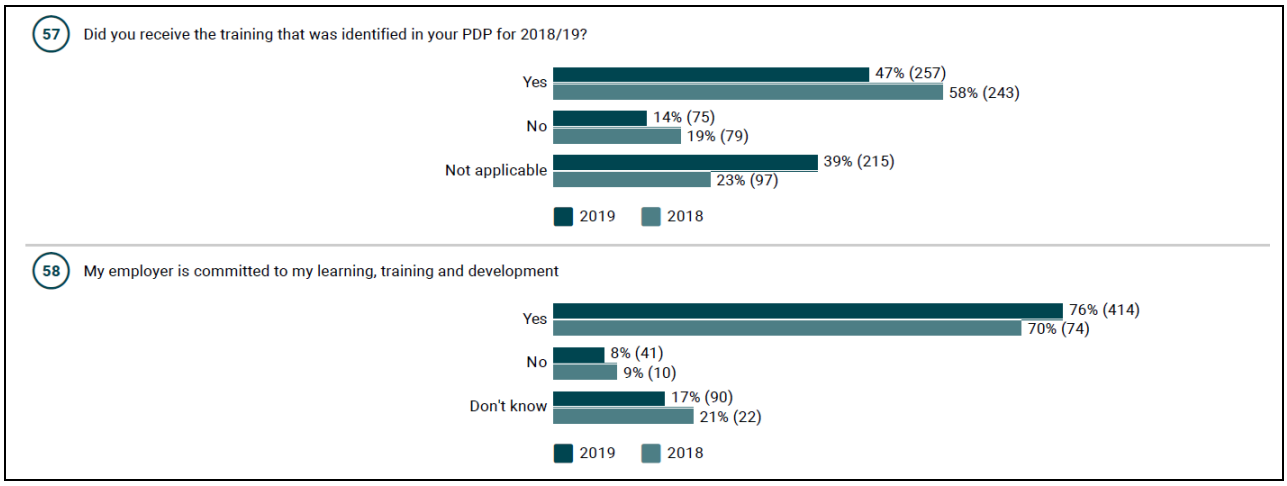
Q52: not asked of staff with less than 1 year service, staff on long-term sick leave, fixed term temp or bank staff.
Q53-Q56: only asked of staff who answered 'Yes' at Q52

You can download the data set for this chart

Over two thirds of those who have had an appraisal agreed that it was useful in helping to improve how they do their job (Q53), and far more (78%) said that the appraisal left them feeling their work is valued (Q55) – both results are slightly higher compared to the 2018 survey. About nine in ten respondents said they had agreed clear objectives for their work (Q54) and a PDP (Q56) as part of their appraisal, broadly in line with the 2018 results.

2.9 Training, Learning and Development

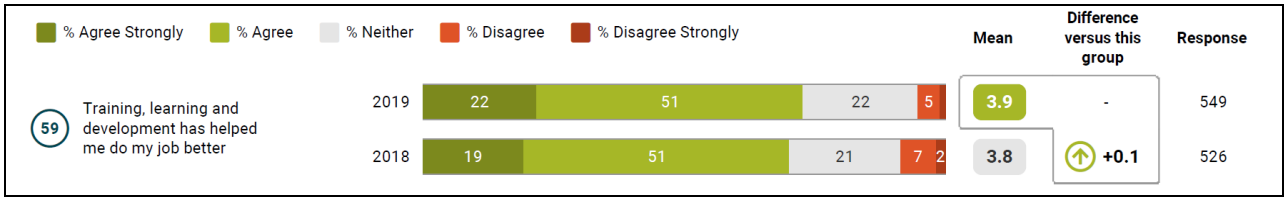
Overall, just under half of the respondents said they received the training identified in their PDP for 2018/19 (Q57), equivalent to 75% of those who had agreed a PDP as part of their appraisal.



You can download the data set for this chart

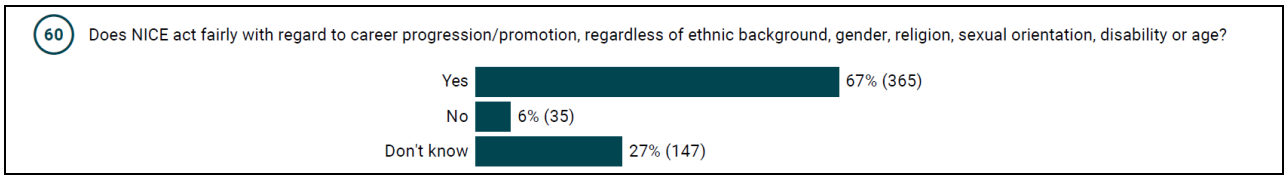
Over three quarters of respondents agreed that NICE was committed to their learning, training and development (Q58), with 17% unable to comment and 8% disagreeing. It should be noted that in 2018, this question was asked only of respondents who did not undergo an appraisal.

When asked whether training, learning and development had helped them to do their job better (Q59), 73% of respondents agreed, a significant increase since the 2018 survey.



You can download the data set for this chart

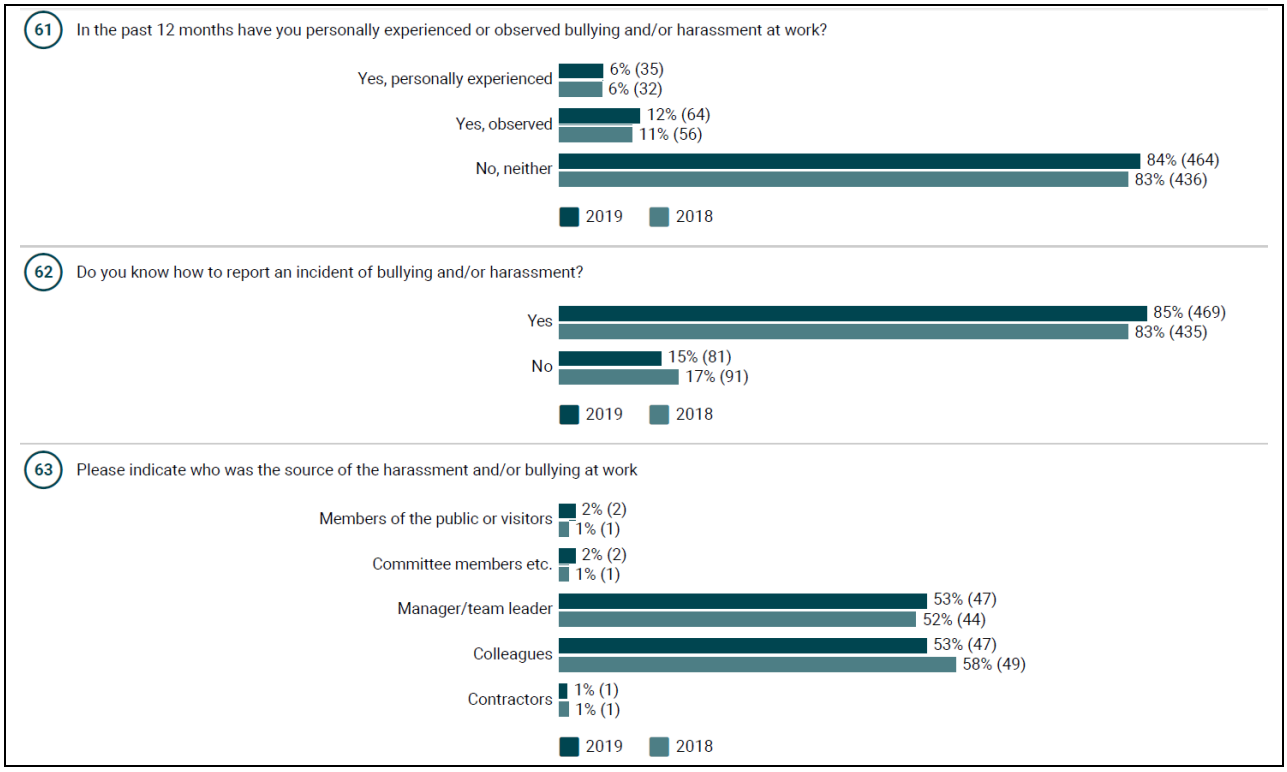
2.10 Equal Opportunities and Dignity at Work



You can download the data set for this chart

A new question exploring whether NICE was seen to be acting fairly with regard to career progression/promotion, regardless of ethnic background, gender, religion, sexual orientation, disability or age (Q60) was added to the survey this year. The results show that 67% perceive NICE to be acting fairly in this regard, with 6% in disagreement. A considerable proportion (27%) felt unable to comment.

As in 2018, all respondents were asked whether they had personally experienced or observed bullying and/or harassment at work (Q61). The results are broadly comparable to those recorded in 2018, with a slightly higher proportion (84%) saying they have not in this year's survey. The proportion of those who said they had personally experienced bullying and harassment is stable at 6%, but a larger group of respondents (12% compared to 11% in 2018) said they have observed bullying and/or harassment. When asked whether they knew how to report an incident of bullying and/or harassment (Q62), 85% of the respondents answered positively, compared to 83% in 2018.

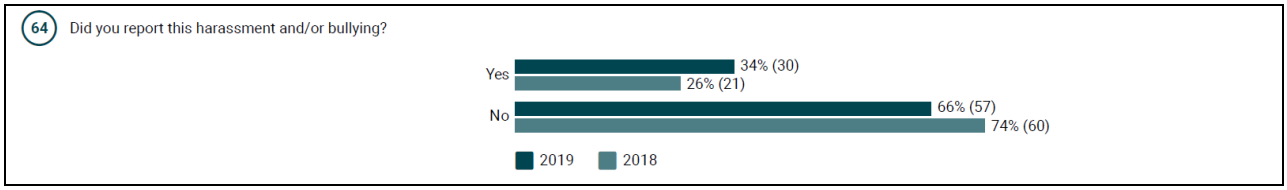


Q63: only asked of staff who personally experienced or observed bullying and/or harassment at work

You can download the data set for this chart

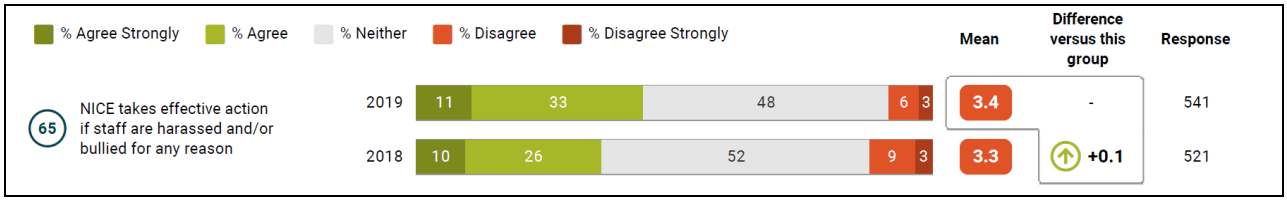
As in 2018, the survey results show the main sources of the harassment and/or bulling at work to be either managers/team leaders or colleagues (Q63).

Those respondents who said they had experienced or observed bullying were then asked whether they reported it – the results show that 34% did, compared to 26% in 2018, a significant increase.



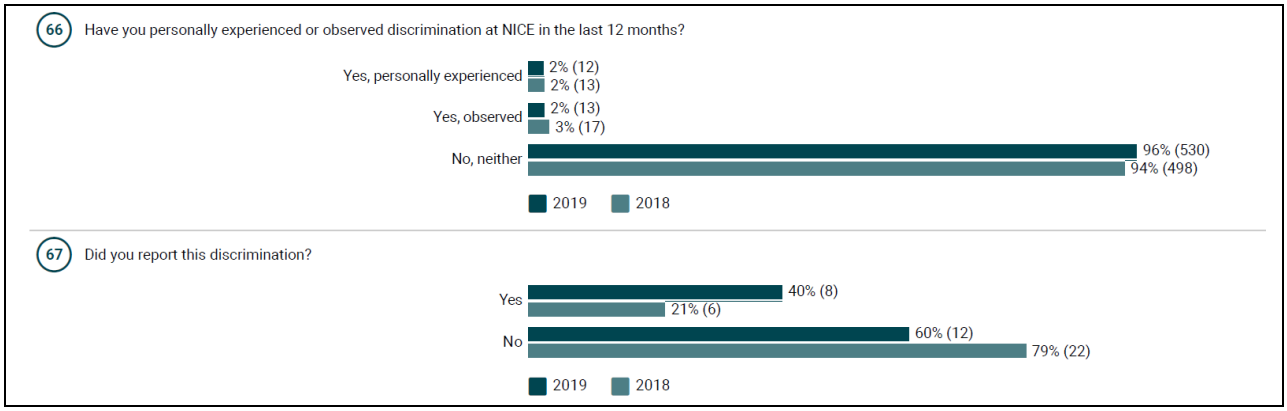
You can download the data set for this chart

Positivity around NICE taking effective action if staff are harassed and/or bullied (Q65) has gone up from 36% in 2018 to 44% this year.



You can download the data set for this chart

As in previous surveys, all respondents were asked whether they had personally experienced or observed discrimination at NICE in the last 12 months. Results show that the proportion of those who said they have personally experienced discrimination has remained unchanged at 2%, with a slight decrease in those who said they have observed it, compared to 2018. However, a significantly higher proportion of respondents – 40% compared to 21% in 2018 – reported this discrimination.



You can download the data set for this chart

3. 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. These comments can be analysed in the online Survey Results Portal.

Appendix B: Staff Survey Action Plan 2018/19

This plan outlines our progress against our actions in the last year

Staff survey 2018 themes	Agreed Actions	Actions to date
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.	NICE's workforce strategy was approved by the Board in November 2018. It made a range of commitments to support career progression such as increasing the focus of career progression in appraisals, coaching and mentoring opportunities, and improved leadership and soft-skills development. **Mentoring** Mentor development days have been offered for aspiring mentors at NICE, and the scheme has been promoted through our intranet and newsletters. Mentoring has been promoted as a development opportunity through manager mini masterclasses – particularly those focussing on appraisals. NICE now has 30 trained mentors. **Leadership development** We are piloting using the apprenticeship levy for leadership development at levels 3, 5 and 7 for line managers with a range of experience, to support their progression into more senior roles.
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	The Chief Executive and Deputy Chief Executive have talked openly about change and job security, particularly in the context of NICE Connect and the potential implications of such a large-scale transformation project. The SMT have been clear that,

	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 to and influence management thinking in deciding what future structures and roles may be required, therefore feeling more involved in future plans.	while this is not a cost-saving exercise, over time there may be changes to the shape of our workforce as the project progresses. NICE has not undergone large-scale change in 2018-19, but nevertheless wherever change has occurred, staff have been supported by their line managers and HR to help them to understand the rationale behind the changes. as well as having access to support with interview and application skills, our Employee Assistance Programme and our mental health first aiders. NICE has done a lot of work to engage staff in NICE Connect, to help them feel part of our future vision. We have held a series of "lunch and learn" sessions hosted by the Deputy Chief Executive and other SMT members. The sessions were designed to be informal and collaborative, and invited questions and suggestions through face-to-face discussions, post-it note suggestions, and emails to our dedicated inbox. All Associate Directors and Programme Directors are invited to regular "NICE Connect progress and planning" meetings to ensure they have the opportunity to understand and shape the direction of the transformation programme.
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	Work has started to create such values and behaviours, which will be linked to NICE Connect as part of our transformation programme.

	other, and facilitate a conversation about how staff can improve their working relationships. 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.	Our Diversity and Inclusion Group is an informal network which meets regularly to share ideas and best practice, as well as feeding ideas into HR and other areas. This group has helped to raise the profile of a number of protected characteristics through blogs and lunch-and-learn sessions. Some key highlights include: - A "rainbow takeover" on our intranet for the 50th anniversary of the Stonewall riots - A careers talk from a senior BAME leaders - A blog on personal experience of Aspergers, which was our most popular ever
	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.	We have continued to promote our zero-tolerance approach to bullying and harassment through our intranet and through manager mini-masterclasses. In areas where the 2018 staff survey identified above-average reports of bullying and harassment, we have held focus groups to understand the issues in more detail, and local action plans are being continuously developed to help staff and managers address it.
	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.	No cases of bullying and harassment have been upheld, but the SMT will be informed as cases arise.

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.	We have worked closely with teams across the organisation. Specifically, helping teams that deliver key services such as the field team, digital services and HR - developing tailored communications and clarifying their role and highlighting opportunities for collaboration with other teams. Additionally, we feature both the work and leaders of teams in NICEtimes quarterly.

Appendix C: Staff Survey Action Plan 2019/20

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

Staff survey 2019 themes	Proposed Actions
Familiarity with NICE's business plan	The key themes of the business plan will be highlighted in all staff meetings and other communications. Directorates and teams will be encouraged to discuss their role in delivering the business plan during their team meetings, and participate in the business planning cycle. Managers will be reminded to ensure that wherever possible, team and individual objectives will be clearly linked to business priorities. The SMT will reflect on the purpose and nature of this question and will consider refocussing the question to ensure staff are able to identify the principle objectives for their area each year.
Having clear, planned goals and objectives	As well as supporting managers and staff to create clear and "SMART" objectives, we will also support managers and staff to cope with continuously shifting priorities. We will do this through our management masterclasses and leadership development.
Training, career development and promotion	Career progression and professional development are already key strands of our workforce strategy, and data from the staff survey provides valuable information for us to focus our activities on areas which will have the greatest impact. We will challenge the perception that there is limited career progression at NICE by sharing data and success stories. For example, through improved reporting mechanisms, we now know that approximately one third of our recruitment results in internal moves or promotions. In 2018-19, we had 49 internal moves, 39 of which were promotions. We will create resources to help staff reflect on their personality and preferences, as well as identifying transferrable skills, to enable to them to think strategically about their future careers and make considered choices. **Mentoring** The scheme continues to grow, and we now have 30 trained mentors across a range of seniorities. We will continue to promote the scheme through directorate training panel meetings. Work is underway to develop a collaborative leadership mentoring scheme amongst some ALBs. Initially this will be for more senior staff, but if it is successful there may be scope to widen it further.

	Apprenticeships Work will continue promoting apprenticeship to line managers as an opportunity to grow their own talent. NICE will continue to engage with external networks and employer groups to seek out and possibly influence the development of new standards e.g. Health Economics. Support will continue for existing apprentices at NICE through the apprenticeship network where staff can invite guest speakers, make suggestions for improvement and share knowledge and best practice, and where appropriate, support apprentices for their next career steps inside and outside of NICE. Work will continue to promote the apprenticeship scheme as a route to gain professional qualifications such as finance and facilities management. **Development opportunities** Work has started to identify the future skills and attributes required for NICE Connect, and creating development plans to meet these needs. The recruitment of an OD & Training Specialist will enable the development and delivery of soft skills training and facilitate team development, along with identifying areas for improvement for the induction process. HR masterclasses will continue to be offered to provide managers with the confidence and capability to apply key policies. Internal training will continue to be promoted through internal communications including our weekly newsletter, our learning management system and through the directorate training panels.
Workload & demands	**Review of demands and workload** Organisationally, we have delivered manager masterclasses on supporting work-life balance. We have workforce planning tools on our intranet. We will continue to work with teams and directorates where work-life balance is a concern, and support managers in streamlining and simplifying processes, and minimising duplication and extra effort. NICE Connect is creating opportunities for us to review this across NICE.
Bullying, harassment and victimisation	**Development of a set of expected behaviours for staff working at NICE** Work has started to create such values and behaviours. The publication of a set of behaviours, for staff working at NICE, would set out our expectations of how NICE staff should behave towards one another, and facilitate a conversation about how staff can improve their working relationships. This should in turn have a positive impact on culture and reduce bullying.

	Continued embedding of equality and diversity in our everyday interactions Formulation and implementation of a diversity & inclusion strategy/policy incorporating the bullying and harassment policy which in turn will promote the values of inclusivity and treating people with respect and dignity. **Freedom to Speak Up Guardians and Mental Health First Aiders** We have broadened the scope of our FTSUGs, and they will be trained with the knowledge and skills to support staff who feel they are being bullied, harassed or victimised. We also have 50 trained mental health first aiders who can signpost staff who believe they are being bullied, harassed or victimised.
Internal corporate communications	Continue to review internal communications channels, specifically the intranet. As well as hopefully improving usefulness for staff, it should also provide opportunities for staff engagement and have the knock-on effect of making change communications more effective. Continue to deliver communications around our major change programmes, Connect, London office move and CHTE 2020. With a multi-channel approach, we will evaluate the effectiveness of our comms on these programmes and other significant change such as policies through polls on NICE Space. Ensure all our channels are fully accessible so all staff can access key information. The SMT will collectively commit to identifying any significant new communications channels, and continue to think creatively to maximise the value of our existing and new channels, whether these are face-to-face or electronic.

National Institute for Health and Care Excellence

NICE impact report: maternity and neonatal care

This report gives details of how NICE's evidence-based guidance contributes to improvements in maternity and neonatal care.

It provides information about NICE's communications activity in relation to the previous impact report on adult social care.

The Board is asked to review the NICE impact maternity and neonatal care report and note the actions proposed by the system support for implementation team and the communications activity.

Professor Gill Leng

Deputy Chief Executive and Director, Health and Social Care Directorate

September 2019

Introduction

1. The attached NICE impact report focuses on maternity and neonatal care and reviews the uptake of NICE guidance in this area. This is the second impact report with a focus on maternity and includes: an update since the last report, maternity and mental health, specialist care of newborns and a spotlight on valproate prescribing. It is guided by the NHS Long Term Plan and the Maternity Transformation Programme. It has been produced in pdf format and as a webpage.

System support for implementation

2. The System Support for Implementation team is currently scoping options to provide support to proactive national partners in 2019/20, to address the implementation issues highlighted in this report. A paper will be presented to the Health and Social Care Senior Leadership Team in late 2019 to outline any proposed activities.

Promoting previous NICE impact reports

3. The latest NICE impact report on social care was published on 22 July and was widely promoted to key social care audiences.

4. What follows is a summary of the various activities and channels used to raise awareness of the social care impact report.

Working with partners and key stakeholder organisations

5. We worked closely with our social care stakeholders to encourage them to spread the word about the social care impact report through their networks and communication channels. We leveraged our relationships with professional bodies, which helped us reach more than 900,290 health and social care professionals, service-users, patients and the public. Below are some examples of the communication activities carried out:

    - The Department for Health and Social Care (DHSC) featured a blog by Gill Leng in its monthly newsletter, which goes out to over 14,000 people. Colleagues at DHSC confirmed that this blog Working together to integrate adult social care, accounted for a spike of 208 site visitors. The DHSC also tweeted about our blog and report to its 263K followers.
    - NHS England/NHS Improvement promoted our social care impact report to its 285K followers. Its communications team also shared the report with relevant colleagues and asked them to disseminate via their networks and contacts.

- The Social Care Institute for Excellence (SCIE) promoted our report via its e-news bulletin, SCIEline, which goes out to over 120,000 members. So far, this has received 219 unique clicks. SCIE colleagues also shared our report via Twitter to over 36K followers.
- Disability Living Foundation tweeted about our report to its 5K followers and included a half-page news item in its monthly newsletter, which reached over 93,300 members.
- The charity, Carers Trust, shared our report with network partners via its practice and policy newsletter. It also shared the report with its 39,000 Twitter followers.
- Skills for Care promoted our report in its monthly eNews bulletin, which went out to 19,594 contacts.
- NHS Benchmarking published a news article on its website linking to our report and included an announcement about it in its monthly bulletin, which went out to over 10,000 members. NHS Benchmarking also promoted the report to its 4,827 followers via both its National Audit of Immediate Care (NAIC) and NHS Benchmarking Network Twitter accounts.
- The Care Quality Commission promoted our report in its August provider bulletin, which went out to all its subscribers.
- The Challenging Behaviour Foundation shared our report via its Twitter account to 4.3K followers. It also featured the report in its policy update, which went out to 581 stakeholders.
- The Coalition for Collaborative Care (C4CC) shared our report with partners in its September email update, which went out to over 1200 members. C4CC also shared the report via Twitter to its 3788 followers.
- National Voices included a link to our report in its members update, which went out to 700 members.
- The charity, Disability Rights UK, promoted our impact report as a news item on its website.
- The learning disability charity, Mencap, shared the report amongst quality team colleagues, who are considering including it in their communications to families of people with learning disabilities.
- The complex disabilities charity, Sense, shared our report with its public policy team members, who will disseminate to their contacts and networks.

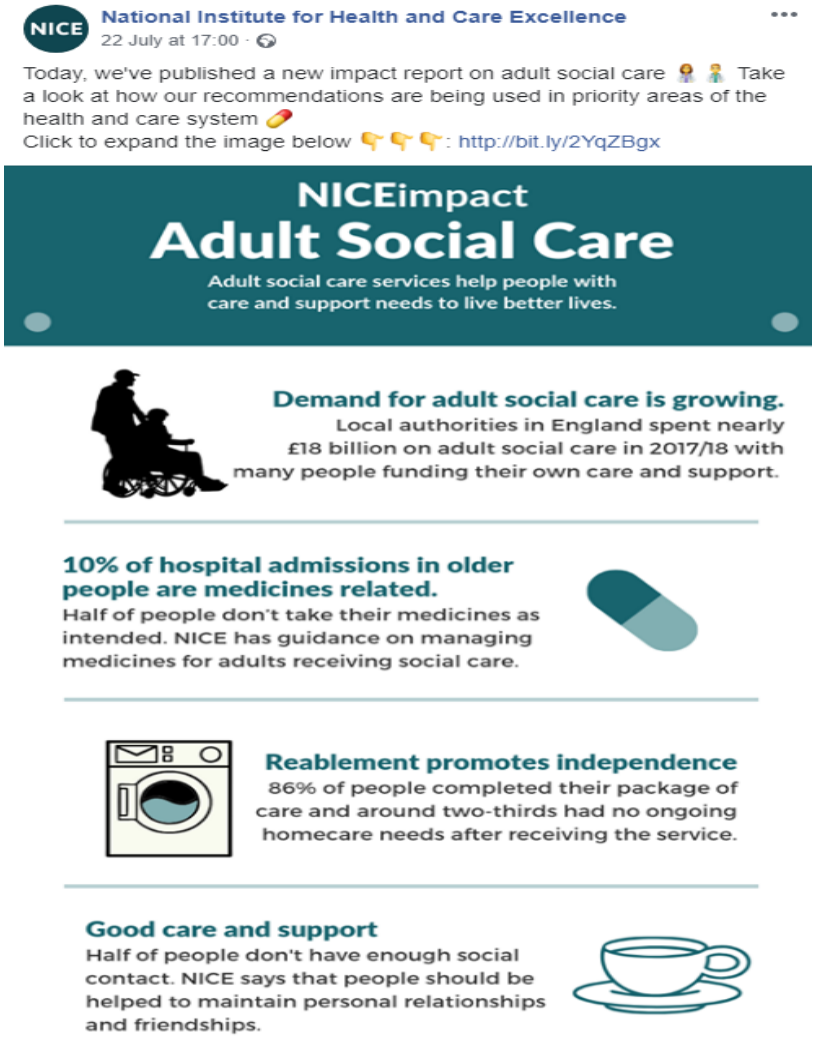
Newsletters

6. We highlighted the social care impact report, as well as the DHSC newsletter blog in 3 of our newsletters: NICE in Social Care (3000 subscribers); NICE News (25,213 subscribers); and Update for Primary Care (12,405 subscribers).

Social media

7. On publication, we promoted the social care impact report via Facebook and Twitter with an infographic illustrating key points. Both posts achieved very good engagement rates, with the post on Facebook performing particularly well. The post was seen by 11,790 people and 97 of those clicked through to our impact report. Organisations such as Skills for Care and a variety of local care organisations shared the post.

Facebook post:

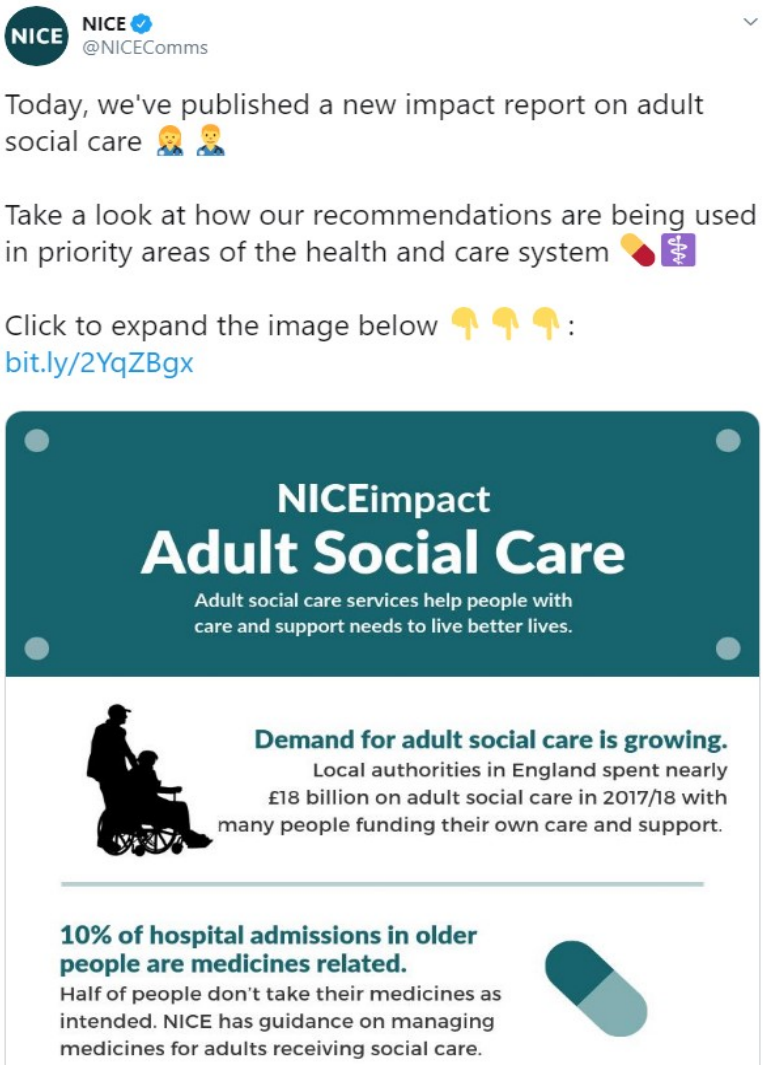


8. Our Twitter channel usually performs much better than Facebook when promoting our impact reports. However, this is the first time Facebook has

outperformed Twitter. We know that people are more likely to share content if it is visually appealing and tells a story that can be easily understood by their followers, and this Facebook post demonstrates that the use of an engaging infographic, teamed with this particular social media platform, works particularly well with our social care audiences.

9. On publication, we shared a link to our social care impact report on Twitter with an accompanying infographic. The post was viewed 12,101 times and 51 people clicked through to the report. We received retweets from The National Institute for Health Research Innovation Observatory, the Royal College of Occupational Therapists and other health care organisations and professionals.

   Twitter post:



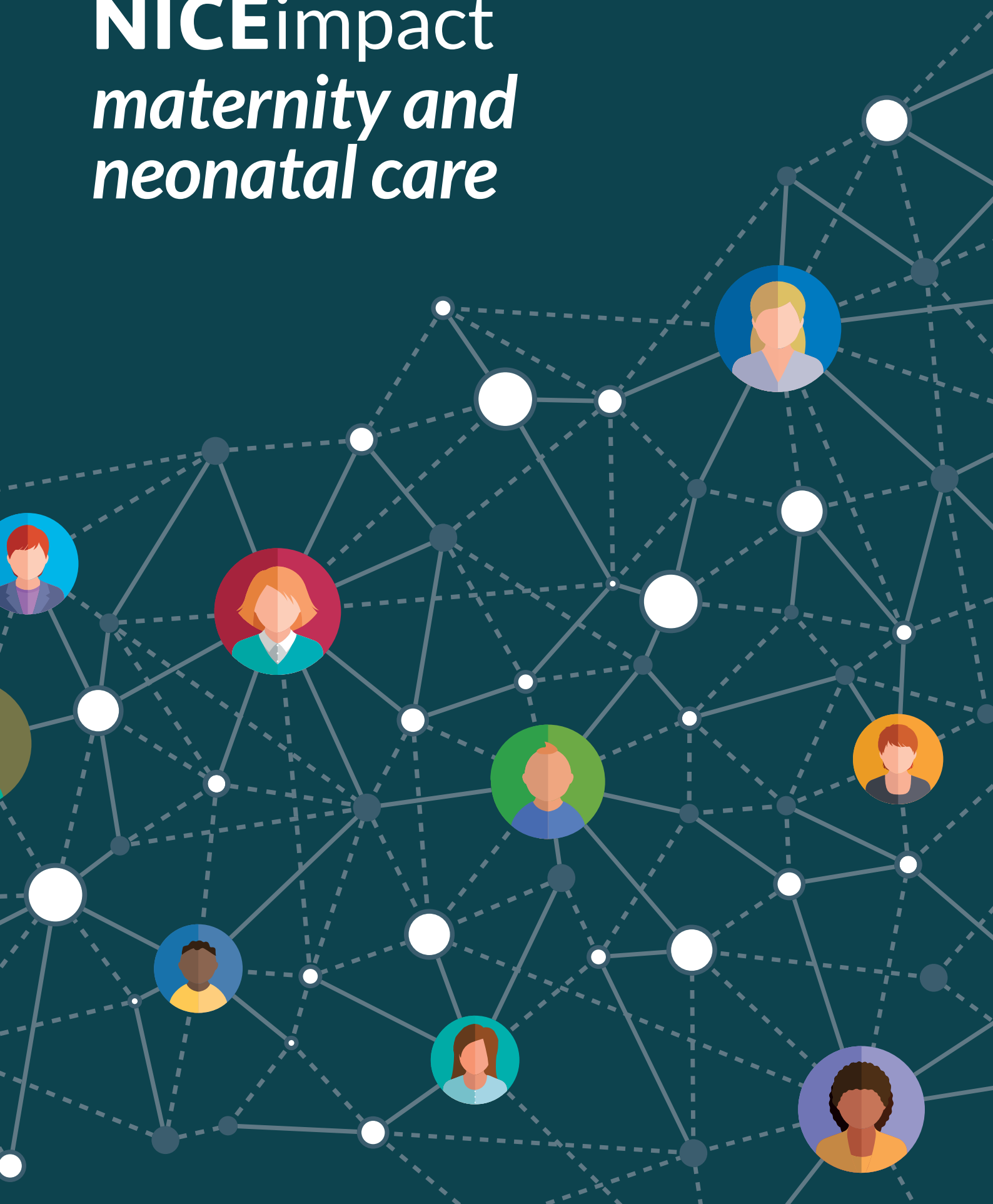
Events

12. Our events team continues to promote our impact reports at all relevant events, exhibitions and speaking engagements. Our social care impact report will be promoted at the following upcoming events: NHS Expo (Manchester, 4-5 September 2019); Community Care Live (London, 24-25 September 2019); The British Association of Social Workers (BASW) conference (Leeds, 17-18 October 2019); The National Children and Adult Services (NCAS) conference (Bournemouth, 20-22 November 2019); and Care England (London, 13 November).

September 2019

NICE National Institute for Health and Care Excellence

NICEimpact *maternity and neonatal care*



NICEimpact *maternity and neonatal care*

There were more than 626,000 births in the NHS in 2017/18, with around 100,000 neonatal admissions to hospital each year. This report focuses on how NICE's evidence-based guidance contributes to improvements in maternity and neonatal care.

This report highlights progress made by the health and care system in implementing NICE guidance. We recognise that change can sometimes be challenging and may require pathway reconfiguration. It may also require additional resources such as training and new equipment.

We work with partners including NHS England, Public Health England and NHS Improvement to support changes. We also look for opportunities to make savings by reducing ineffective practice.

Updates since the last maternity report p4

In May 2018 we published the NICEimpact report on maternity. We review the impact of NICE guidance from the previous report where new data has become available.

Maternity and mental health p7

Up to 20% of women experience perinatal mental health problems, which if left untreated can have long-lasting effects on mother, baby and family. We review how NICE guidance is contributing to improvements in this area.

Specialist care of newborns p11

Newborn babies who are born prematurely or need treatment in hospital require specialist neonatal care. We consider the impact of NICE's recommendations across the care pathway, including how NICE guidance is helping to support mothers to initiate and continue to breastfeed while their babies are receiving specialist neonatal care.

Spotlight on valproate prescribing p16

Babies exposed to valproate in the womb are at a high risk of serious complications. We look at how updated NICE guidance is aligning with regulatory safety advice to reduce risk in this area.

Commentary p18

Dr Kathryn Gutteridge, President of The Royal College of Midwives, reviews recent achievements and considers NICE's role in improving maternity and neonatal care.

Why focus on maternity and neonatal care?

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, NHS Improvement and Public Health England (PHE).

NICE published its first maternity guideline, on antenatal care, in 2003. Since then we have produced a suite of maternity and neonatal related guidance. Since the last NICEimpact report on maternity in May 2018 we have published 3 new and 5 updated guidelines.

The Department of Health and Social Care (DHSC) set out a vision in 2015 to halve the number of stillbirths, neonatal and maternal deaths and brain injuries by 2030. As a result NHS England established the Maternity Transformation Programme. This was the focus of the last NICEimpact report on maternity. Since then the DHSC announced a renewed commitment to achieve this aim by 2025, which was highlighted in the NHS Long Term Plan.

NICE routinely collects data which provide information about the uptake of its guidance. To produce this report, we have worked with national partners to select those data which tell us about how NICE guidance might be making a difference in priority areas of maternity and neonatal care. They also highlight areas where there is still room for improvement.

Antenatal care is the care people receive from healthcare professionals during their pregnancy.

The perinatal period is the period immediately before birth to just after birth.

Postnatal care covers the period after birth.

The neonatal period covers the care of newborn babies from birth to 28 days.

We have produced:

16
Quality Standards

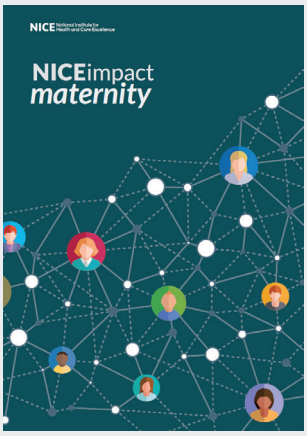
23
Guidelines

on maternity and neonatal care topics.

Updates since the last maternity report

In May 2018 we published the NICEimpact report on maternity. This considered how NICE's evidence-based guidance might contribute to improvements in the safety and personalisation of maternity care.

Since the last impact report new data and quality improvement initiatives have reported on the uptake of NICE recommendations. In addition the NHS Long Term Plan was published which included a renewed commitment to maternity services. This sets out that the NHS will accelerate action to achieve 50% reductions in stillbirth, maternal mortality, neonatal mortality and serious brain injury by 2025.



NICEimpact maternity report

Published in May 2018, our last report considers how NICE's evidence-based guidance might contribute to improvements in the safety and personalisation of maternity care.

Safety – multiple pregnancy

Increasing adherence to NICE guidance for multiple pregnancy helps to contribute to reductions in neonatal admissions and emergency caesarean rates.

Since the last impact report on maternity the Twins and Multiple Births Association (TAMBA) concluded a 3 year maternity engagement project to improve outcomes for multiple pregnancy families by promoting the use of NICE guidance.

As part of this they worked with 30 maternity units across England and published a report on the outcomes, NICE works. There were 40 positive findings, including a reduction in neonatal admissions rates and emergency caesarean section rates for multiple pregnancy.

Findings from units in the TAMBA maternity engagement project

As part of the project, an antenatal care pathway improvement tool developed by TAMBA was endorsed by NICE in May 2018. This provides healthcare professionals with a tool to ensure they meet NICE guidance, therefore ensuring families receive the specialist care they need.

An update for the NICE guidance on twin and triplet pregnancy was published in September 2019.

Implementation of NICE guidance significantly improves outcomes in multiple pregnancy

East and North Hertfordshire NHS Trust has recently implemented a continuity of carer pathway for women with multiple pregnancies to meet the NICE guideline. Following an audit of their service by the Twins and Multiple Births Association (TAMBA) in 2017 they received recommendations to enhance their service and implement a continuity of carer pathway. A later audit in 2018 identified the service as outstanding for multiple pregnancy. Further focus on other areas to improve experience of care have been beneficial. There has been a marked improvement on appointment attendance, enhanced collaborative team working, an enriched education programme for antenatal care and a better communication package. Further information is available in a NICE shared learning example.

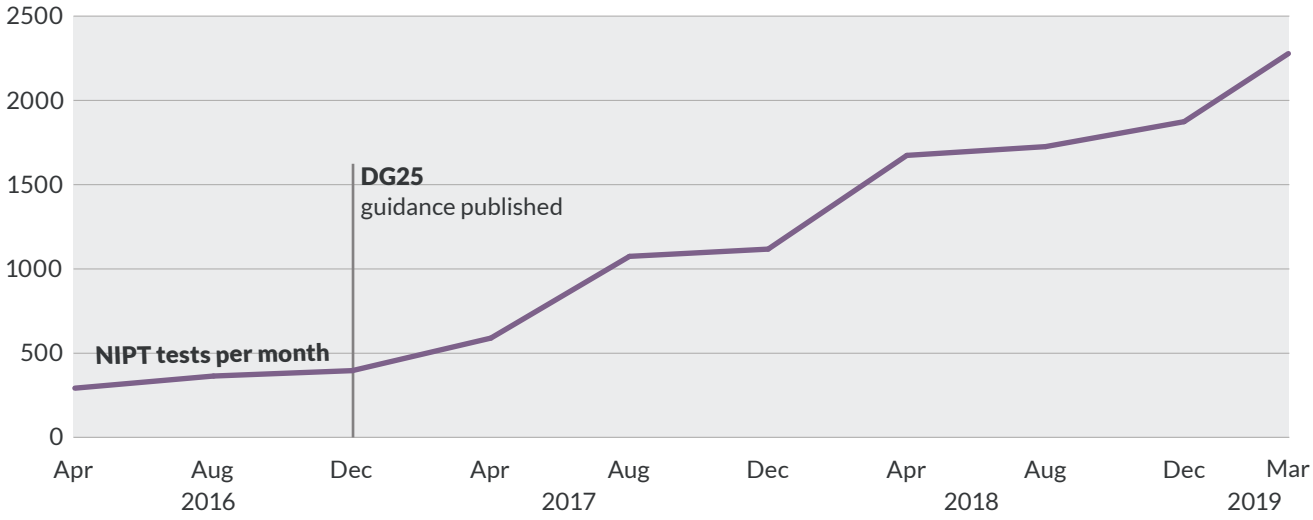
Safety – fetal rhesus-D genotype test

High-throughput non-invasive prenatal testing (NIPT) for fetal RHD genotype, as recommended by NICE in November 2016, was the first reliable way of testing the D status of a baby before it is born. If the baby's D status is different to that of the mother, it can cause serious complications. The test helps to decide whether anti-D immunoglobulin prophylaxis is required to prevent severe fetal anaemia, fetal heart failure, fluid retention and swelling, and intrauterine death.

NICE has produced an adoption support resource which provides practical information and advice to support the adoption of high-throughput non-invasive prenatal testing (NIPT) for fetal RHD genotype.

Since the last impact report on maternity the number of trusts providing NIPT for fetal RHD genotype have increased from 40 to 54 and the number of tests being carried out has continued to increase, as shown in data from NHS Blood and Transplant. This is expected to increase further by 2021/22 when the test is fully rolled out nationally.

NIPT tests per month have continued to increase since the NICE guidance was published in 2016, shown in data from NHS Blood and Transplant



Safety – smoking in pregnancy

Evidence shows that stopping smoking in pregnancy reduces the likelihood of stillbirth. It also reduces the chances of babies being born prematurely, with a low birth weight or suffering from sudden infant death syndrome. Smoking in pregnancy also affects babies later in life who are more likely to suffer from asthma and other serious illnesses. The NICE guideline on stopping smoking in pregnancy and after childbirth contains recommendations on identifying women who need help to quit, referring them to stop smoking services and providing support to help them stop.

Since the last impact report on maternity the proportion of mothers who smoke at the time of delivery has remained similar as shown in the latest NHS Digital statistics on Women's Smoking Status at Time of Delivery in England.

Over the last 3 years, the proportion of mothers who smoke at time of delivery has remained similar

Mothers who smoke at time of delivery

Maternity and mental health

Women can develop mental ill health for the first-time during pregnancy, and pre-existing mental health conditions can get worse in the perinatal period. Perinatal mental health problems affect up to 20% of women with an estimated cost of almost £10,000 per birth.

Perinatal mental health problems are those which occur during pregnancy or in the first year following the birth of a child.

Emotional wellbeing checks ensure women are monitored and supported to maintain good mental health.

Mental health problems during the perinatal period can frequently go unrecognised and untreated, with some women not seeking help because of fear of stigma, or fear of intervention by social services. If left untreated, perinatal mental health problems can have significant and long-lasting effects on the woman and her family, as well as on children's emotional, social and cognitive development. NICE has produced guidance to reduce the risk of mental illness during pregnancy and reduce harm for both mother and child.

Perinatal mental health services

Access to specialist multidisciplinary perinatal community services and inpatient psychiatric mother and baby units can help to ensure that the most appropriate assessment, monitoring and treatment is provided. The NICE quality standard and guideline on antenatal and postnatal mental health state that these services should be available to support women with a mental health problem during pregnancy or the postnatal period. They are currently only found in a minority of providers, as they require redesign of services.

The Five Year Forward View for Mental Health made the commitment to support at least 30,000 more women each year to access evidence-based specialist mental health care during the perinatal period by 2020/21. To provide this care NHS England have developed a five-year national transformation programme to build capacity and capability in specialist perinatal mental health services.

As part of the transformation of these services, in May 2018 the National Collaborating Centre for Mental Health worked with NICE to publish the perinatal mental health care pathways. This provides services with evidence on what works in perinatal mental health care, as well as case studies describing how areas are starting to make this a reality.

These services include community perinatal mental health teams which have been included in the national transformation programme. In 2017, 71% of sites had access to a community perinatal mental health team, as shown in the National Maternity and Perinatal Audit.

In April 2019, NHS England announced the roll out of specialist perinatal community services across the whole of England in line with commitments to transform services from the NHS Long Term Plan.

'I have an amazing local perinatal mental health team. I had a community psychiatric nurse who I had regular sessions with during pregnancy and after my second son was born. When I had a mental health crisis, she was at my house within 45 minutes and my psychiatrist had prescribed my medication so I could start it that day. I owe them so much. Every mother and family should have access to care like that, it would improve so many lives.' Mumsnet – user of specialist perinatal mental health services

Using NICE guidance for antenatal and postnatal mental health to improve the quality of NHS services working with women during the perinatal period

Thames Valley Perinatal Mental Health (PMH) Network designed an online self-assessment tool for NHS services working with women with or at risk of developing perinatal mental health problems. This enables maternity, health visiting, secondary care mental health and Improving Access to Psychological Therapies (IAPT) services to benchmark performance against NICE guidance and Royal College of Psychiatrists PMH workforce standards.

The tool has been endorsed by NICE and is being implemented across NHS England south regions.

Results are available on a live dashboard and can be viewed at regional, Local Maternity System, CCG and service level. The tool identifies good practice and gaps in service provision and data collection; guiding service development tailored to the local service landscape and demand, mapping performance progress over time. Further information is available in a NICE shared learning example.

Emotional wellbeing

Asking women about their emotional wellbeing provides an opportunity to identify potential mental health problems. It also gives women an opportunity to talk about any concerns they might have, such as fears around childbirth, multiple pregnancy, or past experiences, such as loss of a child or traumatic childbirth. This enables healthcare professionals to provide appropriate support and signpost to services as required.

The NICE quality standard on **antenatal and postnatal mental health** highlights that women should be asked about their emotional wellbeing at each routine antenatal and postnatal contact. The NICE guideline on **postnatal care up to 8 weeks after birth** recommends that, at each postnatal contact, women should be asked about their emotional wellbeing, what family and social support they have and their usual coping strategies for dealing with day-to-day matters.

The Care Quality Commission **surveyed women about their experience of maternity care**, with over 90% of eligible women asked.

According to the survey there has been an increase in midwives routinely asking about emotional wellbeing at antenatal check-ups.

Between 2015 and 2018 more midwives are carrying out emotional wellbeing checks at antenatal check-ups

Emotional wellbeing checks at antenatal check-ups

The survey also shows that emotional wellbeing checks continue to be undertaken for most women after childbirth by a midwife or health visitor.

Nearly all women have their emotional wellbeing checked after birth

Emotional wellbeing checks after birth

Most mothers were also told who to contact if they needed advice about any emotional changes they might experience after birth.

Between 2015 and 2018 there was a slight increase in the proportion of mothers who were told who to contact for emotional support after birth

Mothers told who to contact for emotional support after birth

74%
2015

78%
2017

77%
2018

Encouragingly, additional data from the NHS Safety Thermometer showed that in 2018 only 2.1% of women reported being left alone at a time that worried them in a hospital, midwife led unit or community setting.

Specialist care of newborns

Newborn babies may need special, high-dependency, intensive or surgical care if they are unwell. This may be due to being born early (1 baby in 13) or if they are very small and have a low birth weight.

Specialist neonatal care is the care provided for newborn babies who need extra care in neonatal units, for example those born prematurely or who need treatment in hospital.

Pre-term births continue to increase. However, as maternity care has developed, the survival rate of unwell newborn babies is continuing to improve. Specialist neonatal care capacity needs to keep pace with these advances to improve short and long-term outcomes for these babies. NICE's guidance covers the full care pathway from admission to specialist care and follow-up. It also ensures parents are involved as much as possible in the care of their baby.

Admission, transfer and discharge

The NICE quality standard on neonatal specialist care highlights that neonatal transfer services should be in place to provide babies with safe and efficient transfers to and from specialist neonatal care services. This is important as unwell newborns may have difficulty with breathing or keeping warm and require support as they are transferred.

A decrease in children born under 32 weeks admitted with a temperature of less than 36°C suggests an improvement in transfer services maintaining the core body temperature of babies. Data from the Royal College of Paediatrics and Child Health's National Neonatal Audit Programme (NNAP) shows that this decrease continued over the last 3 years.

More babies have a normal core body temperature after transfer to or from specialist neonatal care
Babies with normal body temperature after transfer to or from specialist neonatal care

The NICE quality standard highlights that network commissioners and providers of specialist neonatal care should undertake an annual needs assessment and ensure that each network has adequate capacity.

While the NNAP audit shows that most children requiring specialist neonatal care who are transferred out of a unit remain in their own network area, the Department of Health Toolkit for high quality neonatal services sets the standard at 95%. So, there is still room for improvement.

Most children remain within their own network area once transferred out of a maternity unit

Children remaining in their network area after transfer out of a maternity unit

83%
2014

82%
2015

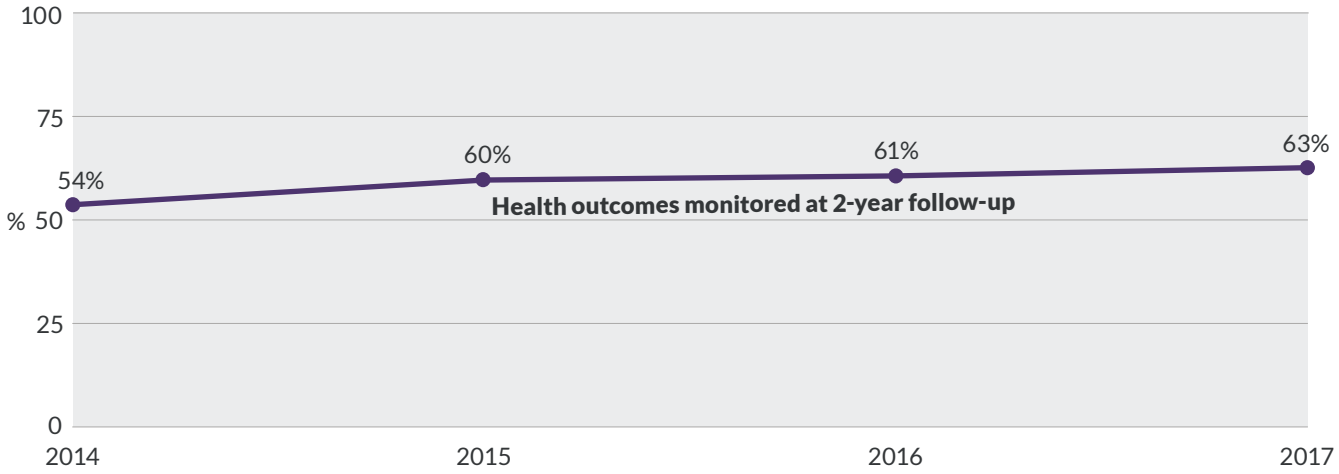
Follow-up

Neurodevelopmental impairment occurs when the development of the central nervous system is disturbed. This can lead to brain dysfunction and problems such as impaired motor function.

The NICE quality standard and guidance on developmental follow-up highlights that health outcomes should be monitored as part of long term follow-up to ensure children continue to get the care and support they need during their development. It also ensures that any developmental issues are identified as early as possible.

The NNAP audit shows that babies receiving specialist neonatal care have increasingly had their health outcomes monitored at 2-year follow-up.

Health outcome monitoring continues to increase

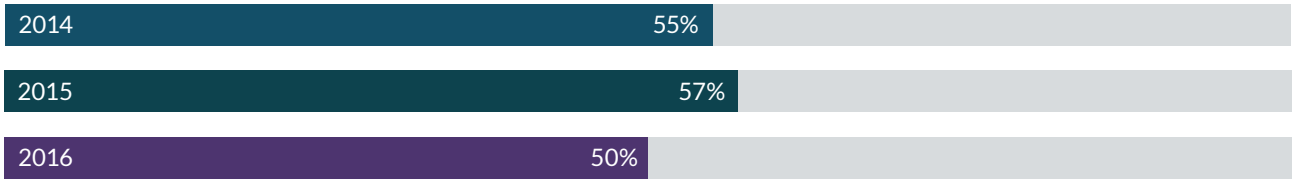


For babies born at less than 30 weeks of gestation, there has been a decrease in those with neurodevelopmental impairment at 2-year follow-up.

Improvements in neonatal specialist care are likely to have contributed to the reductions in neurodevelopmental impairments, as improved services can reduce risk factors associated with conditions such as cerebral palsy.

Half of babies born at less than 30 weeks have neurodevelopmental impairment at 2-year follow-up

Babies born at less than 30 weeks with neurodevelopmental impairment at 2-year follow-up



Parents' experiences of care

The NICE quality standard on neonatal specialist care highlights that parents of babies receiving specialist neonatal care should be supported to be involved in planning of the care pathway. This ensures they are fully informed, and they can engage in the personalisation of care for their baby.

In order to be involved with planning, more parents have a consultation with a senior member of the neonatal team within 24 hours of admission as shown in data from the Royal College of Paediatrics and Child Health's National Neonatal Audit Programme.

Nearly all parents have a consultation with a senior member of the neonatal team within 24 hours of admission

Parents consultation with a senior member of the neonatal team within 24 hours of admission

In addition, the audit reviewed the presence of parents on consultant ward rounds which would ensure they are fully informed of decisions about the care of their baby. It found that, in 2017, around 83% of consultant ward rounds had a parental presence.

'From the moment we stepped foot inside the unit, every member of staff was amazing, they kept us informed of what was going on, allowed us to be involved in Taylor's care routines and looked after us as well. We became experts in oxygen saturation levels, saw countless blood tests and transfusions and learnt about brain scans, chest and lung X-rays, and gravity feeding.'
Sue, mum to a baby born at 25 weeks from Bliss

Breastfeeding

Breastfeeding reduces risk of:
- *infections, with fewer visits to hospital as a result*
- *diarrhoea and vomiting, with fewer visits to hospital as a result*
- *sudden infant death syndrome (SIDS)*
- *childhood leukaemia*
- *obesity*
- *cardiovascular disease in adulthood*

Breastfeeding has long-term benefits for babies which last into adulthood. However, it can be challenging for mothers of babies to initiate and continue to breastfeed in neonatal specialist care.

The NICE quality standard on neonatal specialist care states that mothers of babies receiving specialist neonatal care should be supported to start and continue breastfeeding, including being supported to express milk. This support gives mothers comfort and confidence in their ability to feed their baby. In addition the NICE guideline on postnatal care up to 8 weeks after birth recommends that healthcare professionals should have sufficient time, as a priority, to give support to a woman and baby during initiation and continuation of breastfeeding.

However, in recent years there has been little change in the active support and encouragement women report they received, as shown in the Care Quality Commission's survey of women's experience of maternity care.

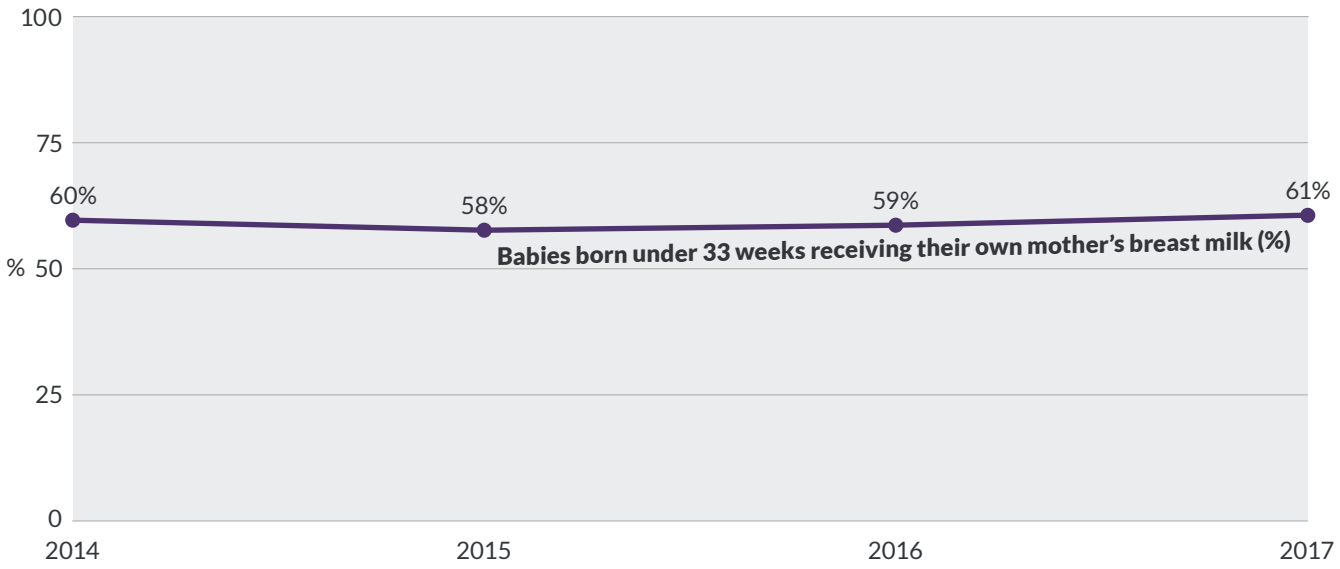
Between 2015 and 2018 the same proportion of women report receiving active support and encouragement from midwives to feed their baby

Women who receive active support and encouragement from midwives to feed their baby

63% 2015 | 64% 2017 | 63% 2018

Between 2014 and 2017 the same proportion of babies born under 33 weeks receive their own mother's breast milk

This trend is reflected in data from the Royal College of Paediatrics and Child Health's, National Neonatal Audit Programme. For babies born under 33 weeks who were discharged there has been little change in those receiving their own mother's breast milk.



The audit also showed that babies that were born between 34 and 36 weeks had a similar rate of breastfeeding initiation at 62%. However, those born full-term at 37 to 42 weeks had the highest rate at 75%. With up to 39% of babies not receiving their mother's breast milk, more support is needed particularly when babies are born pre-term.

Spotlight on valproate prescribing

Babies exposed to valproate in the womb are at high risk of serious complications.

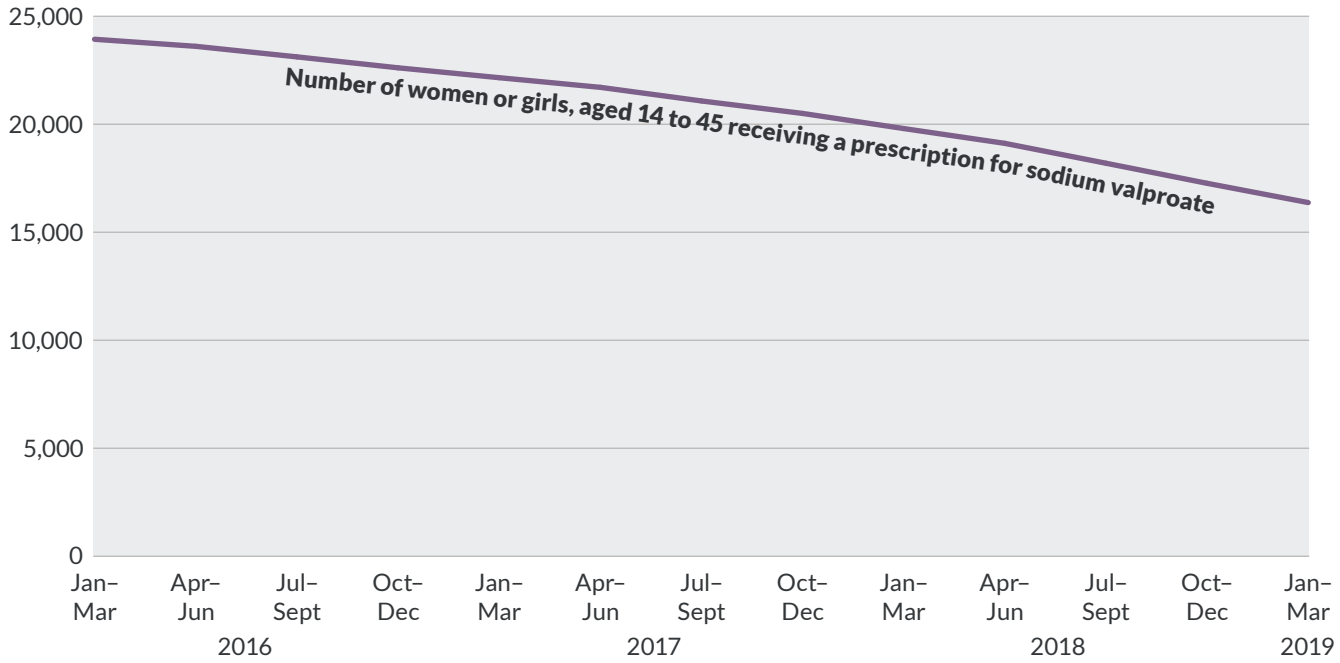
Valproate is licensed for use in treating bipolar disorder and epilepsy. It is also used outside of its product licence (off-label use) for treating neuropathic pain, migraine, depression and dementia.

NICE guidance has been updated to align with the advice provided on the use of valproate by the Medicines and Healthcare products Regulatory Agency (MHRA). Valproate must not be used by any woman or girl able to have children unless there is a pregnancy prevention programme (PPP) in place.

If valproate is taken during pregnancy, up to 4 in 10 babies may have developmental problems and 1 in 10 may have a birth defect, according to data from the MHRA.

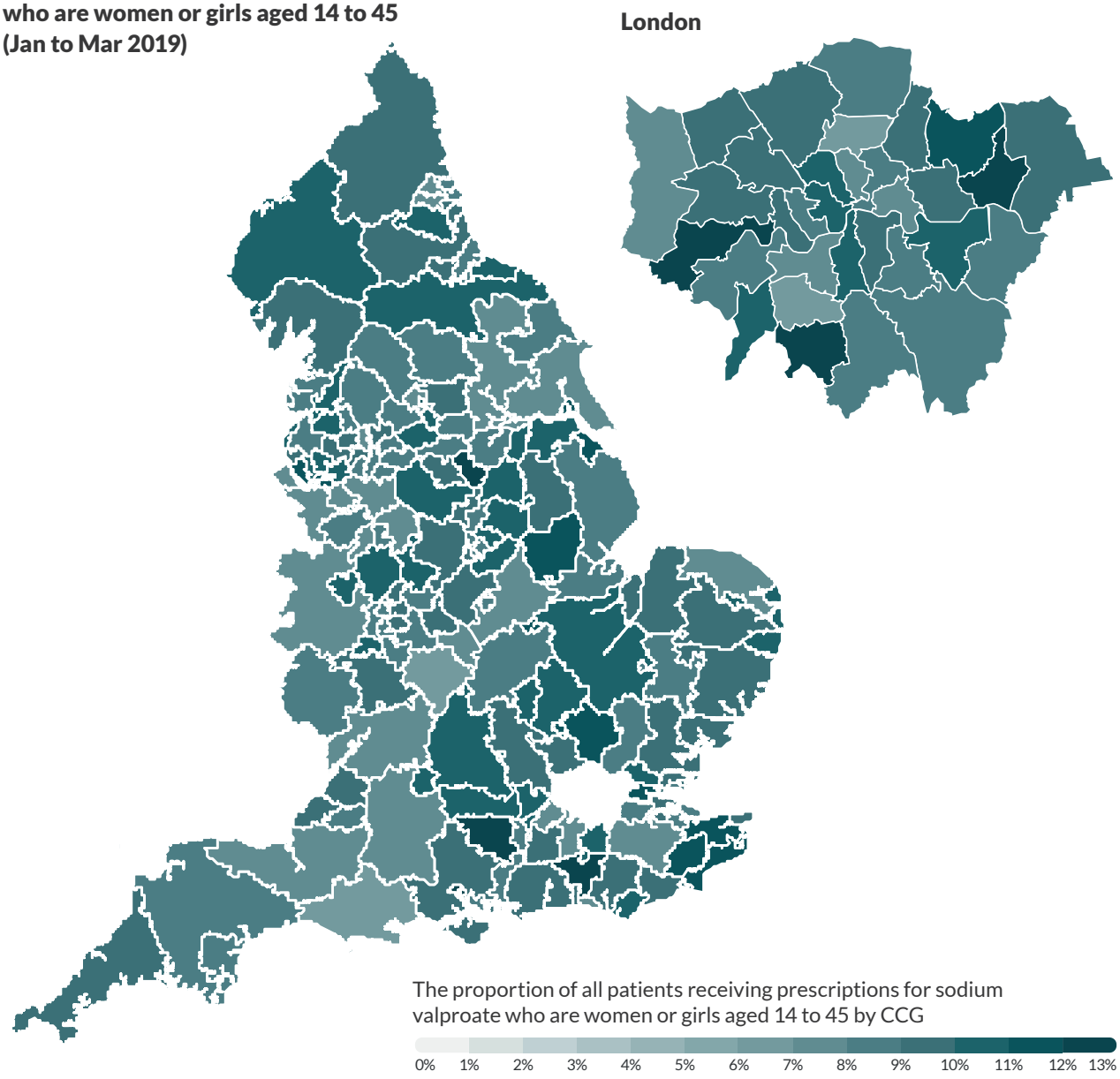
Total prescribing of valproate for women or girls aged 14 to 45 in England has reduced in recent years, as shown in data from the NHS Business Services Authority. Though this trend is positive, some women or girls who can have children continue to take it, which suggests that more can be done to reduce the risk.

Fewer women or girls aged 14 to 45 are being prescribed valproate



Between January to March 2019, the proportion of all patients receiving prescriptions for sodium valproate who are women or girls aged 14 to 45 ranged from 6% to 13% across CCGs. This suggests there is wide variation and there may be room for improvement in many areas.

There is CCG variation in the proportion of all patients receiving prescriptions for sodium valproate who are women or girls aged 14 to 45 (Jan to Mar 2019)



To further address this risk, we have published a summary sheet which brings together existing information and advice on safe prescribing from other sources (for example, MHRA safety alerts, BNF information, summary of products data and information from the Driver and Vehicle Licensing Agency) with NICE's existing guideline recommendations, to produce easy to access, practical recommendations supported by a visual summary.

Commentary

Dr Kathryn Gutteridge, President of The Royal College of Midwives, June 2019

Maternity and neonatal care is an important sector of the NHS and as such attracts a great deal of interest from maternity users and from those clinicians who work in this demanding area. In our society, prospective parents invest a great deal in their pregnancies in a way that would have been unthinkable to our grandparents.

This means that women and their partners have higher expectations about the service and care provision that they will receive. Thus, it is incumbent upon us that any care is evidence-based and clinicians working within maternity are working within these standards and pathways.

NICE has provided maternity and neonatal services with a wide range of guidance and standards that have modernised and streamlined care, improving health outcomes for women and their babies. Much progress has been made with the implementation of mental wellbeing screening programmes during pregnancy that decrease the impact of any underlying or impending psychiatric illnesses. This has reduced the stigma of mental illness during parenthood and helped to increase access to interventions and specialist services.

However, there is still a need to remain focussed as mental health inpatient services for severely ill women are minimal, despite the maternity transformation work that is ongoing. All maternity clinicians are expected to enquire and report where mental wellbeing is liable to change and access to specialist support is necessary.

In recent years the administration of sodium valproate use in controlling bipolar disorder and epilepsy in childbearing women has caused concern. According to the MHRA there remains variation in practice despite the compelling evidence that it can cause an embryo fetus to develop abnormally, causing distress to the family.

Many maternity units in England support this evidence and, where a woman presents to them in pregnancy taking this medication she will be offered and prescribed alternative treatment. General practice and primary care are informed of these changes through their CCG but there remains a need for vigilance to improve the current level of advice.

Multiple pregnancies generate challenges in care provision. Excellent work has been achieved with collaboration between health providers and TAMBA in producing a pathway that seeks to optimise health for all. Although a multiple pregnancy is a minority in many maternity services it has the potential for increased obstetric and neonatal care demand in all areas of perinatal care. Parents require increased support and information which is best delivered within a multidisciplinary approach.

NHS England's programme '**Saving Babies Lives**' is well underway and the expected reduction of harm at birth and reducing stillbirth is being closely monitored. Multiple pregnancies are at increased risk of falling into these statistics which is why any targeted programme of care is welcome. The introduction of Continuity of Carer as directed within the report '**Better Births**' will assist in reducing duplication and avoid separate appointments with a range of clinicians. As a result, care will be provided by a small multidisciplinary team who attend the woman throughout her pregnancy. TAMBA pilot sites found that approaching care in this way and applying NICE pathways reduced unplanned caesarean sections and neonatal admissions.

Examples in this report of smaller maternity units seeing fewer women with multiple pregnancies and consequently working collaboratively with neighbouring units will improve outcomes for those pregnancies. Access to fetal medicine expertise, ultrasonography, specialist midwife, neonatology and infant feeding advisor as part of a multidisciplinary team approach will ensure that the pregnancy is optimised for a healthy mother and baby.

Any maternity improvements must demonstrate validity for women and their families and be easily implemented for clinicians working at all levels. The results seen within this report when applying NICE's guidance are compelling. They should be strongly implemented by all maternity providers as part of improving health and wellbeing for mothers and their babies.

We would like to thank Dr Matthew Jolly, National Clinical Director for the Maternity Review and Women's Health and Dr Kathryn Gutteridge, President of The Royal College of Midwives. We would also like to thank Mumsnet, Bliss and NHS Blood and Transplant for their contributions to this report.

Published September 2019

Any enquiries regarding this publication or any other enquiries about NICE and its work should be made to:

National Institute for Health and Care Excellence
10 Spring Gardens
London SW1A 2BU
Telephone: +44 (0)300 323 0140

National Institute for Health and Care Excellence
Level 1A, City Tower
Piccadilly Plaza
Manchester M1 4BT
Telephone: +44 (0)300 323 0140

Email: **impact@nice.org.uk**
Website: **www.nice.org.uk**

www.nice.org.uk

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 2018/19 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 2018/19 and summarises the workforce profile at 31 March 2019.

The publishing team are producing a short infographic on the report, which will be published on the NICE website alongside the full report.

The Board is asked to receive the report.

Ben Bennett

Director, Business Planning and Resources

September 2019

Annual Equality Report 2018/19

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 information 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:

    - A **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 2018 to 31 March 2019, and the workforce profile at 31 March 2019. The survey of committee members was undertaken in April and May 2019, covering those who were a member of a committee at 31 March 2019.

Summary

NICE's equality objectives

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

6. The first objective is to increase the proportion of committee member applications from people who identify themselves as being from black, Asian and minority ethnic groups. Despite a range of activities to deliver this objective, the proportion of committee member applications from people who identify themselves as from black, Asian and minority ethnic groups decreased in 2018/19, following year on year increases in the previous two years. However, as noted below, when looking at the overall committee membership, the proportion of members who identify themselves as from black, Asian and minority ethnic groups did continue to increase year on year.

7. In line with the second equality objective, the proportion of staff in band 7 and above from black, Asian and minority ethnic groups increased from last year.

Composition of and appointments to NICE committees

8. The survey of committee members reported that:

    - 48% of respondents were women, 50% were men and 2% indicated that it was their choice not to answer the question or gave no response (in last year's survey 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).
    - 10% of respondents identified themselves as disabled and 72% did not. The comparative figures in 2018 were 9% and 73%. The proportion of committee members who stated they were not disabled was lower than the proportion of the general population who do not have an activity limiting health problem or disability.[1] This indicates the ongoing success in ensuring our committees are open to people with a disability.
    - 83% 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 four annual surveys. The proportion

[1] England and Wales, 2011 census

of respondents of black ethnicity is lower than the general population[2] for both lay and non-lay roles. While the proportion of non-lay members of Asian ethnicity is higher than the general population, people of Asian ethnicity are underrepresented in lay roles compared with the general population.

- Just under half (48%) of the respondents in the 2019 survey were between 51 and 65 years old, with 84% between 36 and 65 years old. Overall, the age profile is broadly similar to the 2018 survey.
- 4% identified their sexual orientation as lesbian, gay, bisexual or other, which is slightly lower than the UK general population (5%).[3]
- The largest proportion of respondents were those who identified themselves of Christian belief (45%) and no religion (38%). Compared with the general population[4] NICE's committees are over-representative of those without a religion, and under-representative of those of Christian and Muslim religion.

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 not 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 56% across the guideline committees to 17% on the Interventional Procedures Advisory Committee.
    - The proportion of respondents who identified themselves as being of non-white ethnicity ranged from 44% on the Medical Technologies Advisory Committee to 6% on the Interventional Procedures Advisory Committee.
    - The proportion of respondents who identified themselves as having no religion ranged from 58% on the Technology Appraisal Committees to 8% on the Highly Specialised Technologies Evaluation Committee.

11. Monitoring information collected during the process to appoint members to the committees in 2018/19 indicates that:

[2] England and Wales, 2011 census
[3] 2017 Annual Population Survey published by the Office for National Statistics
[4] England and Wales, 2011 census

- The differences noted above in the profile of existing lay and non-lay members continued in committee applications and appointments. For example, 40% of all lay applicants and 36% of lay appointees identified themselves as disabled, compared with 5% of non-lay applicants and 6% of non-lay appointees.
- Across the roles overall, broadly similar proportions of people sharing the various protected characteristics were appointed to advisory bodies as applied for positions. The main exceptions are age and ethnicity for non-lay appointments.

Guidance production

12. Equality considerations continue to be taken into account in the development of NICE guidance. In 2018/19:

    - There was an increase in the number of potential equality issues identified and also those which subsequently impacted on recommendations compared with 2017/18, 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 (56%) of NICE staff are 40 years old or less, and over two thirds (70%) are women. 79% of staff identify themselves as of white ethnicity and 3.9% 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 April 2016 to March 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 with 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 2018/19 the Public Involvement Programme (PIP) launched revised lay member recruitment documentation. These revised and simplified documents drew on the feedback at workshops and focus groups that discussed methods to encourage and increase applications for lay member roles from black, Asian and minority ethnic groups. The revised documentation seeks to be more accessible and appealing to people from a broader range of backgrounds and who may not have previously considered applying for a role with NICE or similar organisation.

21. These sit along the wider changes to the committee recruitment pages on the NICE website which 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. They include a blog from a committee member encouraging people from black, Asian and minority ethnic groups to apply for committee roles at NICE. We also plan to add a video interview from a committee chair who is from a black, Asian and minority ethnic group, who will talk about their experience working with NICE.

22. In 2019/20, the final year of the objective, PIP will consider the scope to offer mentoring support to lay members, with the aim of ensuring a positive experience for people who have not undertaken a similar role in the past and may be unsure about whether to apply for a vacancy. Guidance teams will also consider whether the guidance development processes place any barriers to involvement for people from black, Asian and minority ethnic groups. Some staff have undertaken unconscious bias training and we are exploring a wider roll-out.

23. The ethnicity of applicants to NICE's advisory committees in the last four years is outlined below. Last year's equality report noted the year on year increase in the proportion of applicants from black, Asian and minority ethnic groups. However, in 2018/19 this trend unfortunately reversed, with the proportion of applicants from black, Asian and ethnic minority ethnic groups falling.

24. The NICE equality and diversity group will review this data and consider any required amendments to the action plan for the objective. It is though positive to note that in the annual committee survey the proportion of committee members who describe themselves as from black, Asian and minority ethnic groups continued to increase year on year (see paragraphs 68-70 for more information).

Table 1: Ethnicity of applicants to NICE advisory committees

Ethnicity	2015/16	2016/17	2017/18	2018/19
Asian or Asian British	8%	9%	10%	8%
Black or Black British	2%	2%	3%	2%
Mixed	2%	3%	2%	2%
White British	67%	67%	63%	68%
Other white background	9%	8%	9%	8%
Any other ethnic group	2%	2%	3%	3%
Undisclosed	4%	4%	7%	5%
Data not held	6%	5%	3%	5%

Equality objective 2

Rationale for setting the objective in 2016

25. 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.

26. 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.

27. 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

28. The number of black, Asian and minority ethnic staff in senior roles (band 7 and above) increased from 64 staff at 31 March 2018 to 68 staff at 31 March 2019. This increased the proportion of staff in band 7 and above from black, Asian and minority ethnic groups from 15% in 2017/18 to 16.6% in 2018/19.

29. 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.

30. In addition to our recruitment channels of Total Jobs and LinkedIn (two of the UK's leading jobs boards), in the last twelve months we have improved our use of social media to target active and passive candidates across multiple communities and channels, which helps us to attract a diverse range of candidates. We have also created recruitment videos and blogs featuring existing staff, which promote the diversity of NICE's workforce and encourage a diverse range of candidates to apply for our roles.

31. NICE is committed to supporting staff regardless of their background. We are Stonewall Diversity Champions (which supports LGBT staff), and we have signed the Time to Change pledge (which aspires to end mental health discrimination). In 2018/19 we achieved the Disability Confident "Employer" standard. We continue to promote specialist development programmes such as the NHS Leadership Academy "Stepping Up" and "Ready Now" programmes which seek to support aspiring and current leaders from black and minority ethnic groups.

32. 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.

33. We are actively engaging with staff members to get feedback on how to improve our recruitment practices for internal and external applicants from black, Asian and minority ethnic groups, or have other or additional protected characteristics. In response to feedback from this group, we organised a talk on career development from an Associate Director from a black, Asian and minority ethnic group background.

34. In 2018/19 we redesigned our recruitment and selection training with an increased focus on diversity, inclusion and understanding unconscious bias.

35. In 2019, NICE will be participating in the workforce race equality standard (WRES) data collection, and we will use this to continue to improve our activities in supporting our staff from black, Asian and minority ethnic groups.

NICE equality and diversity group (NEDG)

36. 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, who liaises with the

executive sponsor for diversity – Alexia Tonnel, Director for Evidence Resources.

37. 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 complements the arrangements to support equality considerations within guidance producing programmes.

38. This year the group received a presentation from Stonewall on LGBT inclusive terminology and noted the work undertaken to use inclusive terminology in NICE's internal HR policies. The group agreed that it would be helpful to clarify NICE's position on the use of gender neutral language in guidance publications through an update to our style guide.

39. The group considered issues arising from the 2017/18 annual equality report. It discussed actions to increase the completion of equality monitoring forms by people applying for committee roles, and the equality impact assessment process across guidance programmes. The group also considered feedback from lay members on their experience on NICE committees.

40. As noted in paragraph 14, NICE's current equality objectives were agreed in March 2016 and run to March 2020. In 2019/20 the group will therefore consider options for objectives for the next period and recommend these to the senior management team and Board for approval.

Composition of and appointments to NICE committees

41. 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.

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

Equalities monitoring of 2018/19 applications and appointments

43. Across the roles overall, broadly similar proportions of people sharing the various protected characteristics were appointed to advisory bodies as applied. The main exceptions are age and ethnicity for non-lay appointments. Further information, by protected characteristic, is outlined below.

Gender

44. There is a difference in the gender balance between lay and non-lay roles. The proportion of applicants and appointees who were women was higher for lay roles (57% and 59% respectively) than non-lay roles (43% and 43% respectively).

Disability

45. The proportion of applicants and appointees who identified themselves as disabled was higher for lay roles than non-lay roles. 40% of all lay applicants and 36% of lay appointees identified themselves as disabled (which is an increase from 2017/18 when the figures were 34% and 32% respectively). In 2018/19, the proportion of people who identified themselves as disabled was 5% for non-lay applicants and 6% for non-lay appointees (a 1% decrease from the previous year).

46. These conversion rates of applications to appointments give an indication of the non-discriminatory nature of the recruitment process and reflect the reasonable adjustments NICE will make to the recruitment process to take account of applicants' specific circumstances.

Ethnicity

47. As shown in tables 2a and 2b, the proportion of applicants and appointees who identified themselves as being of white ethnicity was higher for lay roles than non-lay roles.

48. Last year's equality report noted that while 14% of people who applied for a lay role in 2017/18 identified themselves as being of non-white ethnicity, the proportion of lay appointees who identified themselves as being of non-white ethnicity was only 6%. It is therefore positive that in 2018/19 the conversion rate of applications to appointments to lay roles for people who identified themselves as being of non-white ethnicity improved. People who identified themselves as being of non-white ethnicity accounted for 10% of lay applicants and 13% of lay appointees in 2018/19.

49. However, for non-lay roles, the conversion rate for people who identified themselves as being of non-white ethnicity is lower than it is for people of white ethnicity. People who identified themselves as being of non-white ethnicity accounted for 16% of applications for non-lay roles, but 12% of non-lay appointees. 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 2a: Ethnicity of advisory committee applicants and appointees (lay roles)

Ethnicity	% of all applicants	% of all appointees
White	81%	80%
Non-white	10%	13%
Not disclosed/not held	*9%*	*7%*

Table 2b: Ethnicity of advisory committee applicants and appointees (non-lay roles)

Ethnicity	% of all applicants	% of all appointees
White	75%	76%
Non-white	16%	12%
Not disclosed/not held	*10%*	*13%*

Age

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

- Lay applicants: 59%
- Lay appointees: 58%
- Non-lay applicants: 77%
- Non-lay appointees: 78%.

51. As in 2017/18, 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. The conversion rate of applications to appointments also varies for these age groups. While 52% of all non-lay applicants were appointed, only 26% of non-lay applicants between 18 and 35 were appointed. This profile and variation 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: 79%
- Lay appointees: 78%
- Non-lay applicants: 83%
- Non-lay appointees: 83%.

Religion or belief

53. People identifying themselves as of Christian belief represented the largest group of applicants and appointees across lay and non-lay roles:

- Lay applicants: 35%
- Lay appointees: 41%
- Non-lay applicants: 41%
- Non-lay appointees: 40%.

Data quality

54. 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.

55. Last year's report noted the ongoing improvements in data quality 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, in 2018/19 this trend reversed: monitoring forms were returned for 96% of non-lay applications and 96% of non-lay appointees, and 93% and 94% of lay applications and appointees. The NICE equality and diversity group will therefore consider any action that can be taken in response.

56. Last year's report also noted that the proportion of respondents who returned a monitoring form, but did not disclose the information increased across all of the protected characteristics in 2017/18. Subsequently, the NICE equality and diversity group revisited the information provided to applicants that explains why NICE asks for this information and how it is used. Further information was added to the equality monitoring form to explain how the data is used – that it is aggregated anonymously to see which groups are underrepresented on our committees and consider how we could raise awareness of upcoming committee vacancies to address this. The narrative to the form also explains that the recruiting panel do not see the information about the applicant's background.

57. While these changes were made to the form half-way through the year, it is positive to note that the disclosure rates increased in 2018/19. It will be important to keep a watch on this to identify whether this positive position continues.

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 earlier in the report on applications and appointments over the last year.

59. This year the survey ran from 9 April to 7 May 2019. An email invitation was sent out to 917 committee members, with 566 responses received (a 62% response rate). This is lower than in previous years: 71% in 2018, 69% in 2017 and 78% in 2016.

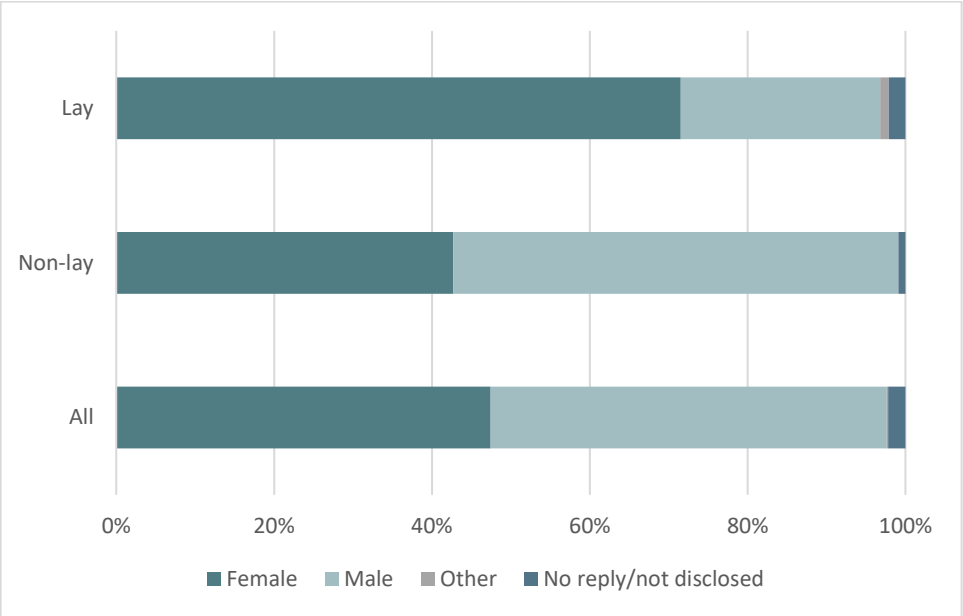
60. We asked respondents whether they were a committee member appointed for their lay expertise or were appointed for their professional expertise (referred to as non-lay members in this report). Of the 566 responses:

    - 95 (14%) were from lay members
    - 438 (77%) were from non-lay members
    - 33 (6%) did not answer whether they were a lay or non-lay member.

61. The responses for each of the protected characteristics are outlined below, including comparisons with last year and variations between the different committees (when looking at the variation in the composition of the committees it is important to note the committee groupings vary in size). The total category in the charts includes all 566 respondents, including the 33 respondents who did not identify whether they were a lay or non-lay member.

Gender

Chart 1: Gender: advisory committee members



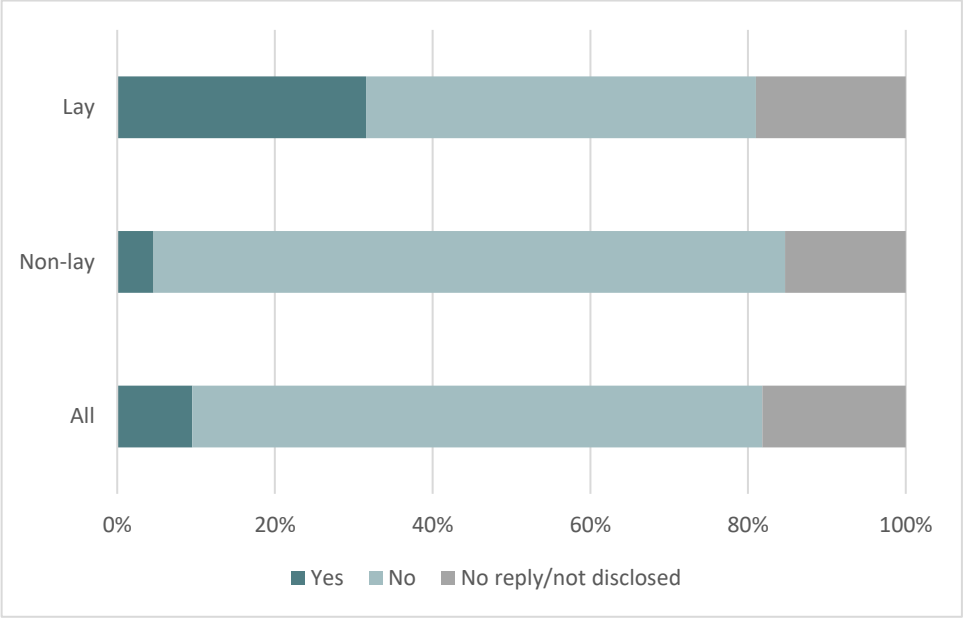
Download the data set for this chart

62. In the 2019 survey 48% 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 72% of lay respondents and 43% of non-lay respondents.

63. There is variation in the gender balance across the advisory bodies. As in previous years, the proportion of respondents who were women was lowest on the Interventional Procedures Advisory Committee (17%) and the Medical Technologies Advisory Committee (19%); followed by the Technology Appraisal Committees (25%). Collectively, the guideline committees had the highest proportion of respondents who were women (56%).

Disability

Chart 2: Disability: advisory committee members



Download the data set for this chart

64. In the 2019 survey, 10% of respondents identified themselves as disabled and 72% did not. The comparative figures in 2018 were 9% and 73%.

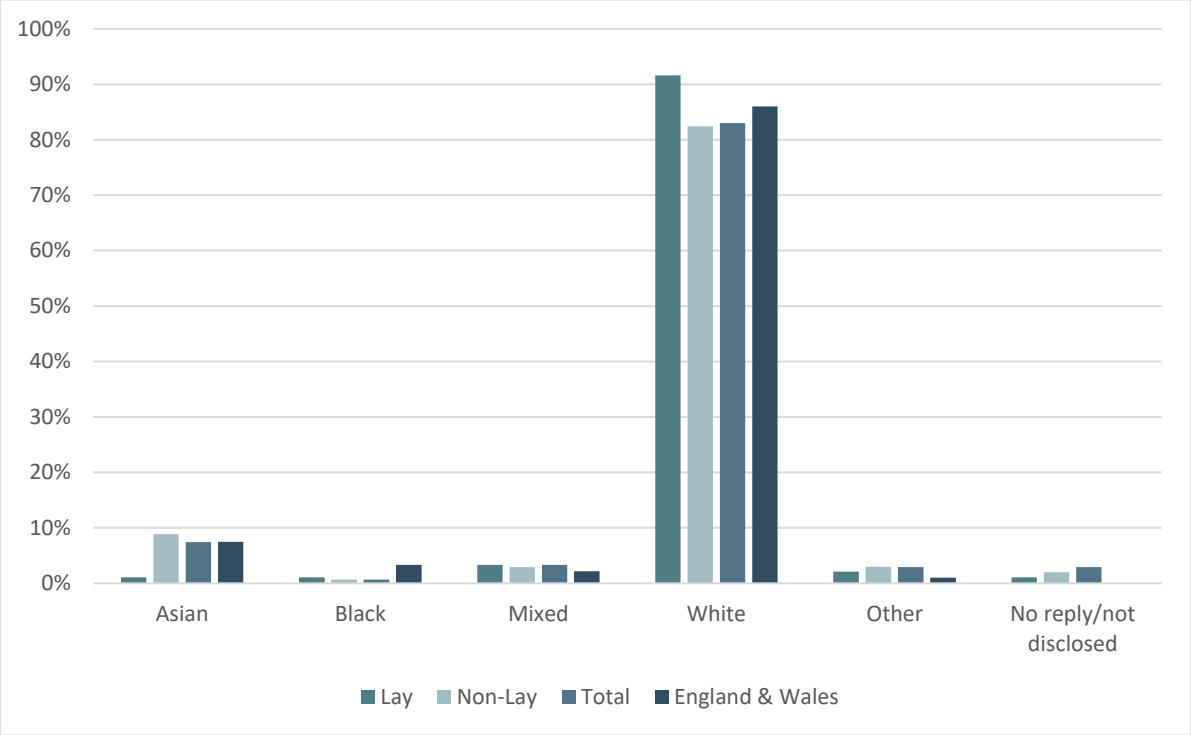
65. As in previous years, a higher proportion of lay members identified themselves as disabled (32%) than non-lay members (5%). The comparative figures in 2018 were 26% and 5%. As noted earlier in the report, this difference between lay and non-lay roles is also reflected in the committee recruitment in 2018/19.

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

67. The Highly Specialised Technologies Evaluation Committee, Indicator Advisory Committee, and Interventional Procedures Advisory Committee 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 (16%) and the guideline committees (12%).

Ethnicity

Chart 3: Ethnicity: advisory committee members



Download the data set for this chart

68. In the 2019 survey, 83% of respondents identified themselves as being of white ethnicity, and 14% as being of non-white ethnicity. As shown in table 3, the proportion of respondents of non-white ethnicity has increased each year over the last four surveys.

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

Ethnicity	2016	2017	2018	2019
Asian or Asian British	5.3%	5.9%	6.9%	7.4%
Black or Black British	1.4%	1.3%	1.0%	0.7%
Mixed	1.8%	2.2%	2.3%	3.3%
Other	2.1%	2.4%	3.4%	2.9%
Total: all non-white	*10.6%*	*11.8%*	*13.6%*	*14.3%*
White	88.1%	85.9%	85.1%	83%
Did not disclose or answer	1.2%	2.5%	1.3%	2.9%

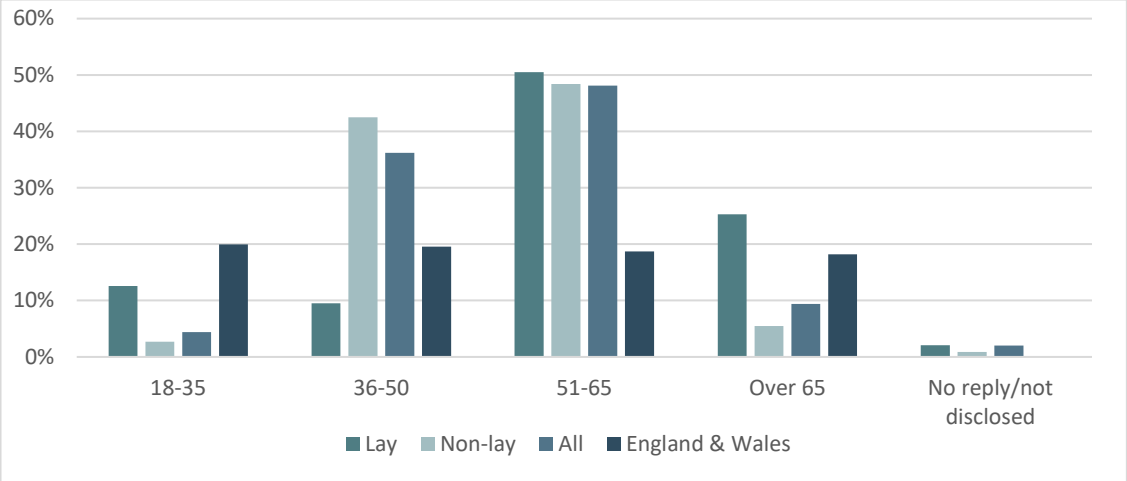
69. The proportion of respondents who identified themselves as being of non-white ethnicity was higher amongst non-lay members (16%) than lay members (8%). The proportion of respondents of Black ethnicity is lower than the general

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 with the general population, but the proportion of non-lay members of Asian ethnicity is higher than the general population.

70. The proportion of respondents who identified themselves of non-white ethnicity was highest on the Medical Technologies Advisory Committee (44%), followed by the Quality Standards Advisory Committees (22%) and Technology Appraisal Committees (22%). It was lowest on the Interventional Procedures Advisory Committee (6%).

Age

Chart 4: Age distribution: advisory committee members



Download the data set for this chart

71. Just under half (48%) of the respondents in the 2019 survey were between 51 and 65 years old, and 84% between 36 and 65 years old. Overall, the age profile is broadly similar to that in the 2018 survey.

72. 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.

73. The proportion of respondents between 18 and 35 years old was higher for lay members (13%) than non-lay members (3%), as was the proportion of respondents over 65 years old (25% of lay members and 6% of non-lay members).

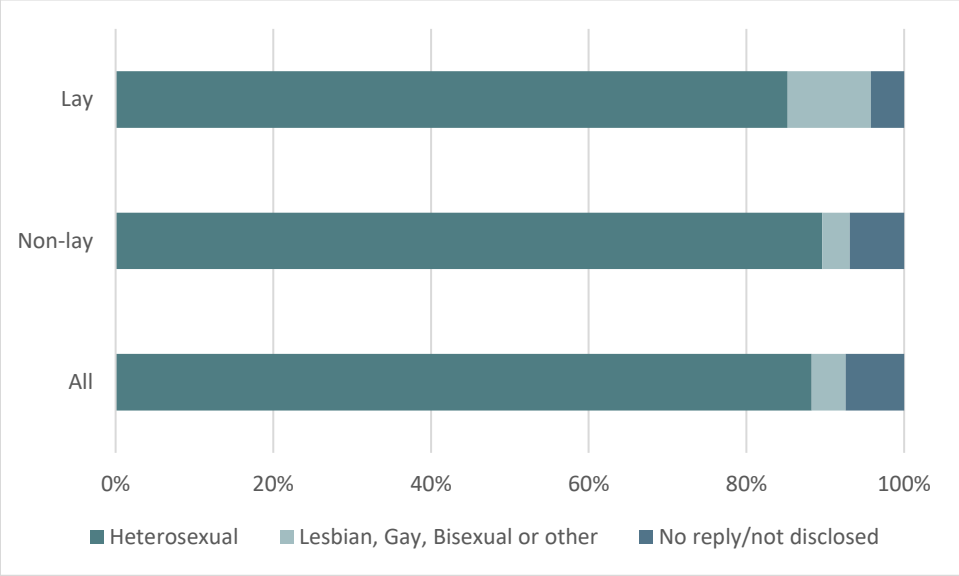
74. Compared with the general population (England and Wales, Office for National Statistics mid-2017 estimates) committees are under-representative of people

under 35 years old and over 65 years old.[5] This is a likely consequence of seeking 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.

75. The proportion of respondents between 51 and 65 years old was highest on the Medical Technologies Advisory Committee (69%) and Quality Standards Advisory Committee (65%). It was lowest on the Indicator Advisory Committee (18%) and Highly Specialised Technologies Evaluation Committee (33%).

Sexual orientation

Chart 5: Sexual orientation: advisory committee members



Download the data set for this chart

76. In the 2019 survey 88% of respondents identified themselves as heterosexual, 4% lesbian, gay, bisexual or other, and 7% did not answer or provide this information. In the 2018 survey, 5% of respondents identified themselves as lesbian, gay, bisexual or other, with 88% identifying as heterosexual and 7% not providing this information.

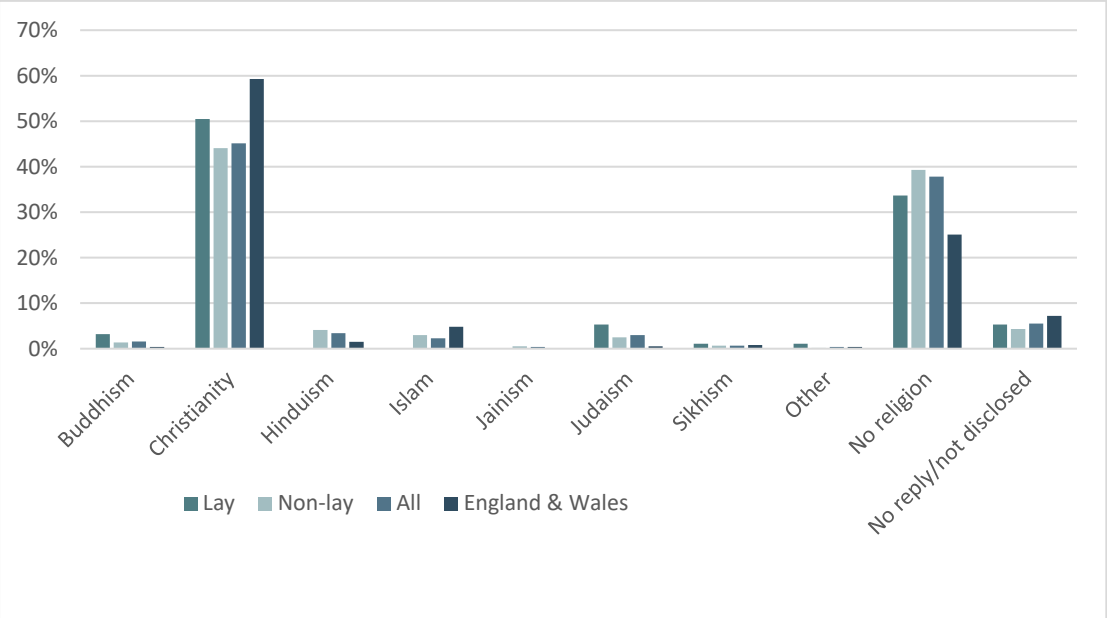
77. As in 2018, the proportion of respondents who identified as lesbian, gay, bisexual or other was higher for lay members (11%) than non-lay members (4%). In 2018, the figures were 7% and 5% respectively.

[5] 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

78. Estimates from the 2017 Annual Population Survey published by the Office for National Statistics, showed that 93% of the UK population identified themselves as heterosexual; 5% as lesbian, gay, bisexual or other; and 4% did not know or answer.

Religion or belief

Chart 6: Religion or belief: advisory committee members



Download the data set for this chart

79. The largest proportion of respondents to the 2019 survey identified themselves of Christian belief (45%) followed by no religion (38%). This is a change from 2018 when the highest proportion of respondents identified themselves as having no religion, but consistent with the responses to the 2016 and 2017 survey when the highest proportion of respondents identified themselves of Christian belief. The proportion of lay respondents who stated they had no religion decreased from 52% in 2018 to 34% in 2019.

80. Compared with the general population (England and Wales, 2011 census) NICE's committees are over-representative of people without a religion, and under-representative of people of Christian and Muslim religion.

81. The proportion of respondents who identified themselves as having no religion was highest on the Technology Appraisal Committees (58%) and lowest on the Highly Specialised Technologies Evaluation Committee (8%). These committees also had the lowest and highest proportion of respondents who identified themselves of Christian belief – 23% and 75% respectively.

Rurality

82. While not a protected characteristic, the Board is mindful of the inequalities arising from rurality, particularly in terms of access to services. It has therefore requested information is collated on the geographical spread of committee members, in particular the proportion drawn from urban and rural areas.

83. Table 4 outlines the spread of committee members' home addresses between urban and rural areas in England. Where a home address was not held, a committee member's work address was used.

Table 4: Distribution of advisory committee members (lay and non-lay) in England between rural and urban areas – March 2019

Area	% of NICE committee members in 2018	% of NICE committee members in 2019	% of population in England
Urban (Connected built up areas identified by Ordnance Survey mapping that have resident populations above 10,000 people (2011 Census) ONS definition)	86	83	82
Rural (Areas that are not urban - consisting of settlements below 10,000 people or are open countryside. ONS definition)	15	17	18

84. Compared with last year the proportion of NICE committee members drawn from urban areas and rural areas respectively is now closer to the split in the overall population in England.

Benchmarking performance

85. 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.

86. Tables 5a-d compare the composition of the NICE advisory bodies (using the results of the 2019 Picker survey) with the population of England, and statistics

published by the Commissioner for Public Appointments (CPA) on regulated appointments made by Ministers between 1 April 2017 and 31 March 2018 (the latest available data).

87. The data indicates that:

- The proportion of women on NICE committees is higher than for the CPA appointments in 2017/18 in both the NHS and overall.
- The proportion of members of non-white ethnicity on NICE's committees is higher than for the CPA appointments in the NHS in 2017/18, and more than twice that for all of the CPA appointments in 2017/18.
- 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.
- The proportion of NICE committee members who identified themselves as lesbian, gay or bisexual was the same as the CPA appointments in 2017/18 both overall and in the NHS.

Table 5a: NICE compared with 'benchmark' organisations – gender

Gender	NICE advisory bodies (%)	All public bodies (%)	NHS bodies (%)	England population (%) 2011 Census
Men	50	45	56	49
Women	48	41	40	51
Undisclosed / not known	2	14	4	0

Table 5b: NICE compared with 'benchmark' organisations – ethnicity

Ethnicity	NICE advisory bodies (%)	All public bodies (%)	NHS bodies (%)	England population (%) 2011 Census
Black, Asian & minority ethnic group (includes mixed)	14	6	10	14
White	83	70	85	85
Undisclosed / not known	3	24	5	0

Table 5c: NICE compared with 'benchmark' organisations – disability

Disability	NICE advisory bodies (%)	All public bodies (%)	NHS bodies (%)	England population (%) 2011 Census
Yes	10	5	4	18
No	72	63	91	82
Undisclosed / not known	18	32	5	0

Table 5d: NICE compared with 'benchmark' organisations – sexual orientation

Sexual orientation	NICE advisory bodies (%)	All public bodies (%)	NHS bodies (%)	England population (%) 2017 Annual Population Survey
Lesbian, gay, bisexual or other	4	4	4	5
Heterosexual	88	58	86	93
Undisclosed / not known	7	38	10	4

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:

    - victims of domestic abuse
    - young people leaving care
    - refugees and asylum seekers
    - people who misuse drugs or alcohol
    - people who are homeless
    - people whose first language is not English or are unable to read
    - carers.

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 outlines the number of potential equality issues identified across the NICE guidance programmes, and the number which subsequently impacted on recommendations. It also provides a breakdown of the potential equality issues that were identified by protected characteristic. It indicates for example, that during the production of the 3 pieces of diagnostics guidance published in 2018/19, 13 potential equality issues were identified, 3 of which related to age. Three of the 13 potential issues subsequently impacted on recommendations.

Table 6: Summary of equality analysis of published guidance

Guidance type	Number of publications	Number of equality issues identified	Age	Disability	Gender reassignment	Pregnancy and maternity	Race	Religion or belief	Sex	Sexual orientation	Socio-economic	Other	Number of equality issues with an impact on recommendations
Diagnostics guidance	**3**	**13**	3	4	1	2	1	1	1	0	0	0	**3**
Highly specialised technologies evaluation	**1**	**1**	1	0	0	0	0	0	0	0	0	0	**0**
Interventional procedures guidance	**36**	**119**	30	31	1	3	19	4	23	0	8	0	**0**
Medical technologies guidance	**5**	**3**	0	3	0	0	0	0	0	0	0	0	**1**
Technology appraisals	**57**	**42**	6	8	0	2	7	2	1	0	1	15	**12**
Clinical guidelines	**14**	**74**	12	19	1	3	10	3	3	1	3	19	**62**
Clinical guideline updates	**4**	**23**	3	4	0	0	3	1	2	1	4	5	**11**
Public health guidelines	**3**	**48**	0	3	0	1	2	1	2	2	2	35	**3**
Antimicrobial prescribing guidelines	**8**	**24**	8	8	0	8	0	0	0	0	0	0	**8**
Quality standards	**17**	**73**	21	14	2	2	7	4	3	2	3	15	**55**
Indicator set	**9**	**10**	3	3	0	0	3	0	0	0	1	0	**0**
Total	**157**	**430**	**87**	**97**	**5**	**21**	**52**	**16**	**35**	**6**	**22**	**89**	**155**

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 equality issues found	Number & % of equality issues found	Number & % of equality issues found	Number & % of issues with impact on recs	Number & % of issues with impact on recs	Number & % of issues with impact on recs	Number & % of issues with impact on recs
	2015/16	2016/17	2017/18	2018/19	2015/16	2016/17	2017/18	2018/19
Age	87 (19%)	64 (18%)	68 (14%)	87 (20%)	30 (15%)	15 (13%)	18 (10%)	26 (17%)
Disability	85 (19%)	56 (16%)	90 (19%)	97 (23%)	41 (21%)	37 (33%)	33 (18%)	39 (25%)
Gender reassignment	10 (2%)	11 (3%)	4 (1%)	5 (1%)	4 (2%)	3 (3%)	3 (2%)	3 (2%)
Pregnancy & maternity	18 (4%)	7 (2%)	16 (3%)	21 (5%)	2 (1%)	2 (2%)	7 (4%)	9 (6%)
Race	54 (12%)	46 (13%)	71 (15%)	52 (12%)	26 (13%)	10 (9%)	21 (11%)	19 (12%)
Religion or belief	21 (5%)	15 (4%)	26 (5%)	16 (4%)	13 (7%)	8 (7%)	11 (6%)	8 (5%)
Sex	46 (10%)	34 (10%)	38 (8%)	35 (8%)	11 (6%)	3 (3%)	8 (4%)	7 (5%)
Sexual orientation	9 (2%)	9 (3%)	13 (3%)	6 (1%)	4 (2%)	3 (3%)	5 (3%)	4 (3%)
Socio-economic	37 (8%)	21 (6%)	38 (8%)	22 (5%)	18 (9%)	8 (7%)	10 (5%)	7 (5%)
Other	80 (18%)	85 (24%)	110 (23%)	89 (21%)	45 (23%)	24 (21%)	67 (37%)	33 (21%)
Total number of issues	**447**	**348**	**474**	**430**	**194**	**113**	**183**	**155**
Total guidance produced	**191**	**163**	**193**	**157**	**191**	**163**	**193**	**157**

95. In 2018/19, 430 potential equality issues were identified during the development of 157 pieces of published guidance. The outcome of advisory bodies' equality analysis was that consideration of 155 (36%) of the issues identified had an impact on recommendations, whereas consideration of 275 (64%) issues did not. Since 2016/17 there has been a year on year increase in both:

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

96. In 2018/19 the percentage of the identified potential equality issues that subsequently impacted on recommendations (36%) was slightly lower than in 2017/18 (39%) but higher than in 2016/17 (32%).

97. 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.

98. 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 for the medical technologies, technology appraisals, highly specialised technologies, and indicators programmes. The extent the identified issues impacted on recommendations also varies between programmes. 62 of the 74 identified potential equality issues (84%) impacted on recommendations in the clinical guidelines. 119 potential equality issues were identified in the interventional procedures programme, but none subsequently impacted on guidance recommendations; this was similar to 2017/18 when none of the 112 identified potential equality issues in the interventional procedures programme impacted on guidance recommendations.

99. 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. For example, the public health and social care guidelines have greater scope to address inequalities and promote the equality duty than programmes focused on evaluating a specific health technology. Some inconsistency in the process between teams was however noted and this will be explored further, following which further training may be offered. In particular, it has been identified that a NICE-wide definition of what constitutes a potential equality issue and the consistency in reporting of identified equality issues needs to be reviewed. This is likely to occur in the CHTE methods review which includes a task and finish group on equality considerations in guidance development and will include members of the NEDG to ensure it is applicable across NICE.

Examples of how equalities considerations have impacted recommendations in guidance published in 2018/19

Guideline NG101: Early and locally advanced breast cancer: diagnosis and cancer

100. The guideline committee noted that there are elevated rates of triple-negative breast cancer among some ethnic groups, for example Afro-Caribbean people, and they are therefore more likely to be affected by delays to optimal treatment if progesterone receptor status is not known.

101. The recommendations made by the committee will reduce this inequality as progesterone receptor testing will be performed upfront in all people allowing for earlier determination of triple-negative status.

NG106 – Chronic heart failure in adults: diagnosis and management

102. The committee noted that older people may face barriers to accessing cardiac rehabilitation as they may be frail and not able to travel distances to access these services. They also noted that older people are more likely to have co-morbidities and be on multiple medication for different conditions, but that limited mobility can prevent them from being reviewed by their GP or heart failure clinic until they become acutely unwell.

103. The guideline contains a recommendation on providing rehabilitation services within the home and community to facilitate access among older people. The guideline also recommends that primary care services recall patients every 6 months as a minimum to review their condition and update their care plan as necessary.

Quality standard 170: Spondyloarthritis

104. The committee highlighted a common misconception that the condition mainly affects men. The quality standard therefore notes that healthcare professionals should be aware that axial spondyloarthritis affects a similar number of women as men. Women are less likely to show sacroiliitis on X ray than men, but they should still be offered X ray for first-line imaging of suspected axial spondyloarthritis.

Quality standard 177: Pancreatic cancer

105. Quality statement 2 states: “Adults with unresectable pancreatic cancer are prescribed enteric-coated pancreatin.”

106. The committee highlighted that pancreatic enzyme supplements are made from pork products, which may be unacceptable to some people because of their religion or beliefs. The quality standards therefore advises that people with pancreatic cancer need to be made aware of the ingredients so they can make an informed decision.

Technology appraisal 574: Certolizumab pegol for treating moderate to severe plaque psoriasis

107. The committee highlighted in recommendations that healthcare professionals should take into account how skin colour can affect the Psoriasis Area and Severity Index (PASI) tool and make reasonable adjustments. Also when using the Dermatology Life Quality Index (DLQI), healthcare professionals should take into account any physical, psychological, sensory or learning disabilities, or communication difficulties, which could affect a person’s responses to the DLQI, and make any adjustments they consider appropriate.

Medical Technologies guidance 41: Senza spinal cord stimulation (SCS) system for delivering HF10 therapy to treat chronic neuropathic pain

108. The committee highlighted in recommendations that when assessing the severity of pain and the trial of stimulation, the multidisciplinary team should be aware of the need to ensure equality of access to treatment with SCS. Tests to assess pain and response to SCS should take into account a person's disabilities (such as physical or sensory disabilities), or linguistic or other communication difficulties, and may need to be adapted.

Diagnostics guidance 34: Tumour profiling tests to guide adjuvant chemotherapy decisions in early breast cancer

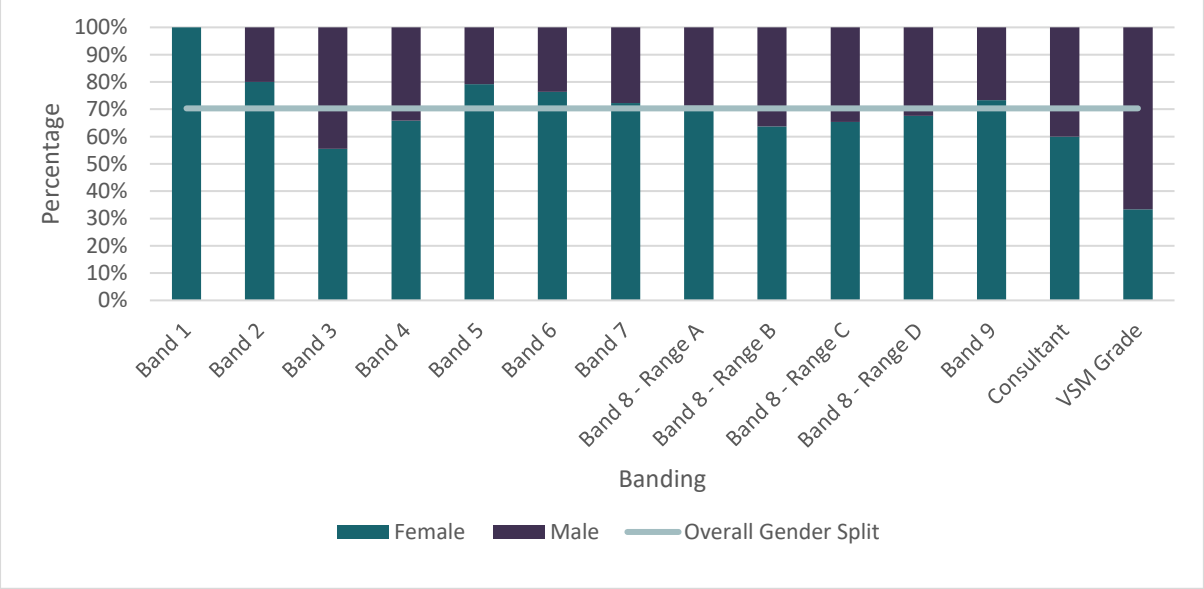
109. The committee noted that one of the three recommended tests was only indicated for use in postmenopausal people but that the two other recommended tests were indicated for use in both pre-and post menopausal people. The committee considered that the positive recommendations for all three tests allowed both pre- and post-menopausal access to testing.

Workforce

110. This section provides a summary of the workforce profile by equality category, as at 31 March 2019. Further information is available in the annual workforce report presented to the Board in July 2019.

Gender

Chart 7: Gender mix of staff by grade



Download the data set for this chart

111. Compared with the overall gender split of the workforce, men are over-represented in the most senior grades and some of the lower grades (bands 3 and 4). The overall gender split of the workforce has not changed significantly

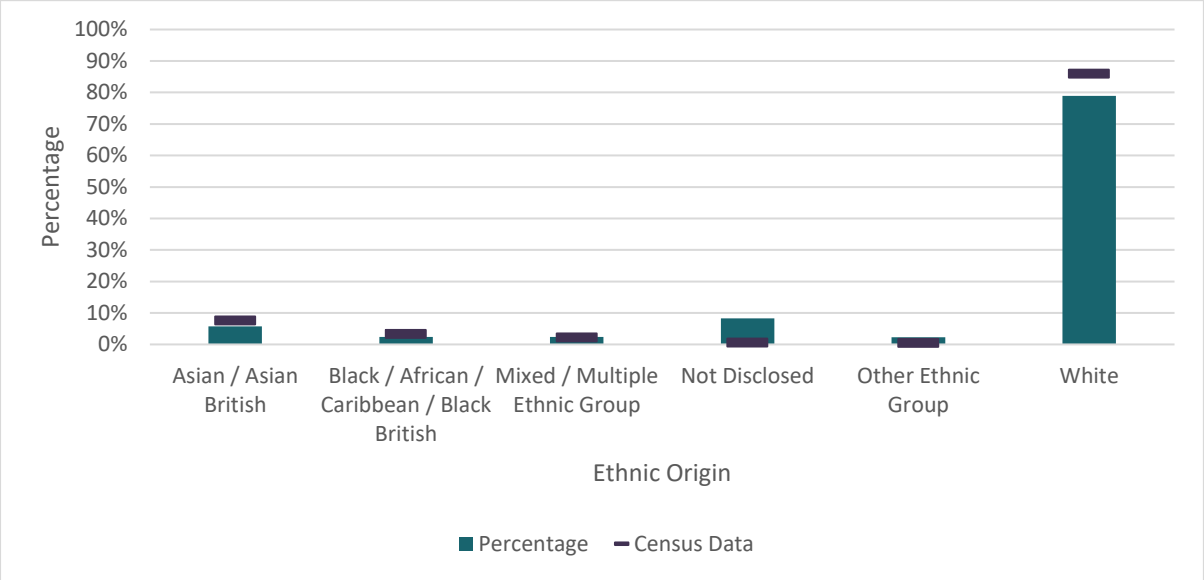
over time. NICE's gender pay gap report is available on our website. The current electronic staff record (ESR), which is nationally used software, does not currently provide an option for employees who prefer to self-describe.

Disability

112. Staff are encouraged to declare any disabilities, which may include learning disability or difficulty, long-standing illness, mental health conditions, physical impairment and sensory impairment. There were 26 staff declaring a disability which is 3.9% of the workforce.

Ethnicity

Chart 8: Ethnicity: NICE staff

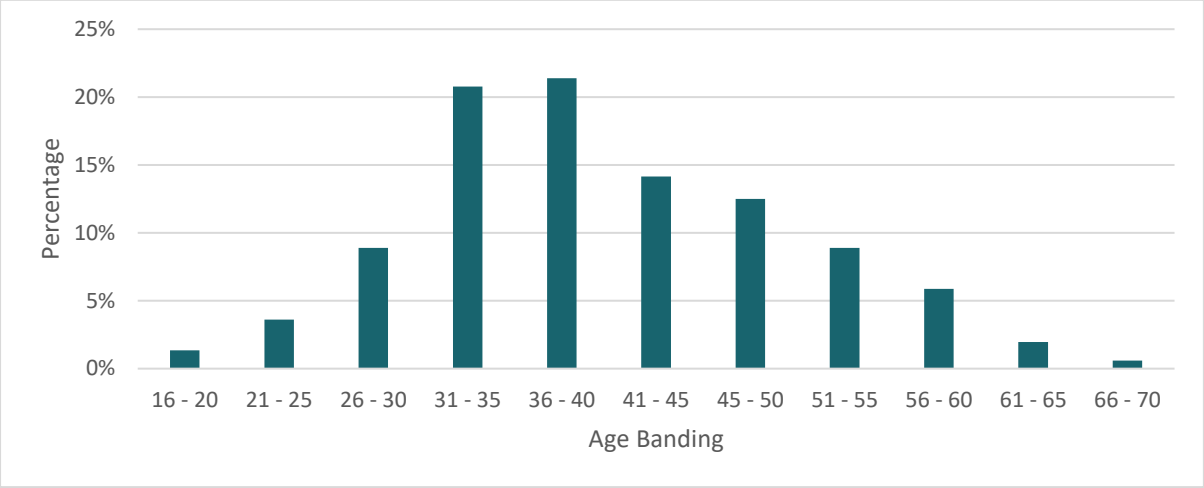


Download the data set for this chart

113. The proportion of staff of white ethnicity increased slightly from 77% in 2017/18 to 79% in 2018/19 (the same as 2016/17). In the 2011 census, the figure for England and Wales overall was 86%.

Age

Chart 9: Age profile: NICE staff

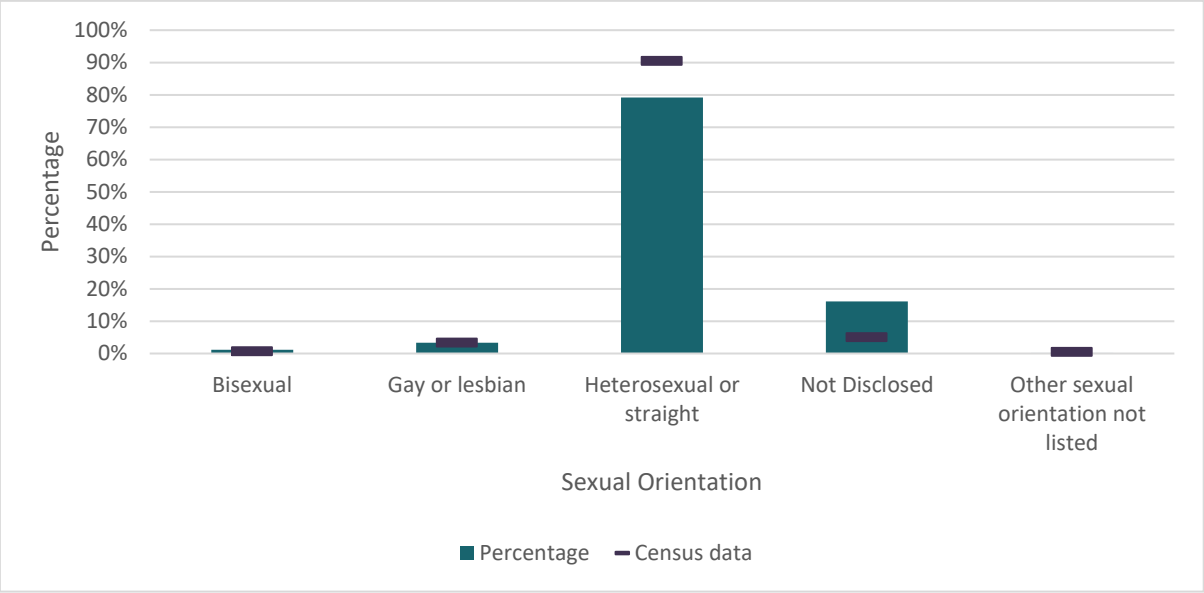


Download the data set for this chart

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

Sexual orientation

Chart 10: Sexual orientation: NICE staff



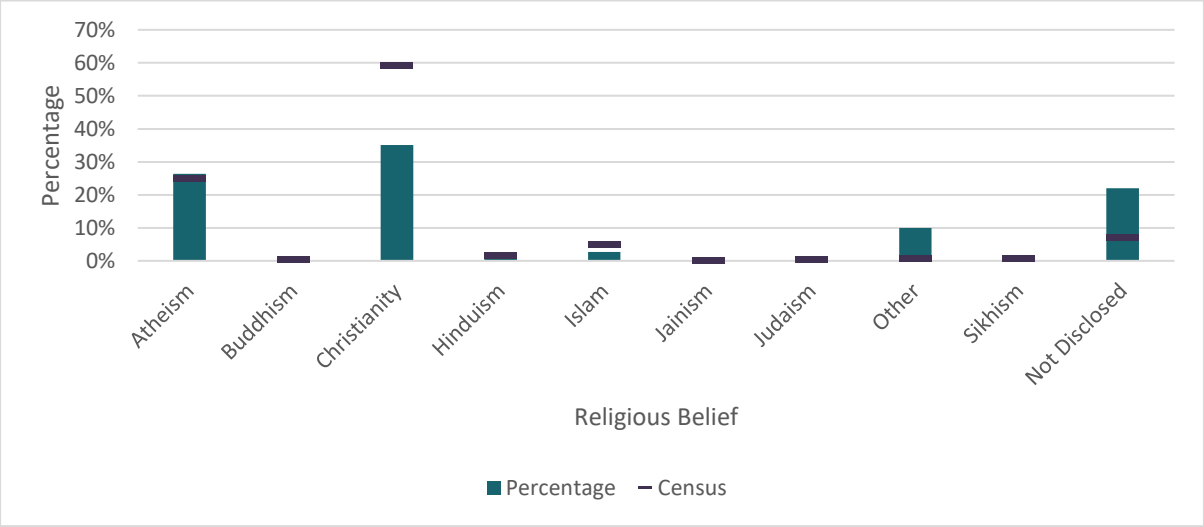
Download the data set for this chart

115. The profile is little changed from 2017/18, with a combined non-disclosure and non-specified rate of 16%. 5% of staff have recorded their sexual orientation as lesbian, gay or bisexual. NICE continue to be Stonewall Diversity Champions, which is a framework designed to help employers to support lesbian, gay,

bisexual and transgender employees to reach their full potential in the workplace.

Religion and belief

Chart 11: Religion and belief: NICE staff



Download the data set for this chart

116. The largest proportion were staff who identified themselves as Christian (35%) followed by no religion (26%), which is similar to last year.

Employment applicants and appointees

117. 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 then automatically transfers to the Electronic Staff Record (ESR) system. There was a total of 6,643 applications for the 152 posts advertised in 2018/19.

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

- Ethnicity: 53% of applicants identified themselves of white ethnicity, compared with 77% of appointees.
- Age: Those aged between 25 and 34 years old accounted for 40% of applicants and 46% of appointees. 12% of applicants were under 25 years old, compared with 7% of appointees.
- Gender: 41% of applicants were men, compared with 24% of appointees.

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

September 2019

National Institute for Health and Care Excellence

Antimicrobial resistance: developing and testing innovative models for the evaluation and purchase of antimicrobials

In November 2018, the Board approved a proposal for NICE to engage in a collaborative project with NHS England to develop and test a new model for the evaluation and purchase of antimicrobials.

Since the Board approval, a central project team comprising staff from NICE, NHS England & NHS Improvement and DHSC has been established, governance arrangements agreed, and the project formally launched. This paper provides an update to the Board on progress with this project and seeks the Board's advice on any aspects of the work.

The Board is asked to note progress to date and provide advice on any aspects of the project.

Nick Crabb

Programme Director, Science Advice and Research

September 2019

National Institute for Health and Care Excellence

Antimicrobial resistance: developing and testing innovative models for the evaluation and purchase of antimicrobials

Purpose

1. This paper aims to outline the NICE and NHS England & NHS Improvement project to develop and test a new model for the evaluation and purchase of antimicrobials.

2. The intention is to develop and test models that pay companies for antimicrobials based primarily on a NICE led health technology assessment of their value to the NHS as opposed to the volumes used. Such models, if demonstrated to be viable and then adopted more widely internationally, have the potential to provide a much-needed incentive for the development of new antimicrobial agents.

Background

3. Antimicrobial resistance (AMR) is one of the most pressing global challenges we face this century. Unchecked, AMR threatens many of the Sustainable Development Goals including those affecting health, food security, trade, and labour supply.

4. While the UK has made progress in reducing the use of antimicrobials in humans and significantly in animals in the last five years, drug-resistant infections in humans increased by 35% from 2013 to 2017 in England.

5. For most antimicrobials, there are few replacement or alternative products in development and even fewer that target priority pathogens. Investment in novel antibiotics is widely seen as commercially unattractive. The high cost and low returns associated with the research and development of novel antimicrobials have led to potential market failure.

6. In November 2018, the Board approved a proposal for NICE to engage in a collaborative project with NHS England to develop and test a new model for the evaluation and purchase of antimicrobials. This followed methods research commissioned by NICE and DHSC that resulted in a report from the Policy Research Unit in Economic Evaluation of Health & Care Interventions (EEPRU) titled “Framework for Value Assessment of New Antimicrobials: Implications of alternative funding arrangements for NICE appraisal”, published in October 2018.

7. Since the Board approval, a central project team comprising staff from NICE, NHS England & NHS Improvement and DHSC has been established, governance arrangements agreed, and the project formally launched. A period of targeted stakeholder engagement has also been initiated, focusing on the evaluation framework, topic selection criteria and the outline commercial model to be used in the project.

Project overview

8. The project is intended to assess the extent to which the framework outlined in the EEPRU report can be used by NICE and NHS England & NHS Improvement to inform antimicrobial value assessment, reimbursement and purchasing decisions.

9. The objectives of this project therefore are to:

    - Develop and test the feasibility of an adapted NICE HTA evaluation framework using two antimicrobials;
    - Develop and test a commercial model for the selected antimicrobials, based on the NICE assessment;
    - Evaluate the feasibility of the wider application of these models to new antimicrobials in the NHS; and
    - Promote the project internationally and share learning with stakeholders to inform the development of incentives for new antimicrobials internationally.

10. A central project team has been established across NICE, NHS England & NHS Improvement and DHSC to lead the work, and to facilitate input from experts and a wide range of stakeholders. The core team have been working together since the beginning of the year on preparation for the project which was formally launched through a joint statement from NICE and NHS England in July 2019. Following the launch, a period of targeted engagement with stakeholders running from 29 July to 6 September 2019 was initiated through a webinar.

11. An outline timetable for the project is:

    - Establish governance arrangements – completed
    - Develop topic selection criteria – draft included in targeted engagement exercise
    - Develop the HTA evaluation framework – draft included in targeted engagement exercise

- Develop a commercial model to be tested – draft included in targeted engagement exercise
- Finalise topic selection criteria, HTA evaluation framework and commercial model following the targeted engagement exercise – by October 2019
- Select two products for assessment – by November 2019
- Evaluate the two selected products – from January to December 2020
- Engage with companies on commercial model – by March 2021
- Implement payments – from March 2021

Targeted stakeholder engagement

Topic Selection

12. An important aspect of the project is the selection of the two antimicrobials used to test the new model for the evaluation and purchasing. The topic selection process has attracted significant interest from the pharmaceutical industry – and there is high risk of challenge. To manage this, we are testing the selection process and prioritisation criteria through targeted stakeholder engagement (see Appendix 1).

13. The proposed topic selection process is broadly based on the existing NICE topic selection process whilst recognising that additional specialist expertise may be needed.

Evaluation Framework

14. A crucial part of the project is the design of an evaluation framework, that will be tested through the evaluation of the two antimicrobials selected through the topic selection process outlined above. The proposed evaluation framework presents both process and methods considerations including:

    - The potential to scale up evaluation processes for other antimicrobials;
    - Company participation in the development of the health economic model;
    - The consideration of other elements of value that antimicrobials generate (e.g. diversity, transmission, enablement, spectrum and insurance value), as indicated in the EEPRU report;
    - The extent to which these elements of value can be captured in terms of quality-adjusted life years (QALYs);
    - The role of expert elicitation;

- The role of presenting summaries of available evidence, including expert commentary on elements of value not included in the economic model; and
- Consideration of wording of recommendations and messaging to ensure that the guidance is of maximal use to those using it in their clinical practice.

15. The considerations outlined above represent significant differences from the approach used to evaluate products in NICE's technology appraisals programme. It was therefore considered important to test the proposals through stakeholder engagement. The evaluation framework shared with stakeholders as part of the targeted engagement exercise is shown in Appendix 2.

Commercial Model

16. The commercial model will set out the approach to reimbursement and in due course the levels of payments for the selected antimicrobials. The design principles and considerations of the commercial model will include:

- Providing payments and predictability of revenue to be commercially attractive;
- Affordability and managing budget impact, while also offering value to the NHS and taxpayers;
- Incentivising company recognition of priorities such as antimicrobial stewardship and agreed environment stewardship;
- Ensuring that the commercial model can be transacted through NHS funding mechanisms and has appropriate data collection to support oversight of product use.

17. It was considered important to test the proposed commercial model with companies to better understand company expectations and requirements. The outline commercial model being shared with stakeholders as part of the targeted engagement exercise is shown in Appendix 3.

Governance

18. The project is led jointly by NICE and NHS England & NHS Improvement, working closely with DHSC to ensure that the work contributes to the international thought leadership on AMR. The project reports into the NHS England & NHS Improvement Programme 1: Human Health of the AMR programme and NICE SMT.

19. A Project Board has been established, with members from NHS England & NHS Improvement, NICE, DHSC and Public Health England. The Project Board is responsible for overseeing the project. The Project Board will sign off most project activities and documents escalating sign off to the NICE SMT and the AMR human health programme board at critical steps for the project.

20. The central project team with members from NICE, NHS England & NHS Improvement and DHSC is responsible for the planning and delivery of the project. An Expert Advisory Group and Stakeholder Group will support wider engagement and provide national and international expertise.

Potential issue with Public Contracts Regulation compliance

21. Procurement experts from NHS England & NHS Improvement have highlighted the need to consider fully the implications of the Public Contracts Regulation (PCR) on the project. It may prove necessary to run the topic selection, evaluation and commercial negotiation stages within a formal procurement exercise which would add complexity and potentially cause some delay.

22. Work is under way to assess how the project can still achieve its aims, while ensuring adherence to the relevant regulations. The Board will be updated on this progress in due course.

Financial implications

23. The central project team is being resourced by NICE and NHS England. Within NICE, staff from the Science Advice and Research function and Centre for Health Technology Evaluation are involved. NHS England has also agreed to contribute approximately £107,000 pa for 2 years to NICE's costs. DHSC is funding the academic value assessment work through its policy research programmes.

Conclusion

24. The project is making strong progress and attracting considerable attention internationally.

Next steps

- Update project plans and processes as appropriate based on responses from the targeted stakeholder engagement exercise
- Determine whether the project needs to be undertaken within a formal procurement process

- Deliver project in accordance with the timetable outlined in this paper (or potentially modified timetable if a formal procurement exercise is needed).

September 2019

Appendix 1: Targeted engagement topic selection criteria

The topic selection process will consider the candidate antimicrobials identified for potential inclusion in project against the following essential criteria and additional considerations (subject to any changes arising from the targeted engagement exercise).

Essential criteria:

To progress to further consideration, candidates must meet all the essential criteria

A. Any company requesting its product to be part of the test project needs to have shown commitment to stewardship and high standards of behaviour from a manufacturing/environmental perspective. The company performance on the AMR benchmarking scorecard could be considered as one indicator of high commitment (https://accesstomedicinefoundation.org/amr-benchmark/report-cards)

B. The product needs to have achieved a marketing authorisation (MA) in the past 2-3 years or have a confident expectation of an MA by end 2020 at the latest with plans to launch in UK.

C. The product needs to be active against a pathogen on the WHO priority pathogen list [see below for detail of WHO priority pathogen list].

Additional considerations

These will facilitate judgement on which two candidates are most appropriate for the pilot project

1. Extent to which the product addresses a high UK unmet need. Input will be sought from APRHAI, PHE and BSAC for confirmation of this

2. Are there existing effective comparators available?

3. Is there a degree of novelty to this product? Does this agent bypass current mechanisms of resistance? Or associated with less toxicity?

4. Degree of clinical severity of target disease area

5. Will the main use of this agent be hospital setting or community setting?

6. How mature is the existing evidence base? Will available data support an evaluation? And specifically, is there UK resistance/sensitivity data?

7. What is the likely usage of this agent? Are there estimates of the potential population likely to receive this drug per annum in the first 1-5 years after launch?

8. What is the current status of the antibiotic pipeline relevant to activity of this agent? Are other agents in development against the target pathogen(s) or disease area?

9. Is there expected usage beyond the current or planned marketing authorisation (MA)? If yes, for what pathogens/disease areas? Are there any estimates of numbers of patients treated per annum outside the MA?

10. Is the marketing indication and likely usage suitable for modelling in a pragmatic, timely way?

11. Is the product active in an area that is commissioned by clinical commissioning groups (CCG) or specialist commissioning? While not a key consideration for selection, the commissioning arrangements may influence the nature of subsequent commercial negotiations.

WHO Global Pathogen Priority List

Priority 1 Critical

- Acinetobacter baumanii- carbapenem resistant
- Pseudomonas aeruginosa- carbapenem resistant
- Enterobacteriaceae – carbapenem resistant, 3rd generation cephalosporin resistant

Priority 2 High

- Enterococcus faecium – vancomycin resistant
- Staphylococcus aureus – methicillin resistant, vancomycin intermediate & resistant
- Campylobacter – fluoroquinolone resistant
- Salmonella – fluoroquinolone resistant
- Helicobacter pylori – Clarithromycin resistant
- Neisseria gonorrhoea – fluoroquinolone resistant, 3rd generation cephalosporin resistant.

Priority 3 Medium

- Streptococcus pneumonia – penicillin non-susceptible
- Haemophilus influenza – ampicillin resistant
- Shigella – fluoroquinolone resistant

Appendix 2 – Targeted engagement evaluation framework

DEVELOPING AND TESTING INNOVATIVE MODELS FOR THE EVALUATION AND PURCHASE OF ANTIMICROBIALS

Activity 1: Evaluation framework

Purpose

1. The evaluation framework will guide the evaluation of two antimicrobials selected through Activity 3 (Topic Selection) in the NICE and NHS England project to develop and test innovative models for the evaluation and purchase of antimicrobials in the UK.

Key stages in the evaluation

2. The main stages in the evaluation of each of the antimicrobials are:

   a. Completion of a scoping document by NICE and the DHSC Policy Research Unit in Economic Methods of Evaluation in Health and Care Interventions (EEPRU)

   b. Submission of relevant evidence and information by the company

   c. Completion of a protocol for the evaluation work by EEPRU

   d. Completion of an HTA report by EEPRU, including a step to allow the company to review a draft

   e. NICE committee process that reviews the HTA report and considers the added value from use of the product and most plausible assumptions on the clinical and economic assessment of value

   f. Completion of a NICE guidance document based on the HTA report and Committee considerations. The guidance will include preliminary recommendations to inform subsequent negotiation between the companies and NHS England, supported by NICE's commercial and managed access programme where appropriate (Activity 5)

   g. Completion of final NICE guidance to reflect the outcomes of the commercial negotiation.

Process considerations

3. The timeline for steps (a) to (f) is anticipated to be 12 months. Step (g) will be undertaken later following the commercial negotiation. The evaluation of the two antimicrobials will be undertaken in parallel, such that the commercial negotiations can commence for both products within the 12-month timeline.

4. In this project, the product evaluations will be undertaken by the EEPRU supported by other experts and DHSC policy research units as appropriate.

5. A special committee will be convened at NICE for this project. It is envisaged that this will comprise approximately 10 members from current NICE Technology Appraisals committees with an additional 6 members with specialist expertise (e.g. treating clinicians, transition modelling experts and clinical data specialists). Members will be appointed by the Central Project Team with oversight from the Project Board. This committee will be appointed ahead of the evaluation so that representatives, including the Committee Chair, can contribute to the scoping.

6. Part of the objective of the current project is to develop arrangements for the evaluation and purchase of new antimicrobials that could potentially be rolled out more widely, depending on the eventual policy informed by this project. It is therefore important that the resources applied to antimicrobial evaluation are not unrealistic and that a similar approach could be scaled up as necessary to a broader range of products. As a guide, resources equivalent to those employed by Assessment Groups working on a NICE multiple technology appraisal (MTA), are considered a realistic starting point for the evaluation of each of the antimicrobials. It may be reasonable, however, to apply some resources in excess of this level to reflect that these are the first evaluations and that some future efficiencies are likely should the approach be rolled out more widely.

7. A consequence of the resource consideration is that the product evaluations need to deliver the best HTA reports possible within the available resources, rather than comprehensively evaluating all scenarios and elements of value.

8. The process will require a company submission of relevant evidence, but this does not need to include an economic model. However, where available, company health economic models will be taken into account.

9. The NICE guidance documents produced in this project will not be Technology Appraisals guidance and some of the process elements included in the Technology Appraisal process, such as public consultation on the preliminary recommendations and final guidance, will not be included.

10. To the extent possible, outputs from the evaluation of the selected products will be made publicly available. Arrangements for handling commercial in confidence

and academic in confidence information will be based on NICE's current processes.

Methods considerations

11. The methodological learning captured in the EEPRU report Framework for Value Assessment of New Antimicrobials should guide much of the work. In addition, where applicable, principles in the NICE guide to the methods of technology appraisal should be followed. Other methods and models for evaluating antimicrobials should also be considered and adopted as appropriate. However, given that these evaluations are highly complex, EEPRU colleagues will be expected to apply their expertise and judgement without being constrained by a prescriptive methodological framework.

12. EEPRU colleagues should seek specialist support for elements of the evaluations as appropriate. Provision has been made for input from other DHSC research units; Operational Research for Emergency Response and Strategic Planning Analysis (OPERA), and Health Protection and Improvement with Operational Research (HAPIOR). Further specialist input may be required, for example from members of JCVI.

13. The scoping of the evaluations is a critical and complex phase. The scoping phase will be co-managed by EEPRU and NICE. The final scope will be signed off by NICE. To be useful in the subsequent commercial negotiations, the HTA reports should cover the full scope of the Marketing Authorisation (MA). Depending on the product, the MA could potentially include multiple scenarios across different pathogens and clinical syndromes. Based on the resource constraints and timelines, it may not be feasible to comprehensively consider and develop health economic models for all these scenarios.

14. Antimicrobials are often prescribed outside of their licensed indications and in some cases, the greatest clinical value of an antimicrobial may not be within the MA. Prior to topic selection and the initiation of scoping, it is essential that there is clear agreement on whether or not indications outside of the MA can be considered. This will be considered by the Project Board and advice will also be sought from the MHRA.

15. It is envisaged that through scoping and protocol development, the following will be identified and agreed:

    a. One or more pathogen/clinical syndrome combination for detailed study and health economic modelling. This should be carefully considered, with input from the project stakeholder advisory group, and be where the product has the greatest potential for addressing unmet clinical need or beneficially impacting public health.

b. Other important pathogen/clinical syndrome combinations that need to be considered within the HTA report but where bespoke economic models will not be developed. In these cases, a summary of relevant available quantitative and qualitative information will be provided.

16. It is important that, in addition to the clinical value that is normally considered in HTA, other elements of value that new antimicrobials generate should be considered, including, but not limited to:

    a. Diversity value (having a range of treatment options available)

    b. Transmission value (avoiding onwards spread of pathogens in the population)

    c. Enablement value (enabling other treatments and procedures to take place, e.g. chemotherapy, organ transplant, surgical procedures)

    d. Spectrum value (benefits of replacing broad spectrum antimicrobials with narrow spectrum antimicrobials).

    e. Insurance value (having antimicrobials available for sudden increase of infections with pathogens resistant to existing antimicrobials).

17. In principle, these elements of value can be captured in terms of quality adjusted life years (QALYs). A number of key parameter inputs for any type of model are unlikely to be available from the literature and may need to be estimated through expert elicitation. Depending on timelines and resource availability, a formal expert elicitation exercise should be considered as a method for more robustly quantifying expert opinion. For the pathogen/clinical syndrome combination(s) selected for detailed evaluation, value should be captured in QALYs where possible. Further considerations include:

    a. The analysis needs to include an estimate of benefits at the population level as well as for the patients treated

    b. Several stewardship strategies might need to be modelled and compared (e.g. rotation of antimicrobials, mixing protocols, combination strategies) to identify the optimal usage scenario

    c. Forecasting models and/or more complex dynamic transmission models may be needed to synthesise the available evidence

    d. Microbiological response rates, as well as clinical cure rates and other individual patient outcomes, may need to be included in order to accurately reflect plausible rates of transmission and resistance, as patients who are cured clinically may still contribute to the spread of pathogens

e. For some model parameters, reliable evidence might not be available and expert elicitation might be needed to inform some model assumptions

18. Given the high uncertainty in evaluating the benefits quantitatively, QALY estimates may need to be expressed as ranges rather than as central estimates. The analysis should be explicit about what elements of value are included in the economic model and which elements are not, together with explanations of why some elements of value are not included.

19. For the elements of value not included in the economic model, summaries of the relevant available quantitative and qualitative information may be included as part of the evaluation.

20. Important evidence on the value of a new antimicrobial could potentially be derived from pre-clinical studies such as the in-vitro antimicrobial activity spectrum and pharmacokinetic and pharmacodynamic (PK/PD) profiles. Such evidence, where relevant, should be included in the product evaluations.

21. Given the anticipated high uncertainty at the time of the initial assessment, the key data for collection following the assessment should be identified.

NICE committee considerations

22. The committee stage is crucial in developing NICE guidance about the value of the antimicrobials and to inform subsequent commercial negotiations. It is important, however, that in the appointment of the committee members it is clear that the task differs from normal NICE committee work. The differences between this project and NICE Technology Appraisals of new medicines are summarised in Table 1.

23. The committee will appraise the evidence to identify the most plausible ranges of benefit of the antimicrobial under evaluation through:

    a. Review of quantitative estimates of benefits for the pathogen/clinical syndrome combination(s) selected for detailed evaluation, including consideration of potentially high uncertainty where the evidence supporting model inputs is limited (e.g. based on expert elicitation)

    b. Review of relevant available quantitative and qualitative information for elements of value not included in the health economic modelling for the pathogen/clinical syndrome combination(s) selected for detailed evaluation

    c. Review of relevant available quantitative and qualitative information for the pathogen/clinical syndrome combinations not selected for detailed evaluation

d. Contributing to guidance development based on the HTA report from EEPRU and the committee consideration leading to NICE guidance documents with initial recommendations that inform subsequent commercial negotiations between the companies and NHS England. The committee will not be expected to make binary yes/no decisions on whether the products should be recommended for use in the NHS.

e. Contributing to the development of final NICE guidance reflecting the outcomes of the commercial negotiation.

Future Policy

24. Future policy, including details of process and organisation roles, will be informed by the outcomes from this project and that no assumptions should be made about the future arrangements for the evaluation of antimicrobials.

Table 1: Comparison of antimicrobial evaluation in this project and NICE Technology Appraisals

	Project	NICE Technology Appraisals
Purpose of the NICE evaluation	To produce guidance on the value of the new antimicrobial with initial recommendations to inform commercial negotiations and final guidance that reflects the outcomes of the commercial negotiations.	To produce guidance on the use of the new medicine, funding of which is mandatory for commissioners in the NHS in England.
Topic selection	Bespoke arrangements (see separate document)	Referral by Secretary of State for Health and Social Care
Process	Bespoke process modelled on the NICE MTA process.	NICE single technology appraisal (STA) process.
Methods	Flexible methods at the discretion of EEPRU taking account of the NICE guide to the methods of technology appraisal.	NICE guide to the methods of technology appraisal.
NICE Committee role	To review the EEPRU HTA report and consider the plausibility of assumptions and estimates of value (quantitative and qualitative) And to translate this to guidance.	To consider the assumptions and plausibility of value estimates and to translate this to guidance to the NHS.
Output from the NICE Committee stage	Preliminary recommendations and draft final NICE guidance.	NICE Technology Appraisal guidance.
Expected impact of the evaluation on NHS use of the product	The guidance will inform commercial terms rather than a binary yes/no decision. The guidance will also inform NHS usage by identifying the preferred usage scenario.	Guidance pivotal to whether or not, and under what circumstances, the new medicine is used in the NHS.
Funding mandate	Does not apply	Applies

Appendix 3 – Targeted engagement commercial model

DEVELOPING AND TESTING INNOVATIVE MODELS FOR THE EVALUATION AND PURCHASE OF ANTIMICROBIALS

Activity 2: Commercial model

Purpose

1. The commercial model will be used to agree payment levels for the selected antimicrobials through negotiations between NHS England and NHS Improvement and companies, informed by the outcome of the evaluation and supported by the NICE Commercial and Managed Access Team.

2. The design principles, considerations and potential approaches to the commercial model are put forward without prejudice to the development of the final commercial model(s), and no assumptions should be made about the future arrangements for the evaluation or purchasing of antimicrobials based upon this paper.

3. This paper sets out:

   a. Design principles and considerations that might inform any commercial model that seeks to pay for the value to the NHS as opposed to the volumes used in the purchasing of antimicrobials; and

   b. Thinking to date on the concepts that might underpin a commercial model.

Design principles and considerations for commercial model

4. NHS England and NHS Improvement consider a number of goals when developing any commercial approach, including:

   a. to substantially improve value for the NHS;

   b. to ensure and improve affordability for the NHS;

   c. to address commercial risk;

   d. to address value for money risk; and

e. to ensure that the approach is operationally manageable without imposing disproportionate additional costs or bureaucracy

5. These goals reflect NHS England and NHS Improvement's commitment to patients benefiting from the most clinically and cost-effective medicines at costs that are affordable for the health service and represent value for money for taxpayers.

6. Accordingly, the design principles and considerations in the development of the commercial model for antimicrobials are expected to include the following:

   a. Taking full account of the value assessment in the NICE guidance

   b. Value Sharing

   c. Managing uncertainty

   d. Promoting stewardship

   e. Creating an incentive

   f. Alignment with topic selection

   g. Distribution and supply

   h. Costs

   i. Alignment with UK 2019 Voluntary Scheme for Branded Medicines Access and Pricing and Statutory Scheme

   j. Supplier capacity

   k. Monitoring

7. Each of these principles and considerations are explored below:

   a) Taking full account of the value assessment in the NICE guidance

8. The negotiation will take full account the value assessment undertaken by NICE, whilst retaining sufficient flexibility to reflect the inherent uncertainty of antimicrobial value assessment so that NHS England and NHS Improvement can ensure value to the NHS and taxpayers. NHS England and NHS Improvement will also need to consider affordability and budget impact in this context. Any QALY estimates in the evaluation and qualitative commentary are intended to be used to inform the negotiation as will an indication of the expected value of the product put forward by the manufacturer. Similarly, the usage

estimates and established market prices for comparable products are likely to be used to inform the negotiations.

b) Value sharing

9. The valuation is anticipated to estimate both the benefit to individual patients and the population as a whole. If supplier payments are set a level equivalent to the estimated value, then all value is effectively retained by the supplier. It is NHS England and NHS Improvement's intention that the payments should be set at a level that enables a reasonable proportion of the value to be retained by the NHS i.e. the value is shared between buyer and supplier.

c) Managing uncertainty

10. The commercial approach is expected to include mechanisms for managing uncertainty. A number of potential commercial options are available, and these may need to be applied flexibly for different antimicrobials based on their attributes of value. For example, the optimum commercial model for a product intended as a last line treatment with strict conservation may be different to that for a product where payments are intended to support use as a first line treatment or in a cycling regime.

d) Promoting stewardship

11. The practical arrangements for the administration of the payment model should ensure that optimal stewardship strategies are implemented. This will include both how the supplier expects to comply with and support stewardship strategies, and how guidance is applied to prescribers.

e) Creating an incentive

12. The arrangements will offer value to the NHS and taxpayers and provide the payment levels and predictability of revenue to be attractive to companies. If this is achieved and other countries offer similar incentives in their own domestic markets, alongside regional or global market incentives solutions, it is hoped that this will provide a sufficient incentive for companies to invest in antimicrobial R&D.

f) Alignment with topic selection criteria

13. The commercial model will need to be sufficiently flexible to respond to the technologies selected for inclusion in the project through the topic selection process. This is expected to require consideration of factors outlined in the topic selection process such as: key target(s) (pathogens) and clinical setting(s); likely sequencing and comparators; and pressing clinical scenarios.

g) Distribution and supply

14. The design of the commercial model will take into account existing distribution and supply channels and payment flows in the health service and the expected route by which the antimicrobial would be made available. This includes, for example; the anticipated time between the order and delivery of the technology; likely manufacturing lead times; mechanisms to ensure that volumes of stock are sufficient to respond to fluctuations in global demand; and assuring continuity of supply. Consideration will also need to be given to whether the antimicrobial is delivered in primary or secondary care, how the model might need to respond to antimicrobials used in different clinical contexts and efficient tax treatment.

h) Costs

15. The commercial model will consider the investment associated with the development of the antimicrobial in addition to sales and marketing costs of the antimicrobial.

i) Alignment with UK 2019 Voluntary Scheme for Branded Medicines Access and Pricing and Statutory Scheme

16. The arrangements will need to be appropriately aligned to the Voluntary Scheme or the Statutory Scheme. The nature of this alignment is expected to be informed by the technology under consideration, the structure of the final commercial model and whether the manufacturer is covered by either the Voluntary or the Statutory Scheme.

j) Supplier capacity

17. The supplier of the product will need to have sufficient operational capacity to engage with negotiations and the commercial model in a timely, efficient and collaborative way.

k) Monitoring

18. NHS England and NHS Improvement, along with Public Health England, will consider the practicality of collecting additional information on the performance of the product against estimated value over time. Consideration will need given to the appropriate infrastructure that would be needed to ensure that information is collected, data linkage and how information collected might inform reimbursement.

Potential approaches to paying for value

19. There are a range of commercial approaches which could be used to meet the objective of paying companies based on an estimate of the value an

antimicrobial brings to the NHS, as opposed to the volumes used, while reflecting the design principles and considerations outlined above.

20. This section provides an outline of concepts that might be considered in any commercial model. It is important to note that both the commercial model and the process by which a manufacturer might enter a commercial arrangement with NHS England and NHS Improvement will be informed by the outcomes of this process of engagement with stakeholders.

21. Also, it should be noted that the commercial process and the commercial model are not completely independent and therefore consideration is also being given to the commercial process determining the final model(s) adopted with suppliers.

22. Any commercial model will need to take account of the level of uncertainty associated with the estimated value of the new product. From a commercial perspective, the most obvious implication of uncertainty is that payment levels might be set inappropriately, creating the potential for the model to fail in providing a proportionate incentive to encourage the development of new antimicrobials, or alternatively failing to represent good value for money for taxpayers.

23. The implications of uncertainty and practical mechanisms to resolve or mitigate uncertainty and other commercial risks (such as ongoing monitoring, opportunities for revaluation or resetting of payment levels or risk sharing arrangements such as the inclusion of ‘cap and collar’ as described below), are therefore a key consideration in the any commercial model.

24. It is expected that any commercial model might incorporate one or more of the elements set out below, since there is an increasing consensus that a single approach may not provide the optimum or only solution. These elements are not mutually exclusive and are expected both to support the objective of ‘de-linking’ revenue from volumes whilst managing uncertainty.

25. While this list is not exhaustive, these elements have been considered by interested stakeholders:

    a. Fixed fee arrangements

    b. Condition-based fee arrangements

    c. Outcomes based arrangements

    d. Cap and collar arrangements

26. An outline of the considerations associated with each of these elements is set out below.

a) Fixed fee arrangements

27. At the simplest level, under a fixed fee model the supplier of an antimicrobial would receive an agreed payment at pre-determined intervals, for the duration of the contract.

28. This approach is expected to provide predictability to both the health service and the supplier of the antimicrobial by determining at the outset the level, duration and timing of payments that the health service would make to the provider of a new antimicrobial.

29. The level of the fixed fee would be informed by the estimated value of the antimicrobial to the health service, whilst providing proportionate incentives for industry to develop new antimicrobials by providing stable and predictable revenue for the company.

30. While this model is simple in principle, a number of considerations arise. Payments at pre-determined levels and intervals may lead to irreversible sunk costs to the health service. As such, the payment level would need to be appropriately aligned so as to provide value to the health service whilst considering the level of uncertainty in the expected value of the new antimicrobial.

31. In setting the payment level, careful consideration will therefore need to be given to how the potential value of the antimicrobial is informed by factors such as gaps in the evidence base, parameter values and anticipated resistance rates, costs and health outcomes and the extent to which these factors can be practically mitigated or resolved over time. In addition, consideration would need to be given to agreeing defined parameters for any re-evaluation at the outset of the arrangement

b) Condition-based arrangements

32. A condition-based arrangement builds on the concept of a fixed fee payment set out above. The supplier of the antimicrobial might receive both an agreed level of payment at pre-determined intervals, as well as additional payments on the fulfilment of pre-agreed conditions linked to the estimated value of the antimicrobial.

33. Consideration can be given to whether these additional payments might be linked to the estimated value of the antimicrobial being realised. For example, reimbursement might be linked to participation in stewardship and conservation policies, investment in infrastructure to support surveillance, or alternatively the investment in the research and development of antimicrobials.

34. This approach implies that payment levels would be flexible, with the potential for a supplier to increase revenue as uncertainty is resolved and value is demonstrated. Such an approach is expected to require some form of monitoring or surveillance to collect additional information however, which may present practical implementation challenges.

35. For example, it may be necessary for the commercial arrangement to support investment in appropriate infrastructure that might resolve uncertainties in the expected value. In addition, consideration would need to be given to both a minimum and an upper level of payments that might be made, and if and how these levels might be adjusted over time.

36. Similarly to the outcomes-based model set out below, this approach seeks to balance the risks between the supplier of an antimicrobial and the health service, since the supplier would only receive additional payments above the agreed minimum payment level if the conditions associated with payment are fulfilled, while the supplier would receive a predictable base payment level.

c) Outcomes-based arrangements

37. Under an outcomes-based arrangement, the supplier of an antimicrobial would receive an agreed upon payment at agreed intervals for the duration of the contract.

38. However, payment levels might be determined by the extent to which the antimicrobial satisfied agreed clinical outcomes. Similarly, to the arrangements outlined above the payment levels might be subject to an agreed minimum and maximum payment levels, which would in turn be linked to the estimated value of the antimicrobial.

39. As with the value-based model set out above, and in contrast to a fixed arrangement, outcomes-based agreements would only compensate suppliers of antimicrobials above the agreed minimum when the agreed outcomes criteria are met.

d) Cap and collar arrangements

40. ‘Cap and collar’ arrangements have been put forward both as a conceptual model to support the objective of delinking revenue from volume, and as mechanism that might manage risk in the kinds of commercial models outlined above.

41. Under a ‘cap and collar’ model, similarly to the fixed fee approach, the supplier of an antimicrobial would receive payments over an agreed duration based upon the volume of antimicrobials supplied. However, at the outset or at pre-determined intervals a maximum level of revenue (a ‘cap’) and a minimum level

of revenue (a ‘collar’) would be agreed. This would mean that as use increases and company revenues exceeds the agreed maximum, the company would provide a rebate to the health service. However, if use is lower, and thus company revenues are lower than the agreed minimum, the company could receive a ‘top-up’ payment from the NHS.

42. The model does mean that the link between company revenues and volume used by the health service is only partially removed. However, the payments made under the arrangement mitigate the risk to industry of very low use and therefore low revenues, while also protecting the payer from the risk of high use of antimicrobials, and budget impact considerations.

43. In addition, a cap and collar arrangement, in which minimum and maximum payment levels are set, without any link to volume, may also be integrated into the other commercial models outlined above. This arrangement would represent a means of providing both predictability and stability to the health service and suppliers by setting an upper and lower limit on payments.

44. Such arrangements, without any link to volumes of antimicrobials supplied, may also inform different commercial models as a mechanism to range uncertainty and the risk of inappropriate payment levels. Similarly, ongoing surveillance and opportunities for renegotiation may also represent a means of mitigating the risk of setting an inappropriate payment level.

National Institute for Health and Care Excellence

Revisions to standing orders and reservation of powers to the Board

Andrew Dillon has announced his intention to stand down as NICE chief executive at the end of March 2020 and the process to appoint his successor is underway.

The Health and Social Care Act 2012 states that the appointment is made by NICE's non-executive directors (NEDs), subject to approval by the Secretary of State. Following advice from NICE's legal advisers minor amendments are proposed to NICE's reservation of powers to the board to clarify that the NEDs will exercise their power to appoint the chief executive and other executive members in a meeting solely of NEDs rather than at a board meeting. An accompanying amendment is proposed to the standing orders to set a quorum of 3 for these NED meetings.

The Board is asked to approve the amendments to the governance documents.

Sir David Haslam

Chair

September 2019

NICE National Institute for Health and Care Excellence

Reservation of Powers to the Board and Scheme of Delegation

Responsible Officer	Business Planning & Resources Director
Author	Corporate Office
Date effective from	December 1999
Date last amended	April 2019
Next review date	March 2020
Audience	NICE Board and employees

Contents

Introduction

1. The purpose of this document is to indicate those powers that are reserved to the Board which are generally matters for which it is held accountable to the Secretary of State for Health and Social Care, while at the same time delegating to the appropriate level the detailed application of NICE's policies and procedures. The board, however, remains accountable for all its functions, even those delegated to the chair, individual directors or officers and will require information about the exercise of delegated functions to enable it to maintain a monitoring role.

2. The board will agree and annually update Standing Orders (SOs) and Standing Financial Instructions (SFIs). These documents, together with this document, enable the board and NICE staff to discharge their duties and responsibilities.

3. Subject to such directions as may be given by the Secretary of State in accordance with the Health and Social Care Act 2012, the NICE board may make arrangements for the exercise, on behalf of NICE, of any of its functions by a committee, sub-committee or joint committee, appointed by virtue of SO 79 – 87 or by an officer of NICE, subject to such restrictions and conditions as NICE thinks fit.

Emergency powers

4. The powers which the board has retained to itself within this document and within its SOs may in an emergency be exercised by the chief executive and chair after having consulted at least two non-executive directors. The exercise of such powers by the chief executive and chair shall be reported to the next formal meeting of the NICE board in public session for ratification.

Delegation to committees

5. The board shall agree from time to time to the delegation of executive powers being exercised by committees, or sub-committees, or joint committees, which it has formally constituted. The constitution and terms of reference of these committees, or sub-committees, or joint committees, and their specific executive powers shall be approved by the NICE board.

6. When the board is not meeting in public session it shall operate as a committee and may only exercise such powers as may have been delegated to it by NICE in public session.

Delegation to officers

7. Those functions of the NICE board which have not been retained as reserved by the board or delegated to an executive committee or sub-committee or joint-committee shall be exercised on behalf of NICE by the chief executive. The chief executive shall determine which functions he or she will perform

personally and shall nominate officers to undertake the remaining functions for which he/she will still retain accountability to NICE.

8. The chief executive shall prepare a scheme of delegation identifying his or her proposals which shall be considered and approved by the board, subject to any amendments agreed during the discussion. The chief executive may periodically propose amendments to the scheme of delegation which shall be considered and approved by the board as indicated above.

9. Nothing in the scheme of delegation shall impair the discharge of the direct accountability to NICE of the business planning & resources director to provide information and advise the board on financial matters in accordance with statutory requirements. Outside these statutory requirements, the role of the business planning & resources director shall be accountable to the chief executive for operational matters.

10. The arrangements made by NICE as set out in the "reservation of powers to the board and delegation of powers" shall have effect as if incorporated into NICE's SOs.

11. All powers delegated by the board can be reassumed should the need arise.

Caution over the use of delegated powers

12. Powers are delegated to officers on the understanding that they would not exercise delegated powers in a matter which in their understanding was likely to be a cause for public concern or which might have an effect on the reputation of NICE.

Directors ability to delegate their own delegated powers

13. The scheme of delegation shows only the "top level" of delegation within NICE. The scheme is to be used in conjunction with the system of budgetary control and other established procedures within NICE.

Absence of officer to whom powers have been delegated

14. In the absence of an officer to whom powers have been delegated those powers shall be exercised by that officer's superior unless alternative arrangements have been approved by NICE. If the chief executive is absent powers delegated to him/her may be exercised by the chair or the deputy chief executive after taking advice as appropriate from other executive directors and/or centre directors.

Reservation of Powers to The Board

General enabling provision

15. The board may determine any matter it wishes in full session within its statutory powers.

Regulation and control

16. Approval of standing orders (SOs), a schedule of matters reserved to the board and SFIs for the regulation of its proceedings and business.

17. Approval of a scheme of delegation of powers from the board to officers.

18. Requiring and receiving a declaration at board meetings of board members' interests which may conflict with those of NICE and determining the extent to which any member may remain involved with the matter under consideration.

19. Disciplining board members who are in breach of statutory requirements or SOs or who are subject to action under NICE's disciplinary policy and procedures.

20. Approval of NICE's disciplinary procedures for staff.

21. Approval of arrangements for dealing with complaints.

22. Approval of the high level organisational structure of NICE and to agree modifications thereto.

23. To receive reports from committees which NICE is required by the secretary of state or other regulation to establish and to take appropriate action thereon.

24. To establish terms of reference and reporting arrangements of all board committees, and to confirm or not the recommendations of the board's committees where the committees do not have decision-making powers.

25. Ratification of any urgent decisions taken by the chief executive and chair in accordance with SO 74.

Appointments

Full Board

26. The establishment and dissolution of committees.

~~27.1. The appointment, disciplining and dismissal of the chief executive.~~

~~28.~~27. The appointment of non-executive members of the board to outside bodies to represent NICE.

~~29.1.~~ ~~Agreeing the arrangements for the appointment, appraisal, dismissal or disciplining of executive directors and other directors.~~

Non-executive members only:

28. The appointment, disciplining and dismissal of the chief executive.

29. The appointment of executive members of the board.

30. Agreeing the arrangements for the appointment, ~~, appraisal, dismissal~~ or disciplining of ~~executive directors and other directors~~members of the senior management team.

Policy consideration

~~30.~~31. The approval of any policies which the board may from time to time reserve itself responsibility.

Strategy and business plans and budgets

~~31.~~32. Setting NICE's strategic objectives.

~~32.~~33. Approval of the NICE business plan.

Risk management

~~33.~~34. Approving NICE's policies and procedures for the management of risk.

~~34.~~35. Reviewing the key organisational risks facing NICE and the effective management of those risks.

~~35.~~36. Reviewing the annual governance statement.

~~36.~~37. Approving NICE's Health and Safety policy and the monitoring of its effectiveness.

Direct operational decisions

~~37.~~38. Approving the acquisition, disposal or change of use of land and/or buildings.

~~38.~~39. The introduction or discontinuance of any significant activity or operation outside of the business plan. An activity of operation shall be regarded as significant if it has a gross annual income or expenditure (that it is before any set off) in excess of £250,000.

~~39.~~40. Approving supplementary expenditure outside of the business plan or a capital or revenue nature amounting to, or likely to amount to over £250,000 per annum.

40.41. Approving extra contractual individual staff compensation payments over £20,000 subject to any permissions required from the Department of Health and Social Care / HM Treasury.

Financial and performance reporting arrangements

41.42. Approve the distribution of NICE's financial allocation as set out in the annual business plan.

42.43. Continuous appraisal of the affairs of NICE by means of the receipt of reports as it sees fit from, committees, officers and senior managers of NICE.

Audit arrangements

43.44. To approve audit arrangements and to receive reports of the audit and risk committee meetings and take appropriate action.

44.45. To review and approve the annual report and accounts as recommended by the audit and risk committee.

Delegation of powers

Delegation to committees

45.46. The NICE board may determine that certain of its powers shall be exercised by standing committees. The composition and terms of reference of such committees shall be that determined by the board from time to time, taking into account where necessary the requirements of the secretary of state. The NICE board shall determine the reporting requirements in respect of these committees. In accordance with SOs, Committees may not delegate executive powers to sub-committees unless expressly authorised by the NICE board.

46.47. Committees of the board:

- Audit and risk committee
- Remuneration committee

47.48. The terms of reference and standing orders for each committee are approved by the board.

Scheme of delegation of officers

48.49. SOs and SFIs set out the financial responsibilities of the chief executive (CE), the business planning & resources director and other executive directors.

49.50. Certain matters needing to be covered in the scheme of delegation are not covered by SFIs or SOs or they do not specify the responsible officer. These are:

Area of responsibility	Overall responsibility
Compliance with the General Data Protection Regulation and Freedom of Information Act	chief executive
Health and Safety	chief executive

~~50.~~51. This scheme of delegation covers only matters delegated by the board to its executive directors and certain other specific matters referred to in SFIs. Each executive director is responsible for the delegation within his/her area(s) of responsibility. He/she should produce a scheme of delegation for matters within his/her area(s) of responsibility. In particular, the scheme of delegation should include how the directorate budget and procedures for approval of expenditure are delegated. The scheme of delegation and list of approved signatories and corresponding budget authority limits should be approved by the chief executive and the business planning & resources director.

SCHEME OF DELEGATION IMPLIED BY STANDING ORDERS

SO REF	DELEGATED TO	DUTIES DELEGATED
12	Chair	Final authority on the interpretation of SOs.
34	Chair	Calling meetings.
41	Chair	Chair all board meetings and associated responsibilities.
92 - 94	CE	Register(s) of interests.
118	CE	Designate an officer responsible for receipt and custody of tenders before opening.
119	Two senior officers	Open tenders.
121	CE	Best value for money is demonstrated for all services provided under contract or in-house.
122	CE or nominated officer	Decide whether any late tenders should be considered.
128	CE	Nominate officers to enter into contracts of employment, regarding staff, agency staff or consultancy service contracts.
129(i)	CE	Determining any items to be sold by sale or negotiation.
130	CE	Keep seal in safe place and maintain a register of sealing.
132	One Executive and one Non-Executive Director	Approve and sign all building, engineering, property or capital documents.
135	CE or nominated officers	Sign on behalf of NICE any agreement or document not requested to be executed as a deed.
136	CE	Existing members and officers and all new appointees are notified of and understand their responsibilities within SO and SFIs.

SCHEME OF DELEGATION IMPLIED BY STANDING FINANCIAL INSTRUCTIONS

SFI REF	DELEGATED TO	DUTIES DELEGATED
14	CE	To ensure all employees and directors, present and future, are notified of and understand SFIs.
15(a) – (c)	BPRD	List of delegated responsibilities of the business planning & resources director including implementing NICE's financial policies and co-ordinating corrective action and ensuring detailed financial procedures and systems are prepared and documented.
16	All directors and employees	Security of NICE's property, avoiding loss, exercising economy and efficiency in using resources and conforming to SOs, SFIs and financial procedures.
17	CE and directors	Ensure third parties and their employees are aware of SFIs
18	BPRD	Approves form and adequacy of financial records of all departments.
19	Audit and risk committee	Provide independent and objective view on internal control and probity. Ensure effective external audit service. Approval and recommendation of annual accounts to board.
22	BPRD	Ensure an effective internal audit service is provided.
24	Head of internal audit	Review, appraise and report on the effectiveness of the arrangements for governance, risk management and internal controls.
28	External audit	Examination of financial statements and preparation of annual audit reports
29-30	CE BPRD	Overall responsibility for expenditure limit control. Ensuring compliance with Department of Health and Social Care requirements, ensure money drawn from Department of Health and Social Care is for approved expenditure only at time of need, and ensuring adequate system of monitoring.
31	CE	Compile and submit the annual business plan.
32	BPRD	Submit budgets to the board and the Department of Health and Social Care.
33	CE	Delegate budget to budget holders.

SFI REF	DELEGATED TO	DUTIES DELEGATED
38	BPRD	Devise and maintain systems of budgetary control.
41-43	BPRD	Preparation of annual accounts and reports.
44-45	BPRD	Banking arrangements.
48 - 58	BPRD	Income systems, setting fees and charges, actions to recover debts, security of cash and cheques.
66	BPRD	Management of effective controls for the payroll process.
68	BPRD	Processing of payroll.
79	BPRD	Prompt payment of accounts and claims, purchasing processes.
85-106	CE	Capital investments, maintaining asset registers and security of assets.
108-113	BPRD	Control of Stores and receipt of goods.
114-125	BPRD	Reporting disposals, losses and special payments.
126-130	BPRD	Adequacy of computerised financial systems.
133	CE	List of contractors.
134	BPRD	Payments to contractors.

NICE National Institute for Health and Care Excellence

Standing Orders

Responsible Officer	Business Planning & Resources Director
Author	Corporate Governance and Risk Manager
Date effective from	February 2001
Last date amended	April 2019
Next review date	March 2020
Audience	NICE Board and employees

Contents

Introduction

1. Non-Departmental Public Bodies need to agree standing orders (SO) and schedules of reservation of powers to the board and delegation of powers.

2. The documents, together with standing financial instructions (SFIs), provide a regulatory framework for the business conduct of the National Institute for Health and Social Care (NICE). They fulfil the dual role of protecting NICE's interests (ensuring, for example, that all transactions maximise the benefit to NICE) and protecting staff from any possible accusation that they have acted less than properly (provided that staff have followed the correct procedures outlined in the relevant document).

3. All executive and non-executive directors and all employees should be aware of the existence of these documents and, where necessary, be familiar with the detailed provisions.

Statutory framework

4. The National Institute for Health and Care Excellence ("NICE") is a statutory body which came into existence on 1 April 2013.

5. The principal place of business of NICE is Level 1A, City Tower, Piccadilly Plaza, Manchester M1 4DB.

6. The statutory functions conferred on NICE are set out in the Health and Social Care Act 2012 and associated regulations amended from time to time by subsequent legislation.

7. NICE has specified powers to act as a regulator, to contract in its own name and to act as a corporate trustee. In the latter role it is accountable to the Charity Commission for those funds deemed to be charitable as well as to the Secretary of State for Health and Social Care.

8. The Statutory Instrument requires NICE to adopt SO for the regulation of its proceedings and business. NICE must also adopt standing financial instructions (SFIs) as an integral part of SO, setting out the responsibilities of individuals.

Delegation of Powers

9. Under the SO relating to the arrangements for the exercise of functions (SO 72 - 73) the board is given powers to "make arrangements for the exercise, on behalf of the board, of any of its functions by a committee, sub-committee or joint committee appointed by virtue of SO 75 or by an officer of NICE, in each case subject to such restrictions and conditions as NICE thinks fit or as the secretary of state may direct". delegated powers are covered in a separate document (reservation of powers to the board and delegation of powers). This document has effect as if incorporated into the SO.

Failure to Comply with Standing Orders

10. If for any reason these SO are not complied with, full details of the non-compliance, including the circumstances and any justification, shall be reported to the next meeting of the audit and risk committee for action or ratification. All members of the board and staff have a duty to disclose any non-compliance with these SO to the chief executive.

11. Failure to comply with SO may be regarded as a disciplinary matter which following investigation under the disciplinary policy and procedure, could result in dismissal.

Interpretation

12. Save as permitted by law, at any meeting the chair of NICE shall be the final authority on the interpretation of SO (on which they should be advised by the chief executive).

13. Any expression to which a meaning is given in the Health and Social Care Act 2012 will have the same meaning in this interpretation and in addition:

    "Accounting officer" shall be the officer responsible and accountable for funds entrusted to NICE. He shall be directly accountable to parliament for ensuring the proper stewardship of public funds and assets. This shall include arrangements for laying NICE‘s annual accounts before parliament. For NICE it shall be the chief executive.

    "Board" shall mean the chair, and non-executive directors, appointed by the secretary of state for Health and Social Care, and the executive directors appointed by NICE.

    "Budget" means a resource, expressed in financial terms, proposed by NICE for the purpose of carrying out, for a specific period, any or all of the functions of NICE.

    “Budget holder” means the director or employee with delegated authority to manage finances for specific areas of the organisation.

    "Chair" is the person appointed by the Secretary of State for Health and Social Care to lead the board and to ensure that it successfully discharges its overall responsibility for NICE. The expression "the Chair of NICE" shall be deemed to include the vice-chair of NICE if the chair is absent from the meeting or is otherwise unavailable.

    "Chief executive" means the chief officer of NICE, and Accounting Officer.

    "Committee" shall mean a committee created by NICE.

"Committee members" shall be persons formally appointed by NICE to sit on or to chair specific committees.

"Contracting and procuring" means the systems for obtaining the supply of goods, materials, manufactured items, services, building and engineering services, works of construction and maintenance and for disposal of surplus and obsolete assets.

"Director" means member of the NICE Board. executive director means officer member and non-executive director means non-officer member.

"Business planning and resources director" means the chief financial officer of NICE.

"Member" shall mean a board member.

“Motion” means a formal proposition to be discussed and voted on during the course of a meeting of the board.

“NICE” means the National Institute for Health and Care Excellence

"Nominated officer" means an officer charged with the responsibility for discharging specific tasks within SO and SFIs.

"Non-officer member" means a non-executive director of NICE appointed by the Secretary of State for Health and Social Care.

"Officer" means an employee of NICE. In certain circumstances, “officer” may include a person who is employed by another authority or by a third party contracted to NICE who carries out functions on behalf of NICE.

"Officer member" means an executive director of NICE who is a member of the board

"SFIs" means standing financial instructions.

"SO" means standing orders.

"Vice-chair" means the non-executive director appointed by NICE to take on the chair's duties if the chair is absent for any reason.

NICE

14. All business shall be conducted in the name of NICE.

15. All funds received in trust shall be held in the name of NICE as corporate trustee.

16. The powers of NICE established under statute shall be exercised by the board meeting in public session except as otherwise provided for in SO 72 - 73.

17. NICE shall define and regularly review the functions it exercises on behalf of the Secretary of State.

18. NICE has resolved that certain powers and decisions may only be exercised by the board in formal session. These powers and decisions are set out in "reservation of powers to the board" and have effect as if incorporated into the SO.

Composition of NICE

19. In accordance with Schedule 16 of Health and Social Care Act 2012 the composition of the Board shall be:

    - At least 6 non-executive directors, one of whom must be appointed as the chair
    - Up to 5 executive directors, including the:
        - chief executive;
        - deputy chief executive
        - business planning and resources director.

20. The board will nominate one executive director to act as deputy chief executive.

Appointment and removal of the chair and non-executive directors

21. The regulations for the appointment, removal, and terms of office of the chair and non-executive directors are determined by the Secretary of State for Health and Social Care.

Appointment and powers of vice-chair

22. Subject to SO 23 below, the board may appoint one of the non-executive directors to be vice-chair for such period, not exceeding the remainder of his/her term as a non-executive director of NICE, as specified on appointment.

23. Any member so appointed may at any time resign from the position of vice-chair by giving notice in writing to the chair. The board may then appoint another non-executive director as vice-chair in accordance with the provisions of SO 22.

24. Where the chair of NICE has ceased to hold office, or where they are unable to perform their duties as chair owing to illness, or any other cause, the vice-chair shall act as chair until a new chair is appointed or the existing chair resumes their duties, as the case may be; and references to the chair in these SO shall, so long as there is no chair able to perform their duties, be taken to include references to the vice-chair.

Appointment of a senior independent director

25. Subject to SO 26 below, the board may appoint a non-executive director as senior independent director. Any appointment will be for such period not exceeding the remainder of their term as a non-executive director as specified on appointment.

26. Any member so appointed may resign at any time from the position of senior independent director by giving notice in writing to the chair. In the event of a resignation, the board may appoint another non-executive director as senior independent director in accordance with SO 25 above.

Joint Members

27. Where more than one person is appointed jointly to a post on the board which qualifies the holder for executive membership or in relation to which an executive member is to be appointed, those persons shall become appointed as an executive member jointly and shall count for the purpose of SO 19 as one person.

28. Where the office of a member of the board is shared jointly by more than one person:

    - Either or both of those persons may attend or take part in meetings of the board;
    - If both are present at a meeting they should cast one vote if they agree;
    - In the case of disagreements no vote should be cast; and,

    The presence of either or both of those persons should count as the presence of one person for the purposes of quorum.

Meetings

Admission of the public and the press

29. The public and representatives of the press shall be afforded facilities to attend all formal meetings of the board but shall be required to withdraw upon the board resolving as follows:

    "That representatives of the press and other members of the public be excluded from the remainder of this 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).

30. The chair (or vice-chair) shall give such directions as they think fit in regard to the arrangements for meetings and accommodation of the public and representatives of the press such as to ensure that NICE’s business shall be

conducted without interruption and disruption. Without prejudice to the power to exclude on grounds of the confidential nature of the business to be transacted, the public will be required to withdraw upon the board resolving as follows:

> "That in the interests of public order the meeting adjourn for (the period to be specified) to enable the board to complete business without the presence of the public" (Section 1(8) Public Bodies (Admission to Meetings) Act 1960).

31. Matters to be dealt with by the board following the exclusion of the press and public shall be confidential to members of the board. Those present shall not reveal or disclose the contents of confidential papers or minutes outside of NICE without the express permission of the board. This prohibition shall apply equally to the content of any discussion during the board meeting which may take place on such reports or papers.

32. Nothing in these SO shall require NICE to allow members of the public or representatives of the press to record proceedings in any manner whatsoever, other than in writing, or to make any oral report of proceedings as they take place, without the prior agreement of NICE.

Calling Meetings

33. Ordinary meetings of the board shall be held at such times and places as NICE may determine.

34. The chair may call a meeting of the board at any time. If the chair refuses to call a meeting after a requisition for that purpose, signed by at least one-third of the whole number of members, has been presented to them, or if, without so refusing, the chair does not call a meeting within seven days after such requisition has been presented to them, such one third or more members may call a meeting.

Notice of meetings

35. Before each meeting of the board, a notice of the date, time and location of the meeting, specifying the business proposed to be transacted will be delivered to every member by appropriate means (including, without limitation, by email or post) so as to be available to them at least three clear days before the meeting.

36. In the case of a meeting called by members in default of the chair, the notice shall be signed by those members and no business shall be transacted at the meeting other than that specified in the notice.

37. Agendas will be sent to members four clear working days before the meeting and supporting papers, whenever possible, shall accompany the agenda, but will certainly be despatched no later than three clear working days before the meeting, save in emergency. Failure to serve such a notice on more than three members will invalidate the meeting. A notice shall be presumed to have been served one working day after posting.

38. Before each meeting of the board a public notice of the time and place of the meeting, and the public part of the agenda, shall be displayed on NICE's website at least three clear days before the meeting.[1]

Setting the agenda

39. NICE may determine that certain matters shall appear on every agenda for a meeting of the board and shall be addressed prior to any other business being conducted.

40. A member desiring a matter to be included on an agenda shall make his request in writing to the chair at least 10 clear working days before the meeting. The request should state whether the item of business is proposed to be transacted in the presence of the public and should include appropriate supporting information. Requests made less than 10 working days before a meeting may be included on the agenda at the discretion of the chair.

Chair of meeting

41. At any meeting of the board, the chair, if present, shall preside. If the chair is absent from the meeting the vice-chair, if there is one and he/she is present, shall preside. If the chair and vice-chair are absent, the board members present shall choose a non-executive director to preside.

42. If the chair is absent temporarily on the grounds of a declared conflict of interest the vice-chair, if present, shall preside. If the chair and vice-chair are absent, or are disqualified from participating, the remaining board members present shall choose a non-executive director to preside.

Notices of motion

43. A board member seeking to move or amend a motion shall send a written notice of their intention to the chair, at least 10 clear working days before the meeting, who shall insert in the agenda for the meeting all notices received, subject to the notice being permissible under these standing orders. This paragraph shall not prevent any motion being moved during the meeting, without notice on any business mentioned on the agenda.

44. The mover of a motion shall have a right of reply at the close of any discussion on the motion or any amendment to it.

45. When a motion is under discussion or immediately prior to discussion it shall be open to a member to move:

[1] Public Bodies (Admission to Meetings) Act 1960 S.I.(4)(a).)

- an amendment to the motion
- the adjournment of the discussion or the meeting
- that the meeting proceeds to the next business *
- the appointment of an ad hoc committee to deal with a specific item of business
- that the motion be now put *
- a motion under Section 1 (2) of the Public Bodies (Admission to Meetings) Act 1960 resolving to exclude the public (including the press)

* to ensure objectivity, motions may only be put by a member who has not previously taken part in the debate.

46. An amendment to a motion shall not be discussed until it has been proposed and seconded. It must be relevant to the motion and not have the effect of negating the motion before the board.

47. No amendment to the motion shall be admitted if, in the opinion of the chair of the meeting, the amendment negates the substance of the motion.

Withdrawal of motion or amendments

48. A motion or amendment once moved and seconded may be withdrawn by the proposer.

Motion to rescind a resolution

49. Notice of motion to amend or rescind any resolution (or the general substance of any resolution) which has been passed within the preceding 6 calendar months shall bear the signature of the member who gives it and also the signature of 4 other board members. When any such motion has been disposed of by NICE, it is not possible for any member other than the chair to propose a motion to the same effect within 6 months. This SO shall not apply to motions moved in pursuance of a report to the board or recommendations of a committee or the chief executive.

Chair's ruling

50. Statements of members made at meetings of the board shall be relevant to the matter under discussion. The decision of the chair of the meeting, or person presiding, on questions of order, relevancy, regularity and any other matters shall be final.

Quorum

51. No business shall be transacted at any meeting unless at least one third of the whole number of the chair and board members is present (rounded to the nearest whole number), including at least one non-executive director and one executive director. For matters relating to the appointment of executive members that are reserved to the non-executive members only, the quorum shall be three non-executive members.

52. An officer attending on behalf of an executive director will not count towards the quorum, unless they have been given formal acting up status (usually for absences over four weeks).

53. If the chair or member has been disqualified from participating in the discussion on any matter and/or from voting on any resolution by reason of the declaration of a conflict of interest (see SO 88 - 91) they shall no longer count towards the quorum. If a quorum is then not available for the discussion and/or the passing of a resolution on any matter, that matter may not be formally discussed or voted upon at that meeting. Such a position shall be recorded in the minutes of the meeting. The meeting must then proceed to the next item of business.

Voting

54. If required, decisions at a meeting shall be determined by a majority of the votes of the chair of the meeting and members present and, in the case of the number of votes for and against a motion being equal, the chair of the meeting or the person presiding, shall have a second or casting vote.

55. All questions put to the vote shall, at the discretion of the chair of the meeting, be determined by oral expression or by a show of hands. A paper ballot may also be used if a majority of the members present so request.

56. If at least one-third of the members present so request, the voting (other than by paper ballot) on any question may be recorded to show how each member present voted or abstained.

57. If a member so requests, their vote shall be recorded by name upon any vote (other than by paper ballot).

58. In no circumstances may an absent member vote by proxy. Absence is defined as being absent at the time of the vote.

59. An officer attending on behalf of an executive director will only exercise any voting rights of that member if they have been given formal acting up status (usually for absences over four weeks).

60. An officer's status when attending a meeting shall be recorded in the minutes.

61. For voting rules relating to joint members see SO 28.

Minutes

62. The minutes of the proceedings of a meeting shall be drawn up and submitted for agreement at the next ensuing meeting.

63. No discussion shall take place upon the minutes except upon their accuracy or where the chair considers discussion appropriate. Any amendment to the minutes shall be agreed and recorded at the next meeting.

64. Where providing a record of a public meeting the minutes shall be made available to the public.

Record of attendance

65. The names of the chair and members present at the meeting shall be recorded in the minutes and published on NICE's website annually.

Suspension of standing orders

66. Except where this would contravene any statutory provision or any direction made by the Secretary of State, any one or more of the SO may be suspended at any meeting, provided that at least two-thirds of the board are present, including one officer and one non-officer member, and that a majority of those present vote in favour of suspension.

67. A decision to suspend SO shall be recorded in the minutes of the meeting.

68. A separate record of matters discussed during the suspension of SO shall be made and shall be available to the board.

69. No formal business may be transacted while SO are suspended.

70. The audit and risk committee shall review every decision to suspend SO.

Variation and amendment of standing orders

71. These SO shall be amended only if the variation proposed does not contravene a statutory provision or direction made by the Secretary of State.

Arrangements for the exercise of functions by delegation

72. Subject to such directions as may be given by the Secretary of State, the board may make arrangements for the exercise, on behalf of the board, of any of its functions by a committee, sub-committee or joint committee, appointed by virtue of SO 75 - 87 below or by an officer of NICE, in each case subject to such restrictions and conditions as NICE.

73. Where functions are delegated this means that although the carrying out of the function (i.e. day to day running) is delegated to another body, NICE retains the responsibility for the service.

Emergency powers

74. The powers which the board has retained to itself within these SO may in emergency be exercised by the chief executive and the chair after having consulted at least two non-executive directors. The exercise of such powers by the chief executive and chair shall be reported to the next formal meeting of the board in public session for ratification.

Delegation to committees

75. The board shall agree from time to time to the delegation of executive powers being exercised by committees, or sub-committees, or joint committees, which it has formally constituted. The constitution and terms of reference of these committees, or sub-committees, or joint committees, and their specific executive powers shall be approved by NICE.

76. When the board is not meeting in public session it shall operate as a committee and may only exercise such powers as may have been delegated to it by NICE in public session.

Delegation to officers

77. Those functions of NICE which have not been retained as reserved by the board or delegated to an executive committee or sub-committee or joint-committee shall be exercised on behalf of NICE by the chief executive. The chief executive shall determine which functions he/she will perform personally and shall nominate officers to undertake the remaining functions for which he/she will still retain accountability to NICE.

78. The arrangements made by NICE are set out in the "reservation of powers to the board and scheme of delegation" and shall have effect as if incorporated in these SO.

Committees

Appointment of committees and joint committees

79. Subject to such directions as may be given by the Secretary of State, the institute may appoint committees of NICE, or together with one or more other authorities appoint joint committees consisting, in either case, wholly or partly of the chair and members of NICE or wholly of persons who are not members of NICE.

80. A committee or joint committee appointed under this standing order may, subject to such directions as may be given by the Secretary of State or NICE, appoint sub-committees consisting wholly or partly of members of the committee or joint committee (whether or not they are members of NICE) or wholly of persons who are not members of NICE or the committee of NICE.

81. The SO of NICE, as far as they are applicable, shall apply with appropriate alteration to meetings of any committees established by NICE.

82. Each such committee shall have such terms of reference and powers and be subject to such conditions (including reporting back to NICE), as NICE shall decide.

83. Where committees are authorised to establish sub-committees they may not delegate executive powers to the sub-committee unless expressly authorised by NICE.

84. NICE shall approve the appointments to each of the committees which it has formally constituted. Where NICE determines, and regulations permit, that persons, who are neither members nor officers, shall be appointed to a committee the terms of such appointment shall be within the powers of NICE as defined by the Secretary of State. NICE shall define the powers of such appointees and shall agree the terms of their remuneration and/or reimbursement for loss of earnings and/or expenses.

85. Where NICE is required to appoint persons to a committee and/or to undertake statutory functions required by the Secretary of State, and where such appointments are to operate independently of NICE such appointment shall be made in accordance with the regulations laid down by the Secretary of State.

86. The committees established by the board are:

    (i) Audit and risk committee

    (ii) Remuneration committee

87. The Secretary of State may specify in statute the requirement to establish committees, or the board may by resolution create (or disband) advisory committees at its discretion. Standing orders and terms of reference will set out the committee's duties and any delegated powers.

Declaration of interests and register of interests

Declaration of interests

88. NICE requires board members to declare interests that are relevant, or could be perceived to be relevant, to NICE's work. This includes indirect interests such as those relating to third parties closely associated with board members, when they are known. All board members should make a declaration of

interests prior to appointment, annually, and when such interests change, in accordance with NICE's policy on declaring and managing interests.

89. If board members have any doubt about the relevance of an interest, this should be discussed with the chair.

90. During the course of a board meeting, if a conflict of interest is established, the board member concerned should withdraw from the meeting and play no part in the relevant discussion or decision.

91. Board members should not occupy a paid party political post or hold a particularly sensitive or high profile role in a political party, and should be guided by cabinet office rules on lobbying by NDPBs.

Register of Interests

92. The chief executive will ensure that a register of interests is established to record formally declarations of interests of members.

93. These details will be kept up to date by means of any new interests being declared at each board meeting, and an annual review of the register. At any one time, the register will give a full picture of all interests declared.

94. The register will be available to the public via the NICE website.

Counter-fraud, bribery and corruption

95. The Bribery Act was introduced in 2010 and came into force in 2011. NICE has a counter-fraud bribery and corruption policy which details the methods for reporting suspected fraud, bribery and corruption and the avoidance of fraud, bribery and corruption.

96. The policy sets out NICE's approach to mitigating the risk of, and dealing with allegations of fraud, bribery and corruption and explains the types of criminal offences falling into each category. . These SOs should be read in conjunction with the counter-fraud bribery and corruption policy.

Standards of business conduct policy

97. Staff must comply with NICE's code of business conduct. The following provisions should be read in conjunction with this document.

Interest of officers in contracts

98. Any member or officer of NICE who becomes aware that NICE has entered into or proposes to enter into a contract in which they or any person closely

associated with them (as defined in SO 88) has any direct or indirect financial interest, should declare their interest by giving notice in writing to the chief executive as soon as practicable.

99. An officer should also declare to the chief executive any other employment or business or other relationship of theirs, or any person closely associated with them, in connection with the commercial sector that conflicts, or might reasonably be perceived to conflict with the interests of NICE.

Canvassing of, and recommendations by, board members in relation to appointments

100. Canvassing of board members of NICE or of any committee of NICE directly or indirectly for any appointment under NICE shall disqualify the candidate for such appointment. The contents of this paragraph of the SO shall be included in application forms or otherwise brought to the attention of candidates.

101. A board member of NICE shall not solicit for any person any appointment under NICE or recommend any person for such appointment: but this paragraph of this SO shall not preclude a member from giving written testimonial of a candidate's ability, experience or character for submission to NICE.

102. Informal discussions outside appointments panels or committees, whether solicited or unsolicited, should be declared to the panel or committee.

Relatives of members or officers

103. Candidates for any employee or advisory committee appointment within NICE shall, when making application, disclose in writing to NICE whether they are related to any member or the holder of any office within NICE. Failure to disclose such a relationship shall disqualify a candidate and, if appointed, render them liable to instant dismissal.

104. The chair and every board member and officer of NICE shall disclose to NICE any relationship between themselves and a candidate of whose candidature that board member or officer is aware.

105. On appointment, members (and prior to acceptance of an appointment in the case of officer members) should disclose to NICE whether they are related to any other member or holder of any office within NICE.

Tendering and contract procedure

Duty to comply with standing orders

106. The procedure for making all contracts by or on behalf of NICE shall comply with these SO (except where SO 66 is applied).

Public contract regulations

107. Directives by the Commission of the European Union issued by the Treasury and the Crown Commercial Service prescribing procedures for awarding all forms of contracts shall have effect as if incorporated in these SO including and not limited to the Public Contract Regulations 2015.

Formal competitive tendering

108. NICE shall ensure that competitive tenders are invited for the supply of goods, materials and manufactured articles and for the rendering of services including all forms of management consultancy, design, construction and maintenance of buildings and engineering works (including construction and maintenance of grounds and gardens); and for disposals. In accordance with the following limits

£0	→	£3,000	1 written quotation
£3,001	→	£10,000	2 written quotations
£10,001	→	£25,000	3 written quotations
£25,001	→	EU threshold (currently £181,302.00)	formal tenders

Above the EU threshold the EU Directives shall apply

109. When seeking tenders, cost should normally be given a 50% assessment weighting in regard to the other selection criteria which are being applied.

110. Formal tendering procedures may be waived as set out below upon the recommendation of a budget holder and with suitable procurement advice:

(i) the audit and risk committee may approve any amount permissible by law;
(ii) the chief executive may approve waivers of a value up to the EU tender limit, currently £181,302; and
(iii) the business planning and resources director may approve waivers of a value up to the EU tender limit currently £181,302.

111. All waivers must have at least one of the following conditions applying:

(i) where the process for tender or quotations has failed to result in any submitted bids, or in any usable tenders;
(ii) where a reasonable assumption can be made that there is only one source of supply or one source of specialist expertise is available throughout the EU and WTO countries. This does not mean only one manufacturer – it means only one supplier;
(iii) there is a clear benefit to be gained from maintaining continuity with an earlier project. However, in such cases the benefits of such continuity must outweigh any potential financial advantage to be gained by competitive tendering; and

(iv) for reasons of extreme urgency brought about by events that could not be foreseen. (However, failure to plan the work properly is not a justification for single tender).

112. Where it is decided that competitive tendering is not applicable and should be waived by virtue of any of the criteria set out above, the fact of the waiver and the reasons should be documented and reported by the business planning and resources director to the audit and risk committee in a formal meeting.

113. The limited application of the single tender rules should not be used to avoid competition or for administrative convenience or to award further work to a consultant originally appointed through a competitive procedure.

114. Where a framework has been created with a number of suppliers following the fair and adequate competition processes as given in NICE's procurement team's intranet pages and such process has resulted in NICE holding information that allows differentiation between the suppliers, then suppliers may be selected by the application of a single differentiator i.e. hourly rates. Where suppliers are equal in terms of differentiators and the framework information held does not provide for a single differentiator a secondary competition will be held between those suppliers within the framework in question or relevant section of the framework in question. In all cases the award of a contract shall be by the application of the best value for money principle and a full record of the differentiators that have been applied kept with the subsequent contract for audit of the award decision.

115. Except where SO 114 or a requirement under SO 108 applies, NICE shall ensure that invitations to tender are sent to a sufficient number of firms/individuals to provide fair and adequate competition as appropriate, as detailed within the SFIs and NICE's procurement team's intranet pages, having regard to their capacity to supply the goods or materials or to undertake the services or works required.

116. Tendering procedures are set out in NICE's procurement team's intranet pages.

Quotations and tenders

117. Quotations and tenders are required for all expenditure or income and they should be obtained in accordance with the directions set out on the procurement team's intranet page in the numbers required by the level of expenditure and based on specifications or terms of reference prepared by, or on behalf of, NICE.

118. Quotations or tenders should be in writing unless the chief executive or his nominated officer determines that it is impractical to do so, in which case quotations may obtained by telephone. Confirmation of telephone quotations should be obtained as soon as possible and reasons why the telephone quotation was obtained should be set out in a permanent record.

119. Quotations shall be sent to the relevant requisitioning officer of NICE who will be responsible for their opening and custody. All tenders shall be sent to the procurement team who will be responsible for their opening and custody. All tenders shall be opened in the presence of two nominated officers of NICE.

120. All quotations or tenders should be treated as confidential and should be passed to the procurement team who will retain them for inspection.

121. The chief executive or his nominated officer should evaluate the quotations and select the one which gives best value for money. Cost should normally be given a 50% assessment weighting in comparison to the other factors being evaluated. If this is not the lowest cost then this fact and the reasons why the lowest cost quotation was not chosen should be in a permanent record.

122. Any quotations or tenders that are received after the appointed deadline shall be notified to the chief executive or his nominated officer and shall only be accepted upon their decision. The reasons for the inclusion of a late submission of a quotation or tender should be set out in a permanent record.

Where tendering or competitive quotation is not required

123. Tendering or competitive quotations are not required when using a supplier that has been appointed for that particular type of supply by a public sector body that exists to supply the entire public sector eg crown commercial services (CCS) for procurement of all goods and services unless the chief executive or nominated officers deem it inappropriate. The decision to use alternative sources must be documented.

124. The chief executive shall be responsible for ensuring that best value for money can be demonstrated for all services provided under contract or in-house. NICE may also determine from time to time that in-house services should be market tested by competitive tendering (SO 108 -114).

Contracts

125. NICE may only enter into contracts within the statutory powers delegated to it by the Secretary of State and shall comply with:

    (i) these SOs;
    (ii) NICE's SFIs;
    (iii) Public Contract Regulations 2015 and other statutory provisions;
    (iv) the intermediaries legislation (IR35), off-payroll working rules;
    (v) any relevant directions including HM Treasury publication "Managing Public Money" May 2012 and Cabinet Office controls guidance.

    Where appropriate, contracts shall be in or embody the same terms and conditions of contract as was the basis on which tenders or quotations were invited.

126. In all contracts made by NICE, NICE shall endeavour to obtain best value for money. The chief executive shall nominate an officer who shall oversee and manage each contract on behalf of NICE.

127. The senior management team and board shall receive regular updates on contract performance, new supplier procurement and contract financial variance, for all significant contracts. This shall be achieved by:

    a. regular financial reporting to SMT and Board, including all new large contract commitments;

    b. Directors reporting contract performance in their periodic reports to the SMT, Board and Audit and Risk Committee.

Employee and agency or temporary staff contracts

128. The chief executive shall nominate officers with a delegated authority to enter into contracts of employment, regarding staff, agency staff or temporary staff service contracts, in accordance within agreed budgets and intermediaries regulations (IR35).

Disposals

129. Competitive tendering or quotation procedure shall not apply to the disposal of:

    (i) any matter in respect of which a fair price can be obtained only by negotiation or sale by auction as determined (or predetermined in a reserve) by the chief executive or his nominated officer;
    (ii) obsolete or condemned items and stores;
    (iii) items to be disposed of with an estimated sale value of less than £1000 (this figure is to be reviewed annually);
    (iv) items arising from works of construction, demolition or site clearance, which should be dealt with in accordance with the relevant contract;
    (v) land or buildings concerning which DHSC guidance has been issued but subject to compliance with such guidance.

Custody of seal and sealing of documents

Custody of seal

130. The common seal of NICE shall be kept by the chief executive in a secure place.

Sealing of documents

131. The seal of NICE shall not be fixed to any documents unless the matter relating to the sealing has been authorised by a resolution of the board or of a committee thereof or where NICE has delegated its powers.

132. Before any building, engineering, property or capital document is sealed it must be approved and signed by one executive director and one non-executive director of NICE.

Register of sealing

133. An entry of every sealing shall be made in a book provided for that purpose and shall be signed by the persons who shall have approved and authorised the document and those who attested the seal. A report of all sealings shall be made to the audit and risk committee at least quarterly. The report shall contain the description of the document and date of sealing.

Signature of documents

134. Where the signature of any document will be a necessary step in legal proceedings involving NICE, it shall be signed by the chief executive, unless any enactment otherwise requires or authorises, or NICE shall have given the necessary authority to some other person for the purpose of such proceedings.

135. The chief executive or nominated officers shall be authorised to sign on behalf of NICE any agreement or other document not requested to be executed as a deed, the subject matter of which has been approved by the board or any committee, sub-committee or standing committee thereof or where NICE has delegated their powers on its behalf.

Miscellaneous

Standing orders to be given to members and officers

136. It is the duty of the chief executive to ensure that existing members and officers and all new appointees are notified of and understand their responsibilities within SO and SFIs. Updated copies shall be issued to staff via the intranet.

Documents having the standing of standing orders

137. Standing financial instructions and reservation of powers to NICE and delegation of powers shall have the effect as if incorporated into SO.

Review of standing orders

138. Standing orders shall be reviewed annually by NICE.

Date: March 2019

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 provide an update on any issues of note.

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 2019

National Institute for Health and Care Excellence

Communications Directorate progress report

1. This report sets out the performance of the Communications Directorate against the directorate's business plan objectives during July and August 2019. The business plan objectives are listed at the end of the report.

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.

Performance

Communications support and strategic advice

4. Following a full tender process we have appointed an agency to deliver the NICE Connect video. There was a lot of interest in the contract with a total of 34 bids. All bids were given thorough consideration. Work is now starting with the agency for an anticipated launch date in November 2019.

5. Work is also underway on a series of visuals to help bring the Connect vision to life. These will be used in presentations and other external engagement.

6. We have refreshed the digital content of the medicines and prescribing team to support ongoing promotion of the work of the associates programme. The new web page includes a video which we developed in-house to bring to life the benefits of the work.

7. We also worked with the guideline development teams to redesign the stakeholder registration pages on the website in response to requests to make the eligibility criteria clearer.

8. In August we commenced a programme of communications activities to support the NICE Fellows and Scholars programme in its eleventh year of recruiting individuals from across health and social care. During the recruitment window, our aim is to encourage diverse and high calibre applications from diverse

applicants with strong networks and an ability to influence, whose work aligns with NICE's priorities. Our suite of communications activities include trade press releases, stakeholder outreach, and filming short vox pop clips about the programme with former Fellows and Scholars to share on our social media channels.

9. Also in August, we submitted a response, based on our guidelines, to the Menstrual Health Coalition (MHC) who had issued call for written evidence concerning heavy menstrual bleeding. The MHC intends to publish a best practice report focusing on the patient pathway and using examples of high quality care provision from across the country.

10. We supported colleagues in CHTE to prepare briefing notes for the DHSC in advance of a Westminster Hall debate on using mesh to repair hernia in men.

Audience insights

11. The findings of the reputation research work were presented in the August 2019 board strategy meeting and introduced at the all-staff meeting. The team are now working on a dissemination plan to ensure the results are shared within NICE.

12. SNAP survey software has now been rolled out to 12 teams across NICE. Superusers have received training from SNAP, and the audience insight team has provided additional support and documentation. During July and August a total of 118 surveys were set up on the new system. This figure includes new projects and those transferred from SurveyMonkey. Moving forward we will continue to work closely with the teams using SNAP to ensure they follow best practice when it comes to user research and survey design, providing further training and support where necessary.

13. We worked closely with the public involvement programme to explore how NICE can improve its meaningful engagement with the public as part of the CHTE Vision 2020 project. Initial results of a survey with patient organisations suggest that enhanced support, training and feedback would be greatly appreciated in meeting this aim.

Editorial and publishing

14. In July and August we prepared 205 documents for digital publication.

15. We prepared and published

    - 1 new and 12 updated guidelines

- 17 new and 2 updated guidance documents (diagnostics, medical technologies, technology appraisals, interventional procedures and highly specialised technologies)
- 4 new and 5 updated quality standards
- 2 new advice products
- 21 new pieces of information for the public
- 80 evidence documents (44 HTML/converted documents and 36 downloadable documents)
- 61 tools and resources (23 HTML/converted documents and 38 downloadable documents).

16. In terms of NICE Pathways, in July and August we:

- Fully updated 4 pathways
- Updated 39 pathways to take account of new guidance or advice (for example, adding new health technology guidance)
- Updated a further 18 pathways to add related pathway links or as maintenance updates.

17. We have updated our editorial house style to support and clarify the use of gender-neutral language where appropriate, to help promote equality.

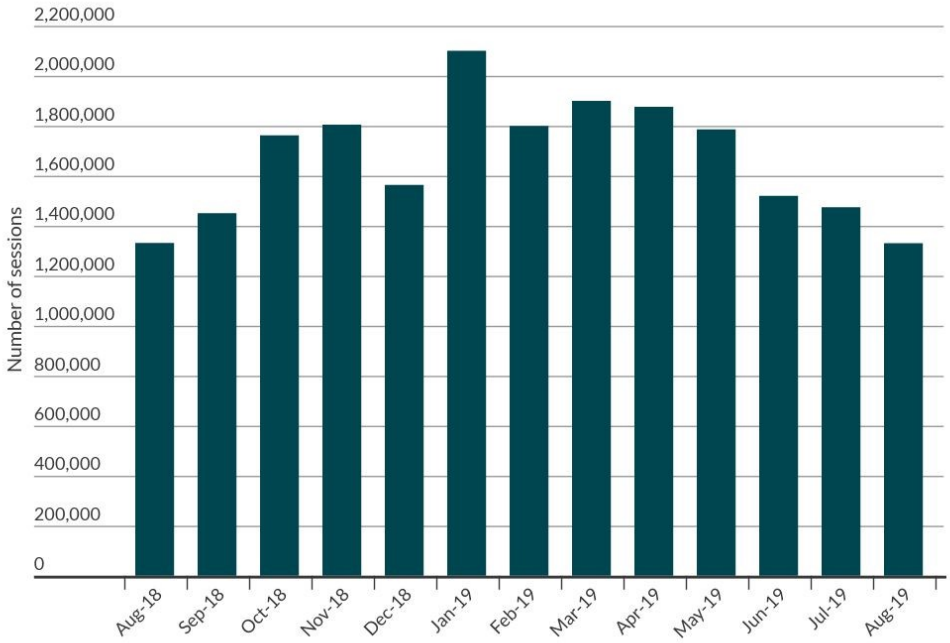
18. Working with colleagues in the corporate communications team, we have provided one-to-one and team training sessions across NICE on accessible content development. In addition, work is under way to update advice on how we use hyperlinks, to make them more accessible.

Website performance

19. The most popular news stories in July and August were the publication of our draft guidance on the use of cannabis based medicinal products, viewed 4,214 times; the publication of our quality standard on Lyme disease, viewed 4,064; and the recommendation of a new medicine to treat type 1 diabetes, viewed 3,703 times.

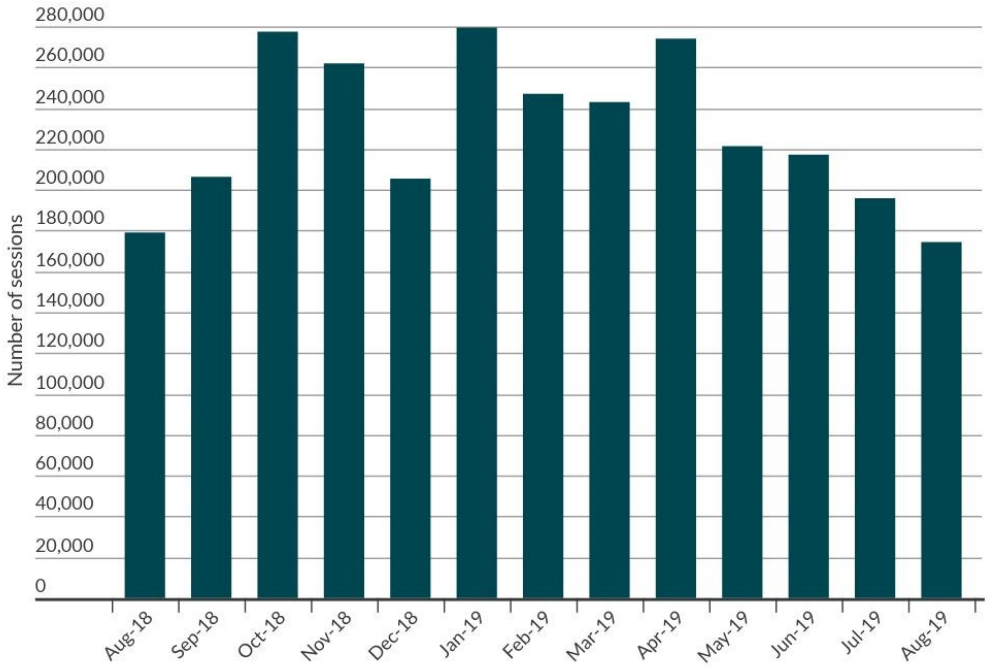
20. In this reporting period there were a total number of 2.8 million sessions on the NICE website which represents a 7% increase on the same period in 2018.

Chart 1: Number of sessions on nice.org - July-August 2019



Download the data set for this chart

Chart 2: Number of sessions on Pathways July-August 2019



Download the data set for this chart

Enquiries

21. During July and August we responded to 1,589 enquiries which included 23 MP letters, 16 Freedom of Information (FOI) requests, and 19 parliamentary questions (PQ).

22. The majority of PQs related to the review of methods in our technology appraisal programme. We also continued to receive PQs on the appraisal of nusinersen for the treatment of Spinal Muscular Atrophy. Topics covered by MP letters were varied but a number related to our appraisal of cerliponase alfa for the treatment of Batten disease.

23. The development of guidance on cannabis-derived products for medicinal use continues to attract public enquiries. Following the publication of the draft guideline we received correspondence from people who were very disappointed with the draft recommendations. We have also received a number of enquiries asking NICE to prioritise the development of guidance on pernicious anaemia and requests to reconsider draft recommendations on metreleptin for treating lipodystrophy.

24. The new Customer Relationship Management system is now live. It has been a challenging project given the complexity of requirements across different teams and directorates. However we will now begin to see the benefits of a more modern and sophisticated system not only for the day-to-day management of enquiries but also for joint reporting across directorates and stakeholder intelligence.

Events

25. The new Zoom platform for delivering webinars has been set up and is ready to roll out. The external communications team has received training on how to host webinars, and is planning to pilot the technology in October with a webinar for patient groups on the methods review currently underway in the Centre for Health Technology Evaluation. If successful, we plan to deliver 4 corporate webinars in the first year, which will complement our other stakeholder communications and events activities.

26. Two speaking engagements were delivered in July: Dr Weeliat Chong, vice chair of the committee developing the guideline on safe use and management of controlled drugs, spoke at the Controlled Drugs Summit in London; and Sir Andrew Dillon delivered the opening keynote address at the Health Tech Week Congress in Auckland, New Zealand.

27. Plans are progressing for the 2020 NICE Annual Conference, which is set to take place on 3 June 2020 at the Deansgate Hilton hotel in Manchester. The

event producer from our conference contractor, Dods Group, has met individually with members of the Senior Management Team in August to discuss topics, themes and streams for the programme. The programme will be finalised and launched in November, at which point ticket, sponsorship and exhibition sales will commence.

Media

28. Sentiment percentages for media coverage in July and August were as follows:

    - Positive 82%
    - Neutral 6%
    - Negative 12%

29. Positive coverage was driven by our advice to prescribe aspirin to lower the risk of colorectal cancer in people with Lynch Syndrome. This was picked up in print and in online versions of The Telegraph and was also featured on the Mail Online. Other positive coverage came from our decision to recommend olaparib for gynaecological cancers which was featured in the online versions of the Daily Mirror, the BBC, the Telegraph and in print versions of the Times and the Daily Mirror. Our positive decision to recommend dacomitinib for non-small-cell lung cancer also appeared on the Mail Online.

30. Coverage of our cannabis-based medicinal products guideline, in which a lack of evidence for the products' clinical effectiveness was highlighted, led to more negative news coverage than we usually receive. Paul Chrisp was interviewed on the Today Programme, Victoria Derbyshire and 5 News. There was also wide coverage online and in print. Continued negative coverage also came from our guideline on mesh and the technology appraisal on cerliponase alfa for Batten disease.

Social media and podcasts

31. We are conducting an audit of our social media techniques and success. The current social media strategy dates to 2017, and with the social media landscape constantly changing, we want to be confident that we are using the right channels and reaching our target audiences.

32. Our month-on-month statistics remain very good. Since the last reporting period we have seen an 11% increase in followers on Instagram - with a total now of more than 2,100 followers. In July-August we saw an impressive engagement on our LinkedIn posts, overall receiving 4,616 likes, shares or comments. Our posts on Twitter are continuing to get wide coverage overall receiving around

1,419,500 impressions (number of times posts are seen) over this 2-month period.

33. In July - August 2019 we released 2 new NICE Talks podcast episodes looking at maternal and child nutrition and caring for people with dementia. Together these episodes have received 2,043 plays.

Notable issues and developments

34. We have been addressing the reduced capacity across the directorate and have made a number of key appointments in the last two months. Jenny Kasher has joined as head of our Audience Insights team and Neil Drake has joined us as the head of Public Affairs. In the coming months we will be reviewing the structure of the directorate to ensure that we are equipped to support the business and promote the work of NICE.

Communication directorate objectives 2019-2020:

35. Ensure guidance and related products from NICE are of the highest quality and that the publishing and editorial function continues to deliver outputs of the highest standard during the NICE transformation programme.

36. Design and deliver a rolling programme of audience research that supports and informs the corporate business objectives.

37. Deliver a programme of strategic communication activities which promote NICE's work and support the uptake of NICE's offer.

38. Contribute communication expertise to the Connect (pathways) project and lead the communications and audience insights work to deliver the proof of concept phase.

39. Ensure communications is centralised and coordinated in the directorate by taking an integrated approach to planning and delivering communications.

40. Shape and manage our resources in order to support NICE and its strategic objectives effectively and efficiently.

September 2019

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 2019. It also highlights discussions on the maintenance of the Public Health guideline portfolio, a potential collaboration with the World Health Organization and the draft guideline on cannabis-based medicinal products.

Performance

2. Two clinical guidelines and one public health guideline were published during July and August 2019. No social care or antimicrobial prescribing guidelines were scheduled for publication during this period. Performance on delivery of the guidelines is on track.

3. Five surveillance reviews were published during this reporting period, of which none were exceptional reviews. All other deliverables are on track.

4. A collaboration with the Office for National Statistics (ONS) is exploring an automated method to identify recommendations across multiple guidelines to identify related recommendations. The ONS has expertise, through its Data Science Campus, in investigating and exploiting data sources for public benefit. The ONS provides free training and work across public sector organisations on data projects that provide insight into key strategic themes. The aim for NICE is to develop a machine learning tool to reduce manual intervention and the potential risk of inconsistency in the guidance surveillance process.

5. The scopes for 1 new guideline, on management of gout, and 1 guideline update, on Meningitis and meningococcal septicaemia have been developed with input from the GP Reference Panel.

6. The order for print copies of BNF78 and BNFC have been placed with the printers and are scheduled for delivery to the mailing distribution contractor (Linney) in September 2019. The main distribution campaign of the print copies of the BNF and BNFC is scheduled to start in October. The Department of Health and Social Care and NHS England continue to discuss content of the Nurse Prescribers Formulary (NPF) to ensure that it is aligned with the most up to date BNF information and the prescribing responsibilities of Community Practitioner Nurse Prescribers. NICE has agreed to distribute print copies of the BNF to nurse prescribers to support them whilst discussions continue.

7. Guideline Committees are sometimes faced with the need to choose between or sequence treatment options which are similar in their effects and costs. In order to help committees do this, we planning a workshop with academic health economic experts and stakeholders. This work will also help to inform the NICE Connect work on medicines pathways.

8. The methods and economics team is also supporting NICE Connect by developing and maintaining cost-effectiveness models that could be used for analyses in both guidelines and technology appraisals. Such models would allow regular and multiple technology appraisals along the whole treatment pathway within rapidly changing disease areas, such as diabetes and lung cancer. If viable, it would also enable the inclusion in guidelines of medicines and technologies that have not been subject to a technology appraisal, using a consistent method, and facilitating more timely updates of guidance and clinical pathways.

9. The Centre for Guidelines submitted over 20 abstracts to the 2019 Guidelines International Network conference (GIN). Of these, eight have been accepted for oral presentations. A member of the team has also been invited to present a plenary session on the use of real-world evidence in guidelines.

10. In August, the UK GRADE Network steering group, which is co-led by NICE and Cochrane, met to review and agree its terms of reference and invited new members representing the UK-based collaborating centres of the Joanna Briggs Institute, Campbell UK and Ireland, National Guideline Centre and National Guideline Alliance.

11. In August, staff from the NICE Centre for Guidelines and science policy and research team met with NETSCC and NHS England to review the research that had been commissioned through NIHR programmes. In the 2018/2019 financial year, NIHR funded 12 new research projects committing in excess of £15 million. Of these, 10 were in response to NICE guideline research recommendations (2 of which were designated as key research priorities).

Notable issues and developments

12. Discussions continue with colleagues at Public Health England and the Department of Health and Social Care on a more focused approach to keeping NICE's public health guidelines up to date and in line with system priorities. This will contribute to the planning for NICE Connect.

13. A potential collaboration with the World Health Organization (WHO) to provide evidence-based recommendations on antibiotic choice for its Essential Medicines List (EML) is being developed. The proposal is to reuse the evidence

reviews that underpin NICE antimicrobial prescribing guidelines. The product would be co-badged, in line with NICE's policy on co-production.

14. The draft guideline on cannabis-based medicinal products was published for consultation on 8 August, generating significant media interest. The final guideline is scheduled for publication in November.

September 2019

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 Heath Technology Evaluation (CHTE) against our objectives during July and August 2019. It also highlights key developments in the centre during that period.

Notable developments

2. Notable developments in the Centre since the report to the July 2019 meeting of the board are as follows:

    - Establishment of the topic Task & Finish Groups to support the methods review for health technology evaluation programmes
    - Publication of the Technology Appraisal guidance, TA588 Nusinersen for treating spinal muscular atrophy
    - Managed Access Team strengthened through the absorption of the Observational Data Unit team.

Performance

Centre Coordination Team

3. During July and August CCT have coordinated recruitments for 13 positions within CHTE & Science Advice and Research (SAR). These vacancies have been created by staff leaving, maternity cover and the creation of new roles.

4. In July and August 8 recruitments are in progress for 25 committee members and 1 chair, across 8 committees. We have made 7 provisional offers to professional members.

Commercial Liaison Team (CLT)

5. The CLT is continuing to work with colleagues in NHS England/Improvement to inform the development of the commercial framework and assess its potential impact. Scoping on a programme of work to develop and implement the working processes needed to deliver a seamless interface for all relevant commercially related conversations between companies NHSE and NICE has commenced. Recruitment to an interim CLT structure is now complete with the final member of staff coming into post in early September. New CLT activities during July/August include the successful transfer of project management responsibility for the

Budget Impact Test from Technology Appraisals and commencing delivery of commercial briefing notes to inform NHSE commercial agreements.

6. The PASLU component of the CLT is continuing to issue PAS advice to NHS England. Completion of 38 commercial access agreements (PASs) is anticipated in 2019/20 with 16 PAS advice reports issued to NHS England by the end of August.

Managed Access Team (MAT)

7. The Observational Data Unit (ODU) joined the MAT during July. This further strengthens the development of a broader focus on all types of managed access in support of the Voluntary Scheme 2019, as well as maintaining the capacity to service NHSE Commissioning Through Evaluation (CtE) requirements going forward. We anticipate up to 17 Managed Access Agreements (MAA) will be developed in 2019/20. Since April 2019, 9 new MAAs have been finalised and associated guidance published.

8. The MAT is coordinating active data collection arrangements for 25 CDF, 3 HST and 2 Technology Appraisal (TA) topics. Data collection has completed for 5 CDF topics in so far in 2019/20, with 1 CDF topic having guidance withdrawn due to withdrawal of its marketing authorisation. Data collection for a further 3 CDF topics, plus 1 HST and 1 TA topic will end before 31 March 2020, which will see these topics re-appraised for a final commissioning decision.

9. During July, the MA team commenced leveraging the knowledge and expertise developed from the CDF, to further develop and clarify the processes associated with MAA exits for non-cancer topics. Among the outputs from this work will be clear step-by-step guidance for all parties to these MAAs to ensure the process for exiting managed is well understood.

10. Ongoing Commissioning through Evaluation (CtE) projects are developing evidence to support NHS England's forthcoming commissioning policy reviews for:

    - Stereotactic ablative radiotherapy (SABR) for re-irradiation of the pelvis and spine - the CtE report has been submitted to NHS England.

    - Stereotactic ablative radiotherapy (SABR) for hepatocellular carcinoma - reports are being drafted.

    - Rituximab for idiopathic membranous nephropathy - data collection is ongoing, overseen by the ODU.

11. Following a public consultation, the EUnetHTA Register Evaluation and Quality Standards Tool (REQueST) and vision paper are being updated ready for publication in September 2019.

NICE Office for Market Access (OMA) & Accelerated Access Collaborative Secretariat (AACS)

12. OMA delivered further engagements (multi-stakeholder and knowledge transfer) in July and August. OMA has a healthy pipeline of prospects and continues to receive a high level of interest in its services from the life sciences industry.

13. The AACS has been working closely with newly established AAC Delivery Unit at NHS England to support delivery of the expanded remit of the AAC. This work includes providing technical resource to assist with development of metrics to demonstrate the impact of the AAC, supporting the development of a single system-wide horizon scanning approach, and working with NHSE & NHSX on support for products selected by the AAC. The AACS team continues to provide governance support, both for the existing and new structures in the AAC.

Diagnostics Assessment Programme

14. The programme remains on track to publish 5 pieces of guidance in the 2019/20 business year. In July 2019 the programme published guidance on Therapeutic monitoring of TNF-alpha inhibitors in rheumatoid arthritis (DG36). There was insufficient evidence to recommend the tests for routine adoption however, the guidance includes recommendations for further research.

15. The programme also started the first rapid update of a piece of diagnostics guidance in July 2019. Since the diagnostics guidance on Myocardial infarction (acute): Early rule out using high-sensitivity troponin tests (Elecsys Troponin T high-sensitive, ARCHITECT STAT High Sensitive Troponin-I and AccuTnI+3 assays) (DG15) published in October 2014, the technologies recommended in the guidance have been selected as a ‘rapid uptake product’ by the Accelerated Access Collaborative (AAC). The guidance will be updated to address several key questions to support the work of the AAC in implementing these technologies.

16. The process for the rapid update will differ from our standard approach to updating diagnostics guidance and follow shorter timelines, as the update has been initiated via the AAC. The earliest possible publication date for the updated guidance is 8 April 2020.

Interventional Procedures Programme

17. The Interventional Procedures Programme were scheduled to publish 4 guidance publications from July to August 2019. It is confirmed that this target will be met.

18. IPAC has considered the most recent evidence base on “Reducing the risk of transmission of Creutzfeldt–Jakob disease (CJD) from surgical instruments used for interventional procedures on high-risk tissues”. This was an update of IPG196. Their draft recommendations went out for consultation in June 2019 and are due to be discussed at Committee on 12 September 2019.

19. There are currently 6 vacancies (out of 25) for IPAC committee members with other committee members nearing the end of their term. This represents unusually high turnover of committee members and recruitment to the positions has been problematic because of a lack of applicants. However, the risks have been managed by the IP team and new appointments are about to be made.

Medical Technologies Evaluation Programme

20. The pipeline of new topics being considered for guidance remains strong as a result of the positive impact of HealthTech Connect. Guidance is currently being developed on 9 technologies. We remain on target to publish 7 pieces of guidance in 2019/20.

21. The programme published 2 MedTech innovation briefings in July and August with briefings in development on 13 more technologies. There are a further 20 technologies awaiting a decision on progress to a MIB. We remain on target to publish 34±4 MIB's in 2019/20

HealthTech Connect

22. HealthTech Connect launched in April 2019 to support the development and adoption of devices, diagnostics and digital health technologies. Over 400 companies have registered to use the system, and 83 technologies have been submitted.

23. NICE is using HealthTech Connect to support topic identification for the AAC, MTEP, and NICE Scientific Advice teams.

24. MTEP have selected 13 technologies for a NICE output (Medtech Innovation Briefing, Medical technologies guidance, or Diagnostics guidance). A further 24 technologies are awaiting a selection decision. No technologies have yet progressed to receiving a scientific advice fee paid service or have been identified for AAC consideration.

25. The number of national organisations using HealthTech Connect has increased from 12 to 14. The NIHR (NOCRI function), and NHS England Innovation, research and life sciences team are now using HealthTech Connect to support topic identification. Discussions are being held with Scotland about replacing its own topic identification portal with HealthTech Connect and enabling its national procurement and planning teams to have access. Discussions are also taking place with OLS and NHSX about how best to feature HealthTech Connect within the AAC innovator portal that is being developed.

Technology Appraisals and Highly Specialised Technologies

26. In August 2019 the HST programme published its tenth piece of guidance 'Patisiran for treating hereditary transthyretin amyloidosis'. The topic was recommended for routine commissioning.

27. All four technology appraisal committees have now considered a topic under the new STA process which was published in April 2018. At the time of writing 50% of new STA committee discussions have resulted in a 'straight to final guidance' decision.

28. The 2019/20 business plan indicates that NICE would publish 78 technology appraisals and highly specialised technologies. At the time of writing the report, 28 have published so far and it is currently anticipated that a final number of 72 pieces of guidance will publish for the 2019/20 business year. This number is lower than anticipated as a number of topics have been suspended or delayed during the business year for a variety of reasons such as licencing changes, on-going discussions with NHS England regarding commercial opportunities, and at company request for delay (resulting in publication in the 2020/21 business year). However, the programmes are working on 84 (75 TA and 9 HST) 'live' topics that are currently between the formal invitation to participate and final guidance publication stages. Another 22 topics are scheduled to start between the September and November NICE Board meetings.

29. Between April and August 26 topics have been subject to the budget impact test process at the committee submission stage. 21 of these have been completed; 10 topics met the budget impact test at this stage and 11 did not.

September 2019

National Institute for Health and Care Excellence

Evidence Resources progress report

1. This report sets out the performance of the Evidence Resources directorate against our business plan objectives during July and August 2019. It also highlights the usage performance of the NICE Evidence suite of on-line services at the end of August 2019.

2. The Evidence Resources Directorate is responsible for the following key functions and services:

    - We provide a high-quality information service to NICE centres and directorates;
    - We manage third party access and re-use of NICE content, including internationally;
    - We support the Centre for Health Technology Evaluations (CHTE) with their digital health evaluation programme;
    - We support NICE's digital transformation activities and maintain all NICE's live digital services;
    - We manage the provision of NICE Evidence Services.

Performance

3. Performance against the Evidence Resources objectives for 2019/20 is summarised in this section.

Information Services

4. During this period the Information Resources teams were re-organised, bringing together all our information specialist professionals into a single information services function ensuring coordinated and efficient support for the guidance producing teams, particularly in relation to the surveillance and updating of guidance.

5. A key objective of the directorate is to deliver efficient and high-quality information services to the NICE centres and directorates. In the last 2 months, alongside undertaking searches to support guidance development, work has focused on strategic developments, including:

    - On-going support to the CHTE 2020 programme, specifically to the topic selection and guidance process workstreams;

- Continuing a range of research projects to improve the efficiency of the searching and sifting processes, including exploring the use of machine learning technologies.

Content re-use

6. A key objective of the team is to articulate and promote NICE's value propositions associated with the re-use of NICE content outside of the UK. In the last two months, the team has responded to 63 requests to re-use NICE content. 12 quotes to re-use NICE content were issued and 10 content and 1 syndication licence were signed. The total income invoiced year to date is £54,000.

Digital Health

7. Our directorate is supporting CHTE to explore with NHS England the options for a digital health technology evaluation workstream, building on the Evidence Standards for Digital Health Technologies published in 2018/19. Over the last two months, we have focused on supporting the following activities:

    - Preparation of papers for the new Digital Health External Steering Group which plays a key role in the pilot;
    - Chairing the August meeting of the External Steering Group;
    - Continued promotion of the use of NICE's Evidence Standards for Digital Health Technologies including enabling engagement with the pilot programme where appropriate.

Digital Services

Strategic planning

8. The first objective of the Digital Services (DS) team for 2019/20 is to identify digital investment priorities, and their sequencing, to align with the NICE Connect project transformation work, reviewing the roadmap quarterly. Over the last two months activity has focused on:

    - Planning for the integration of the DS and NICE IT teams following a strategic decision to bring these together under one Director for future delivery;
    - Starting procurement of strategic support to help shape the integrated team and new target operating model, and to provide external challenge to our technical strategy;
    - Agreeing a short-term approach to the roll out of Office 365 across NICE and organising procurement of resource to support this. This has included starting to plan the longer-term strategy of Office 365 for NICE in the

context of our transformation and identifying expertise required to help shape this;

- Ongoing work to support the shaping and next steps of NICE Connect including scoping and planning for resource and expert input relating our content transformation work;
- Agreement to invest and upgrade our existing NICE Pathways service.

Delivery of strategic digital services projects

9. Our second objective is to deploy our digital expertise to deliver business-led strategic projects in line with an agreed roadmap. Over the last two months activity has focused on:

    - The Evidence Management platform (delivering web tools for searching evidence, systematic review needs and building an evidence surveillance capability): we held meetings with our collaborating centres to understand their remaining needs and agree a plan for feature development and onboarding of these centres in the first half of 2020;
    - Ongoing work to support configuration of a new identity management solution to replace our current in-house 'NICE Accounts' solution;
    - Operational Productivity: we have consolidated activity focusing on replacing the legacy Contact Database and Planning Tools into the NICE Connect programme and established a multi-disciplinary team focused on Operational Productivity. This early work will look across data, process and tooling to support operational activity in the context of our transformation.

Live services maintenance and improvements

10. Our third objective is to manage and maintain the live digital services of NICE utilising user insight and strategic service goals to prioritise use of resource:

    - NICE Digital Services operated within the service levels (99.7%) agreed with DHSC for availability (uptime) with 99.99% average performance in the last two months;
    - In the last 2 months, 67 defects were closed. In the same period, 4 Change Control Requests were completed.

11. Significant planned live service work was undertaken as a result of an upgrade to our Transport Layer Security (TLS) which provides security in the connection of users to our services over the internet.

Cross-cutting updates

12. Recruitment: A campaign to recruit to four vacancies (Associate Digital Performance Analyst, Technical Tester, User Experience Designer and Web

Ops Engineer) completed in July and resulted in appointments to all roles. Staff members will join the team in Q3 2019.

13. The team is currently made up exclusively of permanent staff members. As priorities such as Office 365 have been agreed, we will be targeting additional contractor or consultancy expertise to provide timely support in focused areas.

14. Talent management update: To support the delivery of our technical strategy we are building strong relationships with our existing cloud network providers and have held workshops to explore options for development and support with them both. Technical training will be delivered as part of our ongoing technical strategy and Digital Services/IT integration plans.

15. External collaborations: Our conversations about terminology and interoperability standards in the last 2 months have focused on supporting the preparation of a joint workshop on computable knowledge as part of the concept of a learning health system for the UK.

NICE Evidence Services

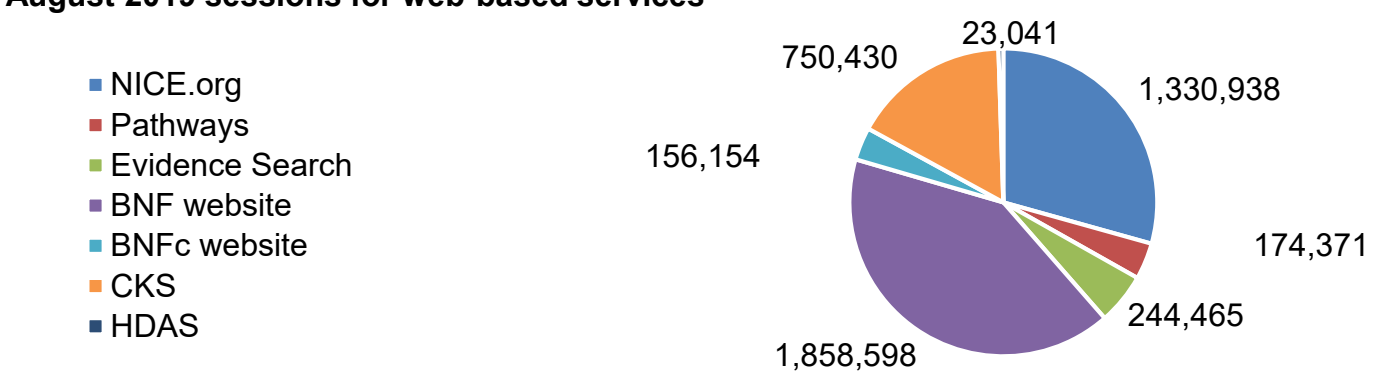
16. A core objective of the directorate is to maintain and monitor the performance of NICE Evidence Services which include CKS, HDAS, the BNF microsites, Evidence Search, and the Medicines Awareness Service. Over the last two months, negotiation has continued on the England-wide licence to access the Cochrane library. The current licence ends in April 2020.

17. To provide these services, a key objective of the team is to enable access to the new National Core Content collection and to procure any additional content in line with Health Education England's (HEE) commissioning decisions. We have met with HEE to explore the search needs of advanced searchers in relation to the HDAS service. We agreed to extend the current link resolver service until the end of March 2021 which was due to expire in October 2019.

Performance statistics for NICE Evidence Services

18. Figure 1 and table 1 below summarise the position of all NICE's digital services at the end of August 2019, contrasting the relative size of the externally facing services of NICE, measured in number of 'sessions'. In August NICE digital services received altogether 4.5 million sessions; although this represented a 6% decline from July the services grew 20% year-on-year. Overall NICE digital services have grown 29% in the last 12 months.

Figure 1 and table 1: Overview of NICE's digital services performance as of August 2019



*Note: a session is a group of interactions a user takes on a website within a given time frame

download the data set for these charts

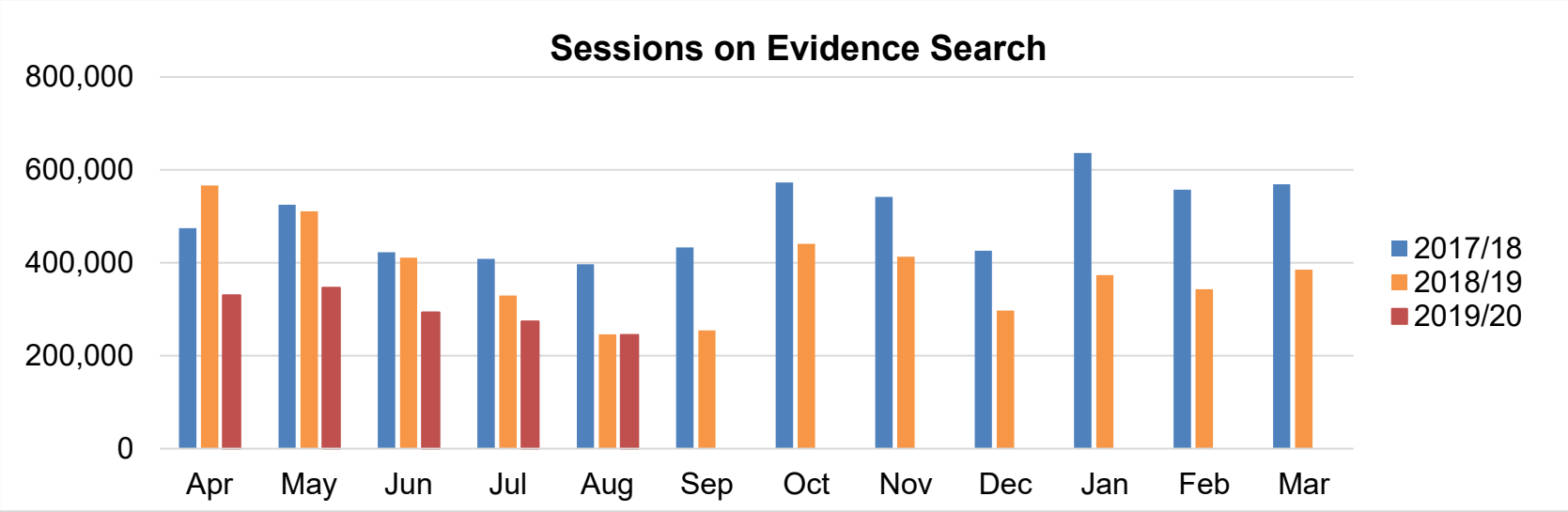
Total sessions* in August 2019 across NICE web-based services	4,537,997
% year-on-year variance	20%
% month-on-month variance	-6%
Total sessions for the full year ending in August 2019 across NICE web-based services	60,906,348
% year-on-year variance	29%

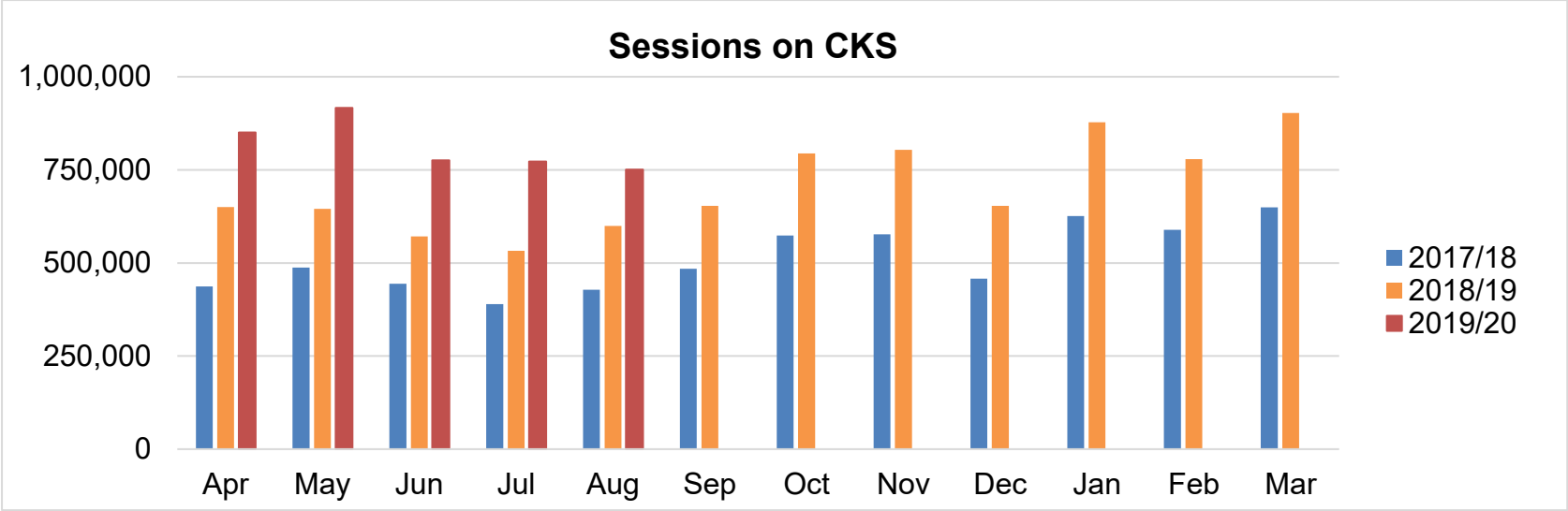
19. Figures 2-4 below detail the performance of the 3 services which provide access to evidence beyond that produced by NICE: Evidence Search, Clinical Knowledge Summaries (CKS) and HDAS.

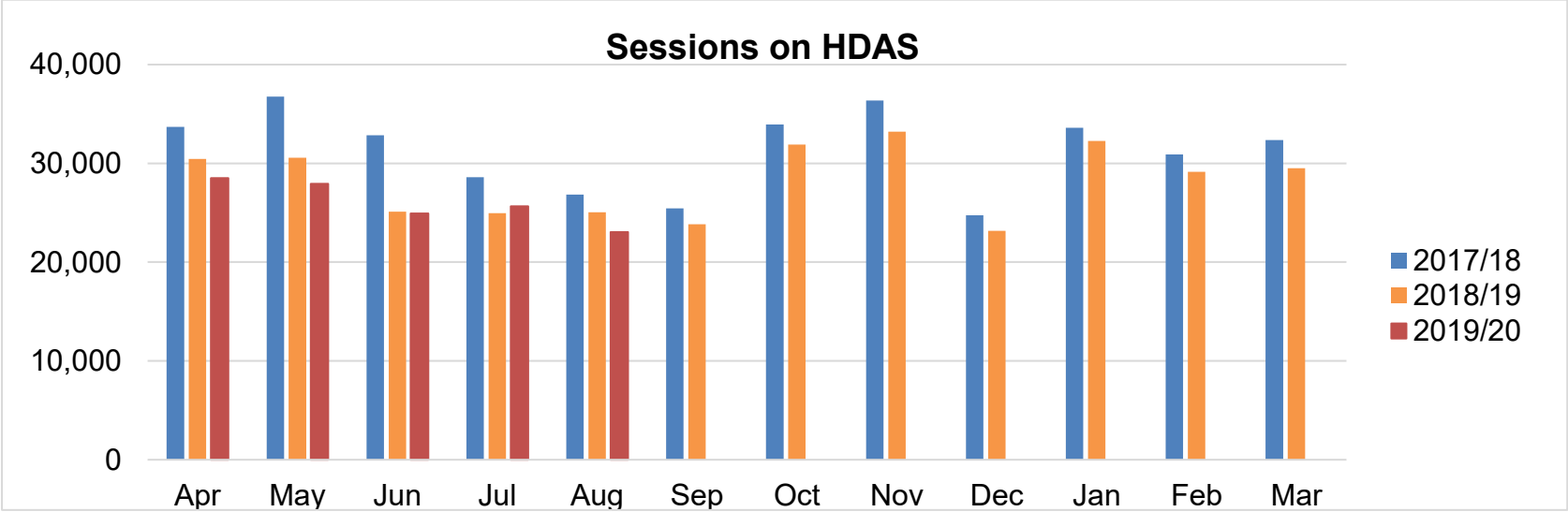
    - The decline in sessions on Evidence Search appears to have stabilised. In August 2019, the number of sessions was comparable to August 2018;
    - In August CKS was little affected by the holidays season since sessions to this service declined only 3% from July. Sessions to this service continue to rise year-on-year (+25% from August 2018);

      Whereas July was a good month for HDAS (the service received a 3% increase in sessions in comparison with July 2018), August sessions (-8% compared to August 2018) indicate that the year-on-year decline of the service continues.

Figures 2-4: Performance of services providing access to 'other evidence' as of August 2019

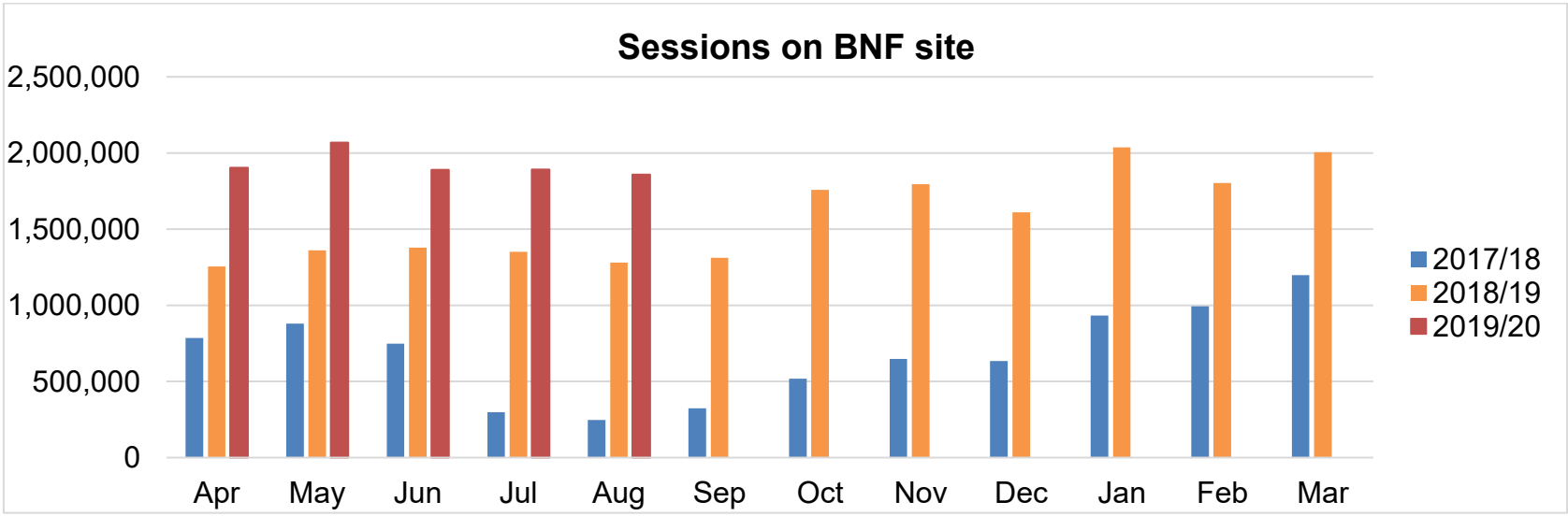


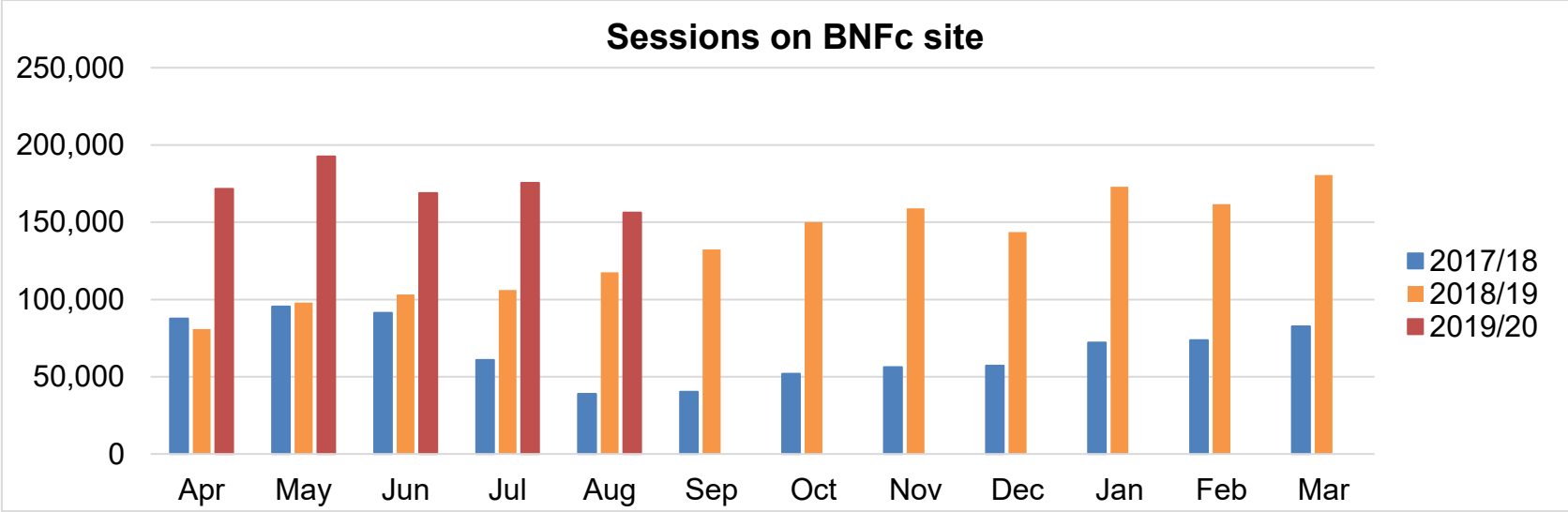

Sessions on CKS
1,000,000
750,000
500,000
250,000
0
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar
2017/18
2018/19
2019/20


Sessions on HDAS
40,000
30,000
20,000
10,000
0
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar
2017/18
2018/19
2019/20

20. Figures 5-6 illustrate the performance of our BNF and BNFc microsites. Although these services have seen a slight seasonal decline in August, they continue to show excellent growth year-on-year (+45% and +33% respectively).

Figures 5-6: Performance of services providing access to BNF content as of August 2019





download the data set for these charts

National Institute for Health and Care Excellence

Health and Social Care Directorate progress report

1. This report sets out the performance of the Health and Social Care Directorate against our business plan objectives for July and August 2019. A summary is also provided for areas of work that have seen significant progress and are of note for the Board.

2. The Chief Executive's Report details the delivery of quality standards.

Performance

3. The directorate has achieved its planned deliverables for this reporting period except for medicines evidence commentaries (MECs) published by the end of August. MECs are selected from new published evidence that meets the criteria for MEC development. 7 MEC topics were identified by end of August, which was below the 10 MECs outlined in the HSC business plan. It is expected that the full year total of 24 MECs published will be achieved by the end of the year.

4. Key publications are detailed in Appendix 1. Progress includes the following areas of work, as set out in the business plan.

Deliver and support the adoption of accessible, up to date and adaptable advice, fully aligned to the needs of our users

5. The ratio of applications to vacancies for lay members on committees during the reporting period was 9.1:1, with the target being 2:1 or greater (91 applications were received for 10 vacancies). Eleven patient experts were identified to give testimony at committee meetings and at NICE's Scientific Advice meetings.

6. As part of the CHTE2020 programme, we conducted an early engagement survey with voluntary and community sector organisations to seek their views on how we can improve, find and use evidence from patients, people who use services, their families and carers. Fifty-one responses were received, and the results will inform proposals which will be included in the broader CHTE2020 consultation next year.

National strategic engagement

7. The 2019/20 strategic engagement plan includes priorities for engagement at a national and regional/local level. The metrics are on track for this reporting period except for the metric to support mental health strategic clinical networks to understand and use NICE guidance and standards. A PowerPoint resource for

local partnerships is being used while an online resource is being finalised. The metric is anticipated to be on track by the end of quarter 2.

8. A new National Design Group for Commissioning for Quality and Innovation (CQUIN) will hold its first meeting in September 2019. We have been invited to be part of this group, which will provide improved oversight of the process for shortlisting ideas for the national CQUIN. The group will ensure that CQUIN indicators are designed to the highest standard and based on up-to-date, robust data. Outputs of the design group have a strategic fit with NICE's work, and a national CQUIN can act as a catalyst in the implementation of NICE guidance.

9. We attended the Care Quality Commission's (CQC's) Online Provider Forum and Online Cross-Regulatory Forum in July, ensuring that references to evidence-based care were included in the final draft of the Regulator's Statement for online primary care.

10. An action group, led by Public Health England (PHE), has been established to implement the public health system's quality framework Quality in Public Health: A Shared Responsibility. As a member of this group, we are supporting the development of a tool to bring together key materials, including links to relevant NICE guidance and standards. Local public health systems will use this tool in implementing the quality framework.

11. We are working with the CQC and Skills for Care to develop a single shared definition of quality for adult social care, plus a resource and workshops to showcase local case studies around quality frameworks. The Quality Matters Board is supportive of these proposals. NICE continues to work with partners to publicise the Unlocking Capacity: Smarter Together digital resource to support collaborative working and promoted a new video clip and resources in July.

12. Alongside other national partners from across health and social care, we led the development of a campaign "Involved and informed: good medicines support". This campaign encourages key audiences to take specific actions from NICE's guideline and quality standard on Managing medicines in the community.

Regional and local strategic engagement

13. We continue to work with mental health networks, sustainability and transformation partnerships (STPs) and integrated care systems (ICSs) as they look to address gaps and deliver their strategic implementation plans.

14. In Northern Ireland, we are supporting delivery of the recommendations in the report of the Inquiry into Hyponatraemia-Related Deaths (5 avoidable deaths of children in hospital). The report has wide implications for the operation and quality of the health service, including governance arrangements and the implementation of evidence-based guidelines. We are supporting 3 of 9

programme workstreams to support guideline implementation and delivery of quality care, and education and training.

15. In Wales, we have supported the development of a set of Guiding Principles for Managing Medication in the Domiciliary Care Sector, which have recently been approved by the All Wales Heads of Adult Services Group. The principles are informed by two NICE guidelines that focus on managing medicines for adults receiving social care and homecare respectively, and also reference the NICE quality standards.

16. The Implementation Facilitator for Wales has worked with a multidisciplinary team to produce a five-year vision for maternity care in Wales. The strategy, published by the Welsh Government on 3 July, specifically references NICE guidance on antenatal and intrapartum care and states “All maternity units should have systems and processes in place for reviewing all relevant NICE guidance/quality standards and identify gaps and action required”.

Notable issues and developments

17. This section includes significant developments or issues that occurred in the reporting period.

NHS Long-Term Plan (LTP)

18. At a national level, engagement with NHSE and NHSI continues in support of the implementation of the LTP. This particularly relates to research and innovation, the medical technology agenda and key clinical areas referenced in the plan. A catalogue of NICE products that relate to the key areas set out in the NHS LTP is being developed. The catalogue will be an appendix to a letter being sent to each clinical Programme Board detailing the support that NICE can provide.

19. NICE's Chief Executive has also written to the new Regional Directors of NHSE and NHSI offering support from the Field Team to the regional teams and STPs/ICSs in implementing the NHS LTP. A positive response has been received from the majority of regional offices.

Quality Improvement

20. Following the successful quality improvement event held in June, NHSE and NHSI are developing a national quality improvement framework. NICE has developed a document that outlines where NICE guidance and resources will complement the framework. Alignment of the quality improvement framework will be considered alongside the update to the Shared Commitment to Quality for health and the frameworks for social care and public health.

NICE Connect

21. The final meeting of the NICE Connect pathways committee took place on 5 September. The committee discussed the lessons learnt from the project and concepts that have been developed from the diabetes work to date. The committee was set up to advise NICE on presenting content in a more accessible and simpler format, with a focus on type 2 diabetes and to discuss approaches to developing a medicines or prescribing pathway. The lessons learnt from the NICE Connect work incorporates the committee learning.

22. The diabetes guideline needs updating as indicated by a recent surveillance review before a medicines or prescribing pathway can be produced, so this work has now been incorporated into existing guideline update processes. There is also a separate workstream being taken forward to focus on the processes and methods for developing prescribing pathways.

NICE Into Action Award

23. NICE supported the NHSE's Chief Allied Health Professions Officer's Awards in July 2019 for the second time through a NICE Into Action award category. This encouraged allied health professionals to showcase how they have used NICE guidance or quality standards to improve the quality of care and how services use resources. Twelve nominations were received, and the 3 finalists were:

    - Royal Devon and Exeter NHS Foundation Trust (winner) who redesigned their approach to bed based intermediate care delivered with their community hospital teams based on NICE's guidance on intermediate care. This resulted in reduced length of hospital stays and an increase in patients returning home directly.

    - Dudley Falls Prevention Service, an integrated multi-agency service, combining NHS, CCG, Local Authority and Public Health services provides multifactorial assessment and intervention to prevent falls, based on the relevant NICE guideline and quality standard.

    - Midlands Partnership Foundation Trust for the OASIS project, which created a high quality and efficient treatment pathway based on the care and management of osteoarthritis.

NICE Implementation Collaborative (NIC)

24. The NICE Implementation Collaborative was established several years ago, in the wake of the Innovation, Health and Wealth report. It is a multi-agency board designed to facilitate the uptake of NICE approved technologies. Following discussions with NICE, NHSE and the Office for Life Sciences, a decision was made in July to step down the NIC board to consolidate and align support and

available capacity to the Accelerated Access Collaborative (AAC). This will reduce duplication of effort from partner organisations, recognising how much effort is currently going into supporting the AAC. The support being offered by the NICE adoption team for PSCK9 inhibitors for familial hypercholesterolaemia and high-sensitivity troponin tests will continue to be provided as part of the AAC rapid uptake portfolio.

Medicines and Technologies Programme Product Portfolio Review

25. The Medicines and Technology Programme has commenced a review of its portfolio of published products. A project steering group has been established which includes representatives from NICE and from a NICE Fellow. The project team is engaging with internal and external stakeholders to collate insights on the product portfolio. A report outlining recommendations from the project steering group will be presented to the Senior Management Team in November 2019.

Appendix 1: Publications - July and August 2019

The table below provides a list of guidance and advice produced in the reporting period.

Product title	Product type
Diagnosis of urinary tract infections (UTIs) - Quick reference tool for primary care: For consultation and local adaptation	Endorsement statement
Chronic heart failure in adults e-learning course	Endorsement statement
Care Home Charter for Swallowing and Medicines	Endorsement statement
About the NICE Guideline on motor neurone disease. Information for people with or affected by MND.	Endorsement statement
TrendCare	Endorsement statement
Low Back Pain Information Leaflet	Endorsement statement
Predict Prostate	Endorsement statement
Velibra for adults with social anxiety disorder	IAPT assessment briefing
Velibra for adults with panic disorder	IAPT assessment briefing
Velibra for adults with general anxiety disorder	IAPT assessment briefing
The Wellbeing Course for adults with Generalised Anxiety Disorder	IAPT assessment briefing
The Wellbeing Course for adults with Depression	IAPT assessment briefing
Suite of indicators to be used to inform negotiations for the 2020/21 Quality and Outcomes Framework	Indicator menu
Intensive glucose control in people with type 2 diabetes	Medicines Evidence Commentary (MEC)
Osteoporosis: 'real-world' adherence and persistence with oral bisphosphonates	Medicines Evidence Commentary (MEC)
Patient decision aid: Bisphosphonates for treating osteoporosis (updated)	Shared decision making product
Patient decision aid: How do I control my blood pressure? Lifestyle options and choice of medicines	Shared decision making product
The successful implementation of a therapeutic class for treatment of Osteoarthritis	Shared learning example
A focus on health: applying NICE guidance to a local authority led adult quality service provider framework.	Shared learning example
Enabling Intermediate Care	Shared learning example
Dudley Falls Prevention Service	Shared learning example

Product title	Product type
Evidence for strengths and asset-based outcomes (QG21)	Social care quick guide
Giving medicines covertly (QG20)	Social care quick guide
Adult Social Care	Topic based impact report

September 2019