NICE National Institute for Health and Care Excellence

NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

PUBLIC BOARD MEETING

21 November 2018 at 1.30pm
Blair Bell Education Centre, Liverpool Women's Hospital, Crown Street, L8 7SS

AGENDA

18/090	**Apologies for absence** To receive apologies for absence	(Oral)
18/091	**Declarations of interests** To declare any new interests and consider any conflicts of interest specific to the meeting	(Item 1)
18/092	**Minutes of the Board meeting** To approve the minutes of the Board meetings held on 19 September 2018	(Item 2)
18/093	**Matters arising** To consider matters arising from the minutes of the last meeting	(Oral)
18/094	**Chief Executive's report** To receive the Chief Executive's report *Andrew Dillon, Chief Executive*	(Item 3)
18/095	**Finance and workforce report** To receive the finance and workforce report *Ben Bennett, Director, Business Planning and Resources*	(Item 4)
18/096	**NICE impact report: anti-microbial resistance** To review the report *Professor Gillian Leng, Deputy Chief Executive and Director, Health and Social Care Directorate*	(Item 5)
18/097	**Workforce strategy** To approve the workforce strategy *Ben Bennett, Director, Business Planning and Resources*	(Item 6)
18/098	**Whistleblowing policy** To approve the updated policy *Ben Bennett, Director, Business Planning and Resources*	(Item 7)
18/099	**NICE Pathways** To approve the pilot *Professor Gillian Leng, Deputy Chief Executive and Director, Health and Social Care Directorate*	(Item 8)

18/100	**Audit and Risk Committee** To receive the unconfirmed minutes of the Audit and Risk Committee meeting held on 26 September 2018 *Dr Rima Makarem, Chair, Audit and Risk Committee*	(Item 9)
18/101	**NICE Charter** To review the Charter *Jane Gizbert, Director, Communications*	(Item 10)
18/102	**Technology appraisal and highly specialised technologies appeals report** To receive the report *Ben Bennett, Director, Business Planning and Resources*	(Item 11)
18/103	**Board Chair and Vice Chair** To approve the proposals *Andrew Dillon, Chief Executive*	(Item 12)
18/104	**Director's report for consideration** Health and Social Care Directorate	(Item 13)
	Directors' reports for information	
18/105	Centre for Guidelines	(Item 14)
18/106	Centre for Health Technology Evaluation	(Item 15)
18/107	Communications Directorate	(Item 16)
18/108	Evidence Resources Directorate	(Item 17)
18/109	**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 at 1.30pm on 30 January 3019 at The Spitfire Ground, St Lawrence, Old Dover Rd, Canterbury CT1 3NZ

NICE National Institute for Health and Care Excellence

Item 1

Interests Register - Board and Senior Management Team

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

		Honorary Professor, Institute of Regional Health Research, University of Southern Denmark.	2007	
Prof Martin R Cowie	Non-Executive Director	Consultancy payments for the membership of Steering committee/DSMBs/Endpoint committees related to Global Clinical Trials or Registries: XATOA, COMPASS, COMMANDER-HF (Bayer); SHIFT, QUALIFY, OPTIMIZE (Servier); RELAX-Region Europe, PARALLAX, VERIFY (Novartis); COAST (Abbott); COAST-AHF (Neurotronik); FIRE1 system (FIRE1); SERVE-HF (ResMed).	2016	
		Associate Editor honoraria from Heart (BMJ Publications) and Journal of the American College of Cardiology.	2016	
		Research grants to Imperial College London to support investigator-led research projects (ResMed; Bayer; Abbott; Boston Scientific; NIHR; British Heart Foundation).	2016	
		Fellowships of the Royal College of Physicians of London and Edinburgh, and of the European Society of Cardiology, the Heart Failure Association of the European Society of Cardiology, and the American College of Cardiology.	2016	
		Chair of the Digital Committee of the European Society of Cardiology, and Member of the Digital Committee of the British Cardiovascular Society.	2016	
		Member of the Advocacy Committee of the European Society of Cardiology.	2016	
		Member of the Medical Advisory Board of two patient charities: the Atrial Fibrillation Association, and the Pumping Marvellous Foundation.	2016	
Elaine Inglesby-Burke CBE	Non-Executive Director	Chief Nursing Officer, Northern Care Alliance NHS Group (Salford Royal NHS Foundation Trust and Pennine Acute NHS Trust).	2004	
		Board Member – AQuA (Advancing Quality Alliance).	2012	
		Professional Advisor (Secondary Care) Governing Body – St Helens CCG.	2014	
		Trustee – Willowbrook Hospice, Merseyside.	2007	
Prof Tim Irish	Non-Executive Director and Senior Independent Director	Life science assets held in a blind trust and managed by an independent trustee	2015	
		Professor of Practice, King's College London's School of Management / Business and a paid consultant to King's Commercialisation Institute.	2017	

		Non-Executive Director, Life Sciences Hub Wales Ltd.	2017	
		Chairman and Non-Executive Director, Quirem Medical BV Supervisory Board.	2015	
		Non-Executive Director, Fiagon AG.	2017	
		Non-Executive Director, eZono AG.	2018	
		Non-Executive Director, Feedback plc.	2017	
		Advisory Board Member, Tibbiyah Holding (Healthcare sector) of Al-Faisaliah group.	2018	
		Non-Executive Director, Styrene Systems Ltd.	2017	
		Board Member, Bournemouth University.	2015	2018
		Trustee & Board Member, CfBT Schools Trust.	2016	2018
		Board Member, Pistoia Alliance Advisory Board.	2017	
		Non-Executive Director, Pembrokeshire Retreats Ltd.	2006	
Dr Rima Makarem	Non-Executive Director	Owner of Healthpeak Limited. (Company currently dormant)	2011	2018
		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	
Tom Wright CBE	Non-Executive Director	Chief Executive, Guide Dogs.	2017	
Senior Management Team				
Sir Andrew Dillon	Chief Executive	Trustee, Centre for Mental Health charity.	2011	
		Visiting Professor at Imperial College London.	2016	
Ben Bennett	Director	None.		

	Business Planning & Resources			
Meindert Boysen	Director Centre for Health Technology Evaluation	Member of the Board of Directors for the International Society for Pharmacoeconomics and Outcomes Research.	2017	
Paul Chrisp	Director Centre for Guidelines	Spouse works in medical communications offering services to a range of pharmaceutical companies.	2009	
Jane Gizbert	Director Communications	Non-Executive Director Tavistock and Portman NHS Mental Health Trust.	2014	
Prof Gillian Leng	Deputy Chief Executive and Health and Social Care Director	Honorary Librarian and Trustee at the Royal Society of Medicine.	2013	
		Editor of the Cochrane EPOC Group.	2012	
		Visiting Professor at the King's College London.	2012	
		Association Member BUPA.	2013	
		Chair - Guidelines International Network (GIN).	2016	
		Spouse is an Executive Director at Public Health England.	2013	
Alexia Tonnel	Director Evidence Resources	Spouse worked part-time as a contract engineer for a medical device start up, at prototype stage, called Sutrue.	2017	April 2018

NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

Public Board Meeting held on 19 September 2018 at King's Hall, Kingsway, Stoke on Trent, ST4 1JH

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

Dr Rosie Benneyworth	Vice Chair and Non-Executive Director
Professor Sheena Asthana	Non-Executive Director
Professor Angela Coulter	Non-Executive Director
Elaine Inglesby-Burke	Non-Executive Director
Dr Rima Makarem	Non-Executive Director
Tom Wright	Non-Executive Director

Executive Directors

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

Directors in attendance

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

In attendance

David Coombs	Associate Director – Corporate Office (minutes)

18/072 APOLOGIES FOR ABSENCE

1. Apologies were received from Sir David Haslam, Professor Martin Cowie and Professor Tim Irish.

2. Rosie Benneyworth welcomed Paul Chrisp to his first Public Board meeting as Centre for Guidelines Director.

18/073 DECLARATIONS OF INTEREST

3. The declared interests were noted, and it was confirmed there were no conflicts of interest relevant to the meeting.

4. Rima Makarem stated that from 1 October she would be a Non-Executive Director and the Audit Committee chair at the House of Commons Commission. The register of interests will be updated accordingly.

ACTION: David Coombs

18/074 MINUTES OF THE LAST MEETING

5. The minutes of the Public Board Meeting held on 18 July 2018 were agreed as a correct record.

18/075 MATTERS ARISING

6. The Board received an update on the actions from the Public Board meeting held on 18 July 2018.

   - Meindert Boysen stated that by the March 2019 Board meeting there should be sufficient information available on the budget impact test's effect on market access timescales.
   - Ben Bennett stated that the variation in the take up of external training courses between centres and directorates has been reviewed, and this reflects the differing training needs across NICE. This information will be presented in a more meaningful format in next year's workforce report. Ben also confirmed that HR will examine the extent it is possible to include commitment to public involvement in recruitment and appraisals when these processes are next reviewed.
   - Gill Leng confirmed that the field team are looking at a more systematic approach for working with ambulance services in response to the suggestion at the last meeting about falls and fragility fractures. In addition, NICE continues to work with national partners such as the Care Quality Commission to promote NICE's guidance on hip fractures.

18/076 CHIEF EXECUTIVE'S REPORT

7. Andrew Dillon presented his report, describing the main programme activities to the end of August 2018 and summarising the financial position at 31 July. At the end of this period, there are no major variances to report.

8. In response to a question from the Board, Andrew stated that the slippage in the delivery of NICE Science Advice projects compared to last year is due to a

reduction in capacity following long-term sickness absence of a senior member of staff. It does not represent a potential longer term reduction in demand. Andrew stated that it will however be important to monitor if any changes to the medicines regulatory process following the UK's departure from the European Union affect the level of demand for NICE Science Advice's services.

9. The Board received the report.

18/077 FINANCE AND WORKFORCE REPORT

10. Ben Bennett presented the report which outlined the financial position at 31 July 2018. The current forecast is for the year-end outturn to be an underspend of £0.5m, after the £0.9m of non-recurrent expenditure agreed by the Senior Management Team on the initiatives outlined the report. Ben highlighted that the Department of Health and Social Care's (DHSC) consultation on the revised regulations to enable charging in the technology appraisal and highly specialised technologies programmes recently closed. This is the final aspect of the strategic savings programme and will be a key aspect of the 2019/20 business planning process that is about to commence.

11. Rima Makarem, chair of the Audit and Risk Committee, asked whether additional savings will be required to fund the agenda for change pay award in future years. Ben Bennett confirmed that the DHSC provided £0.5m this year to fund the additional cost above the budgeted 1% pay award, and it is anticipated further funding will be provided next year.

12. The Board received the report.

18/078 NICE IMPACT: DIABETES

13. Gill Leng presented the report on how NICE's guidance is being used in the national priority area of diabetes. Gill highlighted the extent of NICE's guidance in this area and welcomed the positive commentary from the Diabetes UK Chief Executive.

14. Board members welcomed and praised the report, and asked about the activities to promote the impact reports. Gill Leng and Jane Gizbert highlighted the extensive activities undertaken, including utilising social media and links with professional and voluntary groups. It was agreed that the covering paper for the next report should include an update on the latest engagement and promotion activities in respect of the impact reports.

ACTION: Jane Gizbert

15. The Board received the report.

16. A member of the audience highlighted the work of a GP, Dr David Unwin, on diabetes.

18/079 UPDATED GUIDELINES MANUAL

17. Paul Chrisp presented the paper that set out key comments made on, and changes made to, Developing NICE Guidelines: the manual following public consultation. Over 60 organisations responded to the consultation, with 673 comments received. Paul highlighted the changes made in response to the consultation and thanked his predecessor, Professor Mark Baker, for overseeing the update of the manual and the consultation.

18. The Board noted the consultation outcome and discussed the issues to be considered in future updates of the manual. It was noted that improved labelling and linking of recommendations would enable discrete aspects of a guideline to be more easily updated following an agile surveillance process. This linkage would also help clinicians use multiple guidelines in cases of multi-morbidity. It was noted that if the manual is to be updated more regularly than every three years as at present, it would be appropriate to consider more flexible ways of approving these amendments with only major updates requiring Board approval.

19. The Board approved the manual for publication and implementation.

20. A member of the audience who was an NHS clinician welcomed the decision to retain the standard four week consultation period on draft scopes of partial updates. He welcomed NICE's guidance on multi-morbidity and NICE's increased focus on shared decision making. He stated that given demographic changes, guidance on the very frail elderly would be helpful.

18/080 STAFF SURVEY 2018

21. Ben Bennett presented the report that set out the results of the staff survey and the action plan developed in response. The results paint an overall positive picture of NICE as a place to work, with 95% rating this as excellent, very good, or good. Improvements were reported in most areas, and NICE ranks in 11th place against the other 65 organisations in Survey Solutions' database. Ben thanked Grace Marguerie and Sarah Acton for their work in this area, and highlighted that the results will inform the refreshed workforce strategy that will come to the Board in November.

22. Board members welcomed the very positive results, and made a series of observations and comments. The actions taken to support employees' mental health and wellbeing were noted, as were the proposals in the action plan in relation to bullying and harassment. The importance of recognising the diversity of the workforce in the refreshed workforce strategy was highlighted, including the specific career development aspirations of those in specialist and academic roles.

23. The Board noted the positive results and supported the action plan. Further information was requested on variation in the survey responses between different demographic groups which would ensure actions can be appropriately targeted.

ACTION: Ben Bennett

18/081 ANNUAL EQUALITY REPORT

24. Ben Bennett presented the annual equality report, which has been produced as part of NICE's compliance with the public sector equality duty. The report provides an update on NICE's equality objectives; information on the characteristics of those applying to join the advisory committees in 2017/18, and those subsequently appointed; and the results of the annual survey of committee members. It also includes information on equality considerations in guidance published in 2017/18 and summarises the workforce profile at 31 March 2018. Ben thanked David Coombs for compiling the report, and Fiona Glen for chairing the cross Institute equality and diversity group.

25. The Board received the report.

18/082 FRAMEWORK AGREEMENT BETWEEN NICE AND THE DEPARTMENT OF HEALTH AND SOCIAL CARE

26. Andrew Dillon presented the updated framework agreement, which sets out how the two organisations will work together. It has been drawn up by the Department for Health and Social Care (DHSC) in consultation with NICE, and follows a standard format.

27. Meindert Boysen suggested that the National Institute for Health Research (NIHR) is added to paragraph 2.7. Andrew Dillon noted this section is not a comprehensive list of NICE's partners but would suggest this addition to the DHSC.

ACTION: Andrew Dillon

28. Subject to the above potential amendment, the Board approved the framework agreement.

18/083 GENERAL COMPLAINTS POLICY AND PROCEDURE

29. Ben Bennett presented the updated general complaints policy and procedure, which has been informed by review of other relevant organisations' policies. Ben highlighted the main changes to the policy, including to reduce the number of internal stages in the complaints process from three to two.

30. The Board supported the proposal to reduce the number of stages in the complaints process, noting the benefits for both the complainant and those subject to the complaint of a swifter resolution. It was agreed that paragraph 23 in the new policy should be clearer on the factors that the Chief Executive will consider when deciding who will undertake the stage 2 review of a complaint.

ACTION: Andrew Dillon

31. Subject to this amendment, the Board approved the updated general complaints policy and procedure, with this applying for all complaints received from this point forward. It was agreed that Rosie Benneyworth, as meeting chair, would agree this amendment to paragraph 23 on behalf of the Board.

18/084 DIRECTOR'S REPORT FOR CONSIDERATION

32. Jane Gizbert presented the update from the Communications Directorate, and highlighted the current review of the Directorate's work, which will consider how to most effectively support NICE's ever expanding and diverse work programme. Jane highlighted the recent activity to support and promote the Guidelines International Network conference, and introduced Philip Hemmings, who recently joined NICE as Associate Director, Publishing.

33. In response to a question from the Board on the backlog of enquires, Jane confirmed that responses are usually sent within the agreed timeframe.

34. The Board noted the report and thanked Jane for the Directorate's work.

18/085 – 18/088 DIRECTORS' REPORTS FOR INFORMATION

35. The Board received the Directors' Reports.

18/089 ANY OTHER BUSINESS

36. There was no further business to discuss.

37. The Board then passed the following resolution to move to a part 2 meeting to discuss confidential matters:

> *"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".*

NEXT MEETING

38. The next public meeting of the Board will be held at 1.30pm on 21 November 2018 at Blair Bell Education Centre, Liverpool Women's Hospital, Crown St, L8 7SS.

National Institute for Health and Care Excellence

Chief Executive's report

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

The Board is asked to note the report.

Andrew Dillon
Chief Executive
November 2018

Introduction

1. This report sets out the performance of the Institute against its business plan objectives and other priorities, for the 7 months to the end of October 2018, and for income and expenditure for the 6 months to the end of September. This report also notes the guidance published since the last public Board meeting in September and refers to business issues not covered elsewhere on the Board agenda.

2. Appendix 5 sets out balanced scorecard for the first 6 months of the financial year. The scorecard measures the Institute's performance against a series of significant metrics. Material variations to the targets agreed at the beginning of the year are explained in the table.

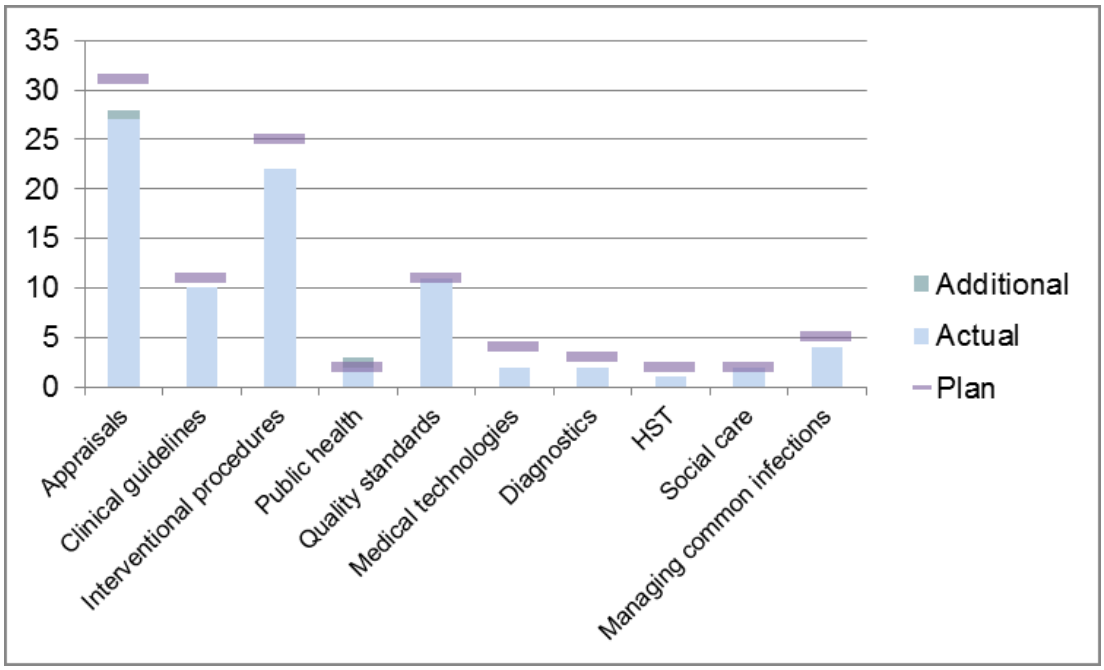
3. The report also contains a report on the performance of the Science, Advice and Research programme.

Performance

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

5. 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 October 2018 is set out in Charts 1 and 2, below

Chart 1: Main programme outputs: April to October 2018



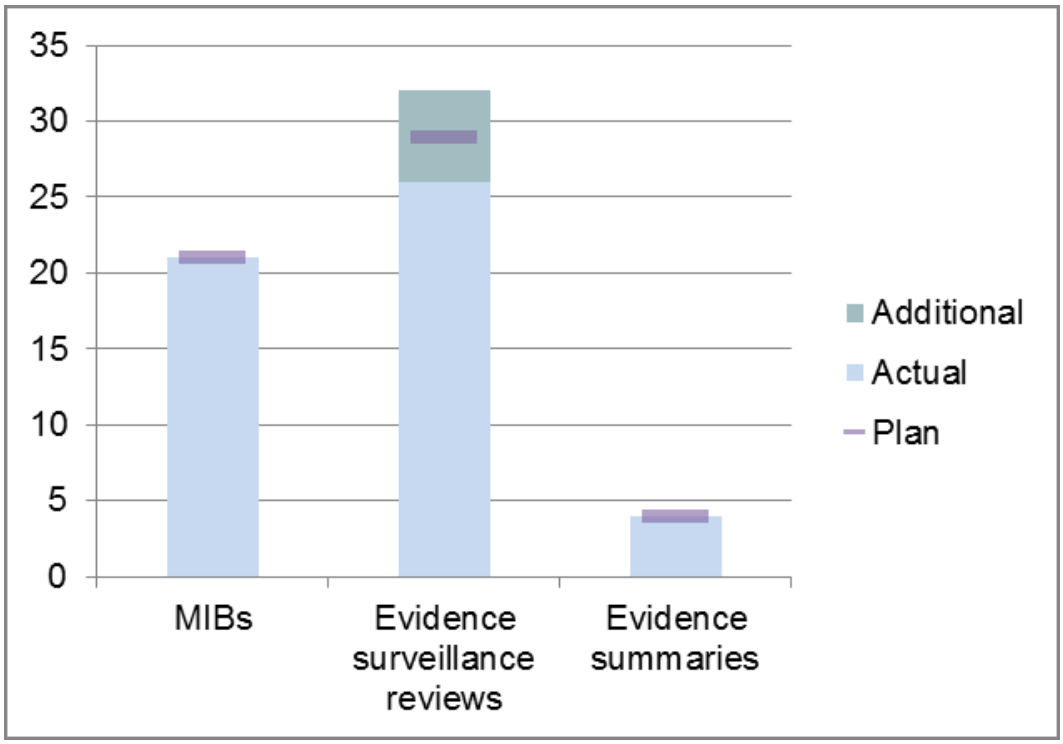
Notes to Chart 1:

a) HST refers to the highly specialised technologies programme (drugs for very rare conditions)
b) The variance is the difference between the target output for the reporting period, as set out in the business plan and the actual performance
c) 'Additional' topics are either those which should have published in the previous financial year, or that have been added since the publication of the business plan

6. 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 September is set out Appendix 4.

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

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



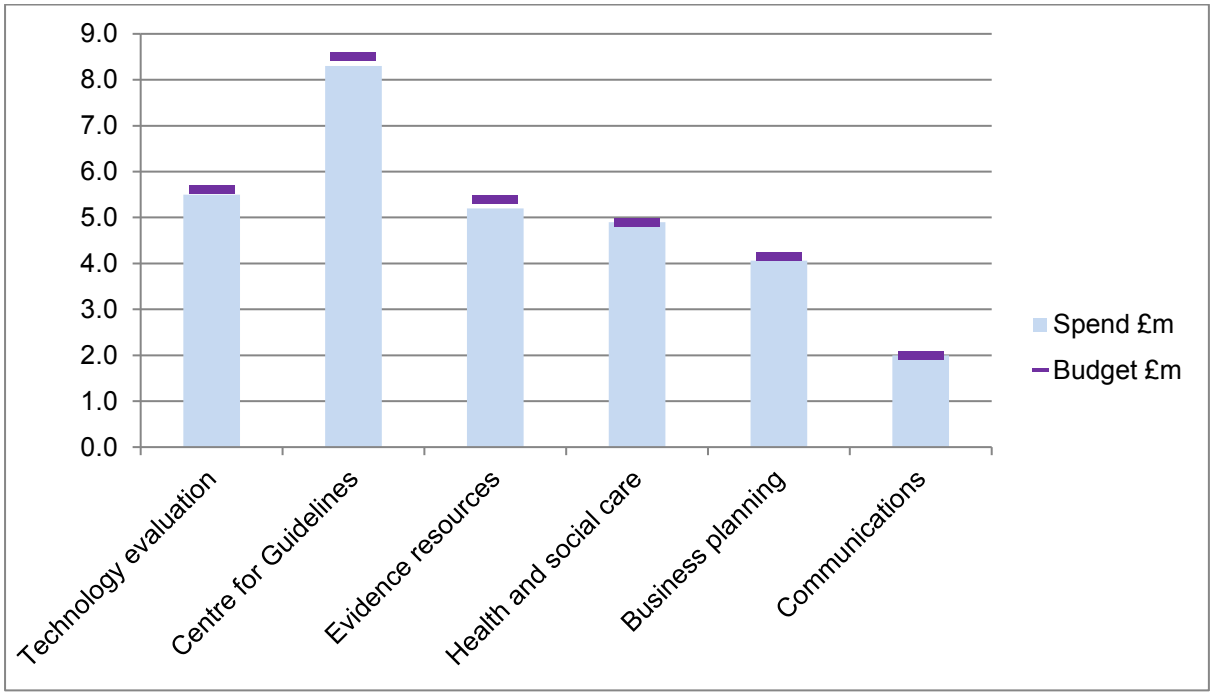
Notes to Chart 2:

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

Financial position (Month 6)

8. The financial position for the 6 months from April to the end of September 2018 is an under spend of £0.6m (2%), against budget. This consists of under spend of £0.5m on pay and £0.2 on non-pay budgets, offset by income being £0.1m lower than planned. The position of the main budget is set out in Chart 3. Further information is available in the Business Planning and Resources Director's report.

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



Science, Advice and Research programme

NICE Scientific Advice

9. Over September and October 2018, NICE Scientific Advice initiated 14 new advice projects, including 3 Light projects for SMEs and 4 projects in collaboration with European Network for HTA (EUNetHTA). A further 7 external engagements were carried out ranging from an ATMP workshop in Paris to an oncology drug development workshop in Boston and a Cell and Gene Therapy meeting in San Diego.

10. In September, the NICE International Knowledge Transfer service moved from the Evidence Resources Directorate into NICE Scientific Advice. In that period, 4 international engagements have already taken place, with clients including the Brazilian Chamber of Medicine's Regulation, the Health Insurance Review and Assessment Service in South Korea, the National Institute of Public Finance and Policy in New Delhi and a delegation of leaders from the Indonesian Health System. There are several other live enquiries from Norway, Japan and Saudi Arabia amongst others as well as early discussions around collaborating with the Department for International Trade and other members of the UK health system to develop an international commercial offering.

Office for Market Access

11. The life sciences homepage that the Office for Market Access developed with colleagues across NICE successfully launched on the NICE website in September 2018. The homepage has helped promote the opportunities for industry to engage with NICE across all stages of health technology development. The Office for Market Access have a number of engagement meetings scheduled until the end of March 2019, covering a broad range of themes and continue to work collaboratively with health landscape partners, and individual companies across the whole life industry to deliver these engagements.

Science Policy and Research

12. SP&R has been working with the Medical Research Council (MRC) to develop a "highlight notice" (a call for research) to develop new methods and techniques for synthesising and assessing evidence for diagnostic technologies. There is growing interest in new and increasingly complex types of diagnostic technologies, such as next-generation sequencing platforms that combine multiple testing techniques in a single platform, and these pose methodological challenges for HTA. The MRC's call encourages applicants to deliver tools which could be implemented by NICE in the near-to-medium term, to support our assessment of diagnostic technologies and add value to recommendations about adoption. The SP&R and Diagnostics Assessment teams will be engaging with applicants to develop their proposals and identify impactful projects in which NICE could be a funded collaborator.

Accelerated Access Collaborative Secretariat

13. The AAC Board has approved 11 products in 7 technology areas to receive rapid uptake support from the AAC partner organisations. The Rapid Uptake products are distinct from the Accelerated Access Pathway products, with the former receiving adoption and diffusion support prior to the launch of the Pathway through the Pathway Transformation Fund. The rapid uptake products were announced on 23 October. The AAC Board met on 18 October and agreed its vision for the AAP and discussed alignment with the forthcoming NHS long term plan.

EUnetHTA

14. At the end of September the NICE EUnetHTA team held focus groups at the NICE London office with 20 partners from agencies across Europe to discuss progress in implementing EUnetHTA assessments. The outcomes from the focus groups will inform work to develop a EUnetHTA implementation strategy

and the scientific and technical mechanism of a permanent mechanism of HTA cooperation.

Appendix 1: Business objectives for 2018-19

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

Objective	Actions	Update
Guidance, standards, indicators and evidence		
Publish guidance, standards and indicators, and provide evidence services against the targets set out in the Business Plan and in accordance with the metrics in the balanced scorecard	• Deliver guidance, standards, indicators and evidence products and services, in accordance with the schedule set out in the Business Plan • Ensure performance meets the targets set out in the balanced scorecard • In conjunction with national partners, develop a process for agreeing a joint narrative on the financial and workforce impact of our guidance	• Details of the main programmes' performance against plan at the end of 2018/19, including explanations for any variances are set out elsewhere in this report.
Implement changes to methods and processes in the technology appraisal (TA) and highly specialised technologies (HST) programmes	• Continue to implement changes to the TA and HST programmes: the TA fast track process, the budget impact test and value assessment in HST • Subject to the outcome of consultation, implement the proposals for increasing capacity in the TA programme • Make changes to the operation of the advisory committees, to improve the efficiency of the overall committee resource	• Following Board approval in March 2018, the new technology appraisal process was successfully implemented on 1 April 2018. • The first topic to go through the new process is Durvalumab for maintenance treatment of unresectable non-small-cell lung cancer after platinum-based chemoradiation (ID1175). The first committee discussion is planned for 14 February 2019. • A number of topics have gone through the new technical engagement step. Although

Objective	Actions	Update
		informal feedback suggests that this step in the process is valued highly by companies, it requires a significant commitment by the NICE team.
Refine and implement new methods and processes to accelerate the development of guidelines	• Review the methods and processes for efficient and timely guideline update outputs • Revise and implement new methods and processes to support the development of guideline updates in-house • Revise and implement new processes for the surveillance of guidelines • Complete and publish a revised Guidelines Development Manual	• The revised Guidelines Manual was published on the NICE website on 31 October. It will be implemented in all new guidelines being developed from 1 January 2019.
Maintain a suite of digital evidence services to meet the evidence information needs of health and social care users and partner agencies	• Maintain and monitor performance of NICE Evidence Services (CKS, HDAS, BNF microsites, Evidence Search), with investment in new features on a strictly needed basis • Procure and implement the national core content in line with Health Education England (HEE) commissioning decisions	• As reported in the Evidence Resources Directorate report, a dip in the performance of Evidence Search service has been observed over the summer. This is being investigated and remedial actions are being taken. The performance of other NICE Evidence services is stable. • In the last 2 months, key stages of the national core content (NCC) procurement, which enables access by NHS staff to scientific publications, have been completed; resources for the new NCC have been selected. Suppliers and users have been notified of the outcome of the procurement and we are moving to award the contracts to successful bidders.

Objective	Actions	Update
Implement NICE-related aspects of the life sciences industries sector deal and the Accelerated Access Review	• Develop an implementation plan for those aspects of the Life Sciences Sector Deal that are relevant to NICE • Operationalise the Accelerated Access Collaborative (AAC) programme office, developing mechanisms for effective engagement with all members of the Collaborative • Establish the infrastructure for the MedTechScan horizon scanning programme • Establish a Commercial Liaison Team to provide input to NHS England to inform their negotiations with companies, based on the outputs of the Technology Appraisal and HST programme • Engage with DHSC and MHRA to ensure operational readiness for the UK's departure from the European Union	• Following the appointment of Lord Darzi as chair, the AAC Board met on 18 October. On 23 October the Secretary of State for Health and Social Care announced the 7 Accelerated Access Partnership Rapid Uptake products. The AAC secretariat is working on the acceleration plans with partner organisations. • The HealthTech Connect Project Board has agreed a sustainable funding model which will be activated when NHS England's 3 year financial support for the set-up phase ends in summer 2020. • The new associate director for the commercial liaison team started with NICE in November.
Review and remodel the approach to developing and delivering NICE guidance to take account of real world data, machine learning and new digital platforms	• Develop a strategy for implementing changes to the development of NICE guidance to take account of new evidence sources, digitally-enabled authoring and machine learning • Subject to SMT and Board agreement, and the availability of resources, develop and implement an action plan for 2018-19	• A cross-Institute team has been established to support the use of data analytics across all NICE guidance programmes, with an associate director and technical adviser now in post. • The first meeting of a new external expert group took place in September and the group will play a key role in informing NICE's future use of data analytics. • The initial action plan is being further developed, now that staff are in post, with a focus on a cross-Institute framework for

Objective	Actions	Update
		data and analytics, and external relationships.
Adoption and Impact		
Deliver a programme of national, regional and local strategic engagement to support alignment across the health and care system and the uptake of NICE guidance and standards	• Work with local health and care systems to promote the use of NICE guidance and quality standards, measured against the metrics in the 2018-19 strategic engagement plan • Support the use of NICE guidance and standards through the work of other national organisations in health, public health and social care, measured against agreed metrics • Work with key system partners, in particular NHSE and PHE, to deliver mutually supportive communication activities • Use our membership of the Arm's Length Bodies CEO group to promote a compelling narrative about the value of our work to the health and care system • Work with the devolution communities to ensure awareness of the NICE offer and help with system and service design	• Progress against agreed metrics is reported to the Board on a 6-monthly basis. • Engagement with other national organisations is on track, with detail included in the report from the Health and Social Care directorate.
Deliver a programme of support to encourage the adoption of drugs and other medical technologies recommended by NICE	• Promote the innovation scorecard within the clinical community to encourage the uptake of recommended drugs and technologies • Deliver budget impact assessments to inform application of the budget impact test within the NICE TA and HST programmes	• Stakeholders and users are being consulted on plans to develop the scorecard. The work of the Accelerated Access Collaborative (see above) will complement this work. • Budget impact assessments are being delivered as planned.

Objective	Actions	Update
Monitor the impact and uptake of Health and Social Care products and services and ensure that guidance and standards meet the needs of our audiences	• Produce 6 topic based reports showing uptake and impact of NICE guidance and standards • Deliver a rolling programme of audience research projects including an annual stakeholder reputation audit	• Topic based reports are presented to the Board at each public meeting. In November 2018 this covers antimicrobial resistance. • During July and August the audience insight team completed an evaluation of the Quality Improvement Resource tool for the social care team. • The insight team also provided advice and practical support to NICE Scientific Advice to refresh their feedback forms and evaluation measures. • The tender for the 2018-2019 reputation research project has been awarded to Populus. The project will start in late November with a workshop to discuss topics and questions. Fieldwork is due to take place in January and February with a final report to be completed by the end of March. The project will include an online survey of stakeholders and interviews with 25 senior stakeholders.
Promote NICE's work and help users make the most of our products by providing practical tools and support, using innovative and targeted marketing techniques. Contribute to	• Undertake a programme of enhancements to content on the website for different audiences including visual summaries and improving the 'user journey' on the NICE website to enable users to easily find the information they want • Support shared decision making within NICE through delivery of commitments in the action plan of the Shared Decision Making Collaborative	• A meeting of a core group of the Shared Decision Making (SDM) Collaborative is planned for January to share updates on SDM activities across members and to set the focus and priorities for the next full collaborative meeting. • NICE is now routinely developing shared decision aids and has held the first meeting

Objective	Actions	Update
demonstration of impact though regular evaluation	• Deliver a programme of quality assurance activities including endorsement, shared learning and the shared learning award	of its internal decision aid topic prioritisation group. Development of the NICE SDM guideline is now underway. Recruitment of early committee members has taken place and the scoping workshop for the topic will be held in early December. Finally a key therapeutic topic (KTT) around SDM is being developed for publication in Q4. • Quality assurance activities are progressing as planned. The shared learning award for 2019 is now open for entries from across health and social care.
Promote collaboration on evidence management, system integration and data science initiatives across ALBs and with academic establishments and other external stakeholders	• Support NHS Digital to understand the domain model of NICE (and its broader evidence context), and explore the opportunities/value of introducing common interoperability standards (such as SNOMED) into the structure of NICE's content • Support NHS England to deliver the digital IAPT pilot programme (Improving Access to Psychological Therapies)	• At the Guidelines International Network (GIN) conference in September, the Digital Services team hosted a workshop to bring together NHS Digital and guideline standards developers to discuss how to improve collaborative working. Interoperability and use of standards have been the subject of further discussions with NHS England as NICE provided feedback on the digital transformation workstream of the NHS Long Term Plan. • So far, 4 digital therapy technologies have been found to be eligible to enter the IAPT assessment programme and IAPT assessment briefings have been started, or are scheduled to start, later in this financial year.

Objective	Actions	Update
Create a structured and coordinated approach for working with and listening to stakeholders	• Implement agreed actions from the public involvement strategic review including introduction of the Expert Panel and pilot novel methods in relation to user-focused evidence • Further develop a system to capture audience insights (including Twitter and Website analytics) and provide regular reports to senior management • Develop metrics to measure the extent and impact of our engagement with social care audiences	• Implementation of the actions from the strategic review is ongoing, and development of methods to allow lay people to submit their interest in working with NICE (outside of applying for specific committee recruitments) is in progress. • Collaborative work with the Audience Insight team has resulted in applicants for lay vacancies routinely being invited to join the Insight Community, to ensure that interested and engaged people have the opportunity to work with NICE, whether or not their committee application is successful. • The Insights team is finalising a social care report, bringing together insights from a number of audience research projects that have included responses from social care respondents. The report will inform discussion about what social care audiences expect from NICE and how we can track our future work with these audiences. The draft report has been produced and shared with the Social Care Forum. We are now producing a summary version that will be distributed more widely.
Deliver new digital service projects, maintain NICE's existing digital services and implement service	• Deliver digital service projects that support NICE's strategic goals and transformation agenda. The projects will be prioritised and scoped throughout the year to support NICE in four key areas: evidence management,	A number of digital projects are underway across the portfolio, including:

Objective	Actions	Update
improvements based on user insights and service performance and strategic priorities	structured content development, process optimisation and dissemination/channels • Maintain all live NICE Digital Services to agreed service levels (service availability and time to defect resolution) • Translate data and observations about the performance of NICE Digital Services into actionable improvement proposals and implement in line with business priorities • Undertake continuous improvement of live services in response to user insights and service performance. For the NICE website, formally establish a new priority-led approach ('Journey Maps') to service improvement	• Evidence Management project: work is progressing on delivering evidence synthesis functionality. This phase of feature development consists of advanced Meta-analysis functionality offered through alternative statistical programming languages and approaches to support non-intervention based analysis processes. • The Comment Collection project (work to bring efficiencies to the external consultation process) continues to progress well. The tool was used 'live' for the first time to consult on a technology appraisal ACD (appraisal consultation document). In parallel, development of features to support the administration of the consultation process within NICE continues. • The procurement of an identity management solution and support for implementation has been approved by Government Digital Services and the Department for Health and Social Care and is progressing with an expectation that the new identity management solution can be rolled out to NICE Digital Services from Quarter 1 2019 onwards. • The procurements for the Content Health Check and Data Management Strategy are ongoing. The identified supplier of the Content Health Check work is engaged and

Objective	Actions	Update
		we are working toward contractual confirmation to commence work in December 2018. • The maintenance of the planning and contact tools supporting stakeholder management and planning activities was transitioned to the Digital Services at the end of September. Prior to this the team worked with the retiring developer to complete knowledge transfer. Longer term plans to develop NICE's wider stakeholder management capabilities are in the early stages of consideration.
Inform the review of the Pharmaceutical Price Regulation Scheme (PPRS)	• Engage with the Department of Health and Social Care to inform the re-negotiation of the PPRS, focussing attention on those aspects of the Scheme which have an impact on the development of NICE guidance	• The CHTE centre director and senior members of the team are actively participating in meetings with the Department of Health and Social Care, NHS England and colleagues from the pharmaceutical industry to support the arrangements for a new PPRS.
Operating efficiently		
Operate within resource and cash limits in 2018-19	• Deliver performance against plan for all budgets and achieve or exceed on non-Grant-in-Aid income targets	• The Institute is operating within its resource and cash limit.
Implement the third year of a three year strategy to manage the reduction in the Department of Health	• Centres and directorates to continue to deliver the savings expected from them in order enable the Institute	• All savings targets are being achieved.

Objective	Actions	Update
and Social Care's Grant-In-Aid funding and deliver a balanced budget in 2018-19	to manage within the reduced Grant in Aid funding received from DHSC, by April 2019 • Ensure that fully designed and tested financial and operational arrangements for cost recovery charging for technology appraisals and highly specialised technologies are in place in time for charging to begin	• A final decision, by the Department of Health and Social Care (DHSC), on the introduction of charging is pending.
Further develop and grow NICE Scientific Advice	• Re-establish NICE Scientific Advice as a business unit with increased devolved autonomy within the NICE legal entity • Work with relevant NICE corporate functions (HR, Finance and Communications) to define the scope of devolved autonomy and governance arrangements • Drive the business unit as a market facing way to deliver increased revenue and influence	• Following launch of the NICE Scientific Advice (NSA) business unit in April 2018, the new director took up her post in November. • Since April, NSA initiated 32 advice projects and 22 commissions/events/ speaking engagements and 15 other external events including business development site visits to companies from the Life Sciences industry. • As part of a focused sales drive, NSA has reached out to over 30 existing and target clients for re-engagement and the introduction to our latest service offerings. • An NSA team is attending the ISPOR conference to engage with industry and drive sales. • To broaden our parallel advice service, NSA is currently working with CADTH (Canadian HTA agency) on a parallel advice pilot. We are also developing a parallel advice offer with a major US health insurance provider.

Objective	Actions	Update
Actively pursue revenue generation opportunities associated with international interest in the expertise of NICE and the re-use of NICE content and quality assurance	• Articulate and promote NICE's value propositions associated with the re-use of NICE content outside of the UK, including permissions to use content overseas, adaptation of guidance, quality assurance services and syndication services • Promote our capacity for knowledge sharing with international organisations interested in NICE's expertise and experience and take advantage of country-specific opportunities	• Over the last two months, the team has continued to respond to requests to re-use NICE content. 18 quotes to re-use NICE content were issued and 8 licences were signed. A contract to syndicate NICE content was renewed for 5 years. The total income invoiced for the year-to-date for content re-use services amounts to approximately £150,000. • During September 2018, the work to deliver Knowledge Transfer Services (KTS), which typically consists of short training events and delegation arrangements, transferred to the NICE Scientific Advice (NSA) team, as part of a commitment to assemble all of NICE fee-for-service activities under one management structure. Recent requests resulting in engagement have come from South Korea, Norway, Brazil and Indonesia.
Enthuse and enable staff to deliver on the Institute's objectives, ensuring that every member of staff has a clear set of personal objectives, a personal development plan and an annual appraisal	• Ensure that all staff have clear objectives supported by personal development plans • Actively manage staff with the objective of ensuring that the global job satisfaction index in the annual staff survey is maintained or improved from its 2017 level	• The Board will consider an updated workforce strategy at its November meeting. • The 2018 staff survey has been undertaken. The results and the accompanying action plan were reported to the Board in September.

Objective	Actions	Update
Develop an accommodation strategy, taking into account projected future demand and national policy	• Consider the options for future office space in London, taking account of current lease arrangements • Prepare a strategy for Board approval by December 2018	• We are engaged in the Department of Health and Social Care's London office accommodation strategy which is being facilitated by NHS property services. The option of moving with the British Council to Stratford before the end of the current lease in London in 2020 is being actively pursued as part of the strategy.

Appendix 2: Extracts from the Directors' reports

Director	Featured section	Section/ reference
Health and social care	The infrastructure to enable NICE to embed routine consideration and analysis of healthcare data into our programmes is now in place. We have recruited two members of staff to the new Healthcare data and analytics team, who will start in post in November. A cross-NICE steering group responsible for high level coordination of NICE's activities associated with real world data has been established, and will provide strategic support to the new team. September saw the first meeting of an external reference group constituted to provide expert input into the programme. Next steps include finalising a definition and principles of use of healthcare data and analytics, and work will begin to confirm processes and methods across NICE's programmes.	Para 34
Guidelines	On 21 September there was a judgement against the action of Bayer and Novartis where they challenged the lawfulness of a policy of 12 CCGs on the treatment of age-related macular degeneration (AMD) which stated that Avastin will be offered to certain patients with wet AMD "as the preferred treatment option". Avastin (bevacizumab) is an anti-vascular endothelial growth factor (VEGF) treatment. The NICE guideline on the treatment of AMD recommends that patients are offered anti-VEGF treatments, and that no clinically significant differences in effectiveness and safety between the different ant-VEGF treatments have been seen in the trials considered by the committee. Bevacizumab does not have a license for use in AMD. Given the guideline committee's view that there is equivalent clinical effectiveness and safety of different anti-VEGF agents including bevacizumab, comparable regimens will be more cost effective if the agent has lower costs. NICE's guidance still stands following this judgement, although this may not be the final legal position if an appeal is lodged.	Para 9

Health technology evaluation	The PASLU and CDF teams have become part of the broader programme of work that we refer to as the 'commercial and managed access programme' (CMAP). This programme also provides leadership oversight for the Accelerated Access Collaborative secretariat and the Office for Market Access; highlights of activities for these programmes of work are included in the Chief Executive's report. The appraisals of all licensed treatments initially made available via the old model of the CDF are virtually complete, with publication of the last piece of guidance expected in December 2018. Of the 33 topics, 30 resulted in recommendations for routine commissioning, 1 appraisal was terminated and 2 had negative recommendations (with 1 being a draft final recommendation). In October PASLU had engagement with companies and NHS England on 2 complex PAS that have not been approved and one complex PAS that has been needed as an alternative to an MAA. There have been additional discussions about changes to 2 existing PAS to accommodate uncertainties highlighted at the technology appraisal committee meeting. PASLU has also been involved in continued engagement around the complicated supply agreements that have been emerging for the CAR-T products.	Para 9-11
Evidence resources	A strategic review of live services, designed to support prioritisation of capacity and resource to maintain live services, is progressing well. The first stage of the review, the technical assessment, has been completed for all 30 live digital services. The next steps of the strategic review will investigate service cost/benefit against evolving business needs. The first outcome of the review was the Senior Management Team's approval to retire the NICE Guidance App. Closure of the Guidance App is scheduled for the end of 2018. A news story has been published by the communications team with tweets and the newsletter to follow, all informing users of the closure of the app and where to access guidance. This will be repeated in November. A message will also appear when users launch the app on their device. Content updates will continued to be released until the app's final closure.	Para 18-19

Communications	There was a great deal of national coverage related to the CAR-T approval for children with leukaemia. Although this was sparked by an NHSE announcement, the sentiment was largely positive for both NICE and NHSE. We also generated positive trade coverage for the approval of new melanoma treatment, debrafanib. Cannabis was also a popular story over September and October, and was covered heavily on broadcast media. The general excitement that NICE will be reviewing medicinal cannabis for use on the NHS contributed to much of this positive coverage. The coverage regarding vaginal mesh, in reaction to the update of our guideline, was fairly neutral. Most stories followed the 'mesh as a last resort' angle and did not have a negative stance. There was some negative coverage related to the rejection of MS drug, Ocrelizumab. Stories about antidepressant withdrawal symptoms, which mentioned the Roehampton study and NICE guidelines also contributed to this negative coverage.	Para 32-34
Finance and workforce	During September 2018, the actual headcount was 612 wte against a budget of 680 wte, with vacant posts totalling 68wte (a 10% vacancy rate). The vacancy rate has been consistently around 10% for the first 6 months of the year, with overall headcount having fallen by 9 heads since 31 March 2018. Although 40 new starters have joined NICE in the first 6 months, 49 employees have left in the same period. The underlying vacancy rate would normally be expected to be in the region of 5% of budgeted posts. It is anticipated that the current vacancy rate will reduce towards this level by the end of 2018/19, particularly as a number of external candidates have recently been appointed (but are yet to start) in new posts within the technology appraisals programme to increase capacity and to establish the commercial liaison unit. Further, the HR team are looking at ways to increase recruitment from external sources and also improve staff retention rates. Further details are provided in the mid-year review section of this report.	Para 9-10

Appendix 3: Guidance development: variation against plan April 2018 - October 2018

Programme	Delayed Topic	Reason for variation
Clinical Guidelines	1 topic delayed	Suspected neurological conditions: Delayed to accommodate discussions with NHS England on the scope. Publication date is to be confirmed.
Interventional procedures	3 topics delayed	Bronchial thermoplasty for severe asthma: Second IP consultation required due to change in recommendation. Anticipated publication on 19 December 2018.
		Ex vivo machine perfusion for extracorporeal preservation of livers for transplantation: Because important consultation comments were received late, the topic is being returned to the committee. Anticipated publication on 19 December 2018.
		Subcutaneous automated low-flow pump implantation for refractory ascites: Delayed going to Guidance Executive. Anticipated publication 14 November 2018.
Medical technologies	1 topic delayed	Neuropad: Delayed for consideration of resolution (appeal) requests. Publication date is now September 2018 (Q2 2018-19).
Public Health	1 additional topic published in 2018-19, that was not planned for this financial year	Flu vaccinations: Originally planned to publish in 2017-18. Published in August 2018 (Q2 2018-19).
Quality Standards	No variation against plan 2018-19	
Diagnostics	1 topic delayed	Tumour profiling tests to guide adjuvant chemotherapy decisions in early breast cancer: The assessment is now at the resolution stage and publication of the final guidance is anticipated within Q3 2018-19, date to be confirmed.
Technology Appraisals	4 topics delayed	Blinatumomab for acute lymphoblastic leukaemia [ID1036]: Following a regulatory timing update from the company the topic is to be rescheduled. New publication date is to be confirmed.

Programme	Delayed Topic	Reason for variation
		Abiraterone for treating newly diagnosed metastatic hormone-naive prostate cancer: Topic suspended. NICE are awaiting confirmation from the company of the price. Expected publication to be confirmed.
		Nivolumab with ipilimumab for untreated metastatic renal cell carcinoma: Topic suspended following a negative licencing opinion. This appraisal will therefore be re-scheduled and a further update will be issued in due course. Expected publication to be confirmed.
		Ocrelizumab for treating primary progressive multiple sclerosis: Originally due to publish 31 Oct 2018. The appraisal has been paused while commercial discussions between the company and NHS England are taking place. Expected publication to be confirmed.
	1 additional topic published in 2018-19, that were not planned for this financial year	Lutetium (177Lu) oxodotreotide for treating unresectable or metastatic neuroendocrine tumours: MTA was split into 2 appraisals in 2017/18, with one part published last year (TA449) and one part (TA539) in August of this year.
Highly Specialised Technologies (HST)	1 topic delayed	Afamelanotide for treating erythropoietic protoporphyria [ID927]: Following receipt of an appeal, which was upheld at the appeal hearing on 30 July 2018, the topic has been returned to the committee. Publication for final guidance is now to be confirmed.
Social Care	No variation against plan 2018-19	
Managing Common Infections	1 topic delayed	Catheter associated urinary tract infections: New evidence identified at consultation so publication delayed. Anticipated publication date 23 November 2018.

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

Programme	Topic	Recommendation
Clinical Guidelines	Chronic heart failure in adults: diagnosis and management	General guidance
	Pancreatitis	General guidance
	Renal replacement therapy and conservative management	General guidance
Interventional procedures	Transurethral water jet ablation for lower urinary tract symptoms caused by benign prostatic hyperplasia	Special arrangements
	Intravesical microwave hyperthermia and chemotherapy for non-muscle-invasive bladder cancer	Special arrangements
	Selective internal radiation therapy for unresectable primary intrahepatic cholangiocarcinoma	Only in research
Medical technologies	Neuropad for detecting preclinical diabetic peripheral neuropathy	Not recommended
	iFuse for treating chronic sacroiliac joint pain	Recommended
Diagnostics	No publications	
Public Health	Preventing suicide in community and custodial settings	General guidance
Managing Common Infections	Urinary tract infection (lower): antimicrobial prescribing	General guidance
	Prostatitis (acute): antimicrobial prescribing	General guidance
	Pyelonephritis (acute): antimicrobial prescribing	General guidance
	Urinary tract infection (recurrent): antimicrobial prescribing	General guidance
Social care	Decision-making and mental capacity	General guidance
Quality Standards	Asthma	Sentinal markers of good practice
	Eating disorders	Sentinal markers of good practice
	Emergency and acute medical care in over 16s	Sentinal markers of good practice
Technology Appraisals	Cabozantinib for untreated advanced renal cell carcinoma	Recommended
	Tofacitinib for treating active psoriatic arthritis after inadequate response to DMARDs	Optimised

Programme	Topic	Recommendation
	Dabrafenib with trametinib for adjuvant treatment of resected BRAF V600 mutation-positive melanoma	Recommended
	Pembrolizumab for treating relapsed or refractory classical Hodgkin lymphoma	Recommended (optimised) for use within the CDF
	Inotuzumab ozogamicin for treating relapsed or refractory B-cell acute lymphoblastic leukaemia	Recommended
Highly Specialised Technologies (HST)	Burosumab for treating X-linked hypophosphataemia in children and young people	Recommended
Evidence summaries	Infliximab for neurosarcoidosis	Summary of best available evidence
	Sapropterin for phenylketonuria	Summary of best available evidence
Medtech Innovation Briefings (MIB)	OxyMask for delivering oxygen therapy	Summary of best available evidence
	The Vest for delivering high-frequency chest wall oscillation in people with complex neurological needs	Summary of best available evidence
	Servo-n with Neurally Adjusted Ventilatory Assist (NAVA) for babies and children	Summary of best available evidence
	gammaCore for cluster headache	Summary of best available evidence
	myAIRVO2 for the treatment of chronic obstructive pulmonary disease	Summary of best available evidence
Evidence Surveillance Reviews	CG93 Donor milk banks: service operation	Surveillance review decision
	CG103 Delirium: prevention, diagnosis and management	Surveillance review decision
	CG116 Food allergy in under 19s: assessment and diagnosis	Surveillance review decision
	CG191 Pneumonia in adults: diagnosis and management	Surveillance review decision
	CG186 Multiple sclerosis in adults: management	Surveillance review decision

Programme	Topic	Recommendation
	CG102 Meningitis (bacterial) and meningococcal septicaemia in under 16s: recognition, diagnosis and management	Surveillance review decision
	CG84 Diarrhoea and vomiting caused by gastroenteritis in under 5s: diagnosis and management	Surveillance review decision
	NG59 Low back pain and sciatica in over 16s: assessment and management (exceptional review)	Surveillance review decision
	NG33 Tuberculosis (exceptional review)	Surveillance review decision

Key to recommendation types

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

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

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

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

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

Quality standards:
The statements in our Quality Standards identify important aspects of practice in which there is significant variation across the NHS.

Technology appraisals and highly specialised technologies:
This guidance can ‘recommend’ the use of a new drug or other treatment, ‘optimised use’, in which the recommendation is positive for some but not all uses, or ‘not recommend’ routine use in the NHS. Research only use is also sometimes recommended.

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

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

Appendix 5: Balanced Scorecard 2018-19: April 2018 – September 2018

Delivering services and improvements

Outputs	Measure	Target	Planned Q1 & Q2	Actual Q1 & Q2	Cumulative performance	RAG
Development and publication of guidance and evidence outputs (as specified in Business Plan)						
Publish 2 public health guidelines	Publication within stated quarter	80%	2	3	150%	Green
Publish 19 clinical guidelines, including updates	Publication within stated quarter	80%	9	9	100%	Green
Publish 4 management of common infections	Publication within stated quarter	80%	0	0	N/A	Green
Notes: *No publications have been planned.*						
Publish 2 social care guidelines	Publication within stated quarter	80%	2	1	50%	Amber
Notes: *Decision making and mental capacity: Delayed due to the need for a full legal review of all of the recommendations*						
Publish 75 technology appraisals guidance	Publication within stated year	100%	26	25	94%	Amber
Notes: *Blinatumomab for acute lymphoblastic leukaemia [ID1036]: Following a regulatory timing update from the company the topic is to be rescheduled. New publication date to be confirmed.* *Abiraterone for treating newly diagnosed metastatic hormone-naive prostate cancer: Topic suspended. NICE are awaiting confirmation from the company of the price abiraterone will be available to the NHS for this indication. Once this price is confirmed the appraisal will re-start.* *Unplanned publication:* *Lutetium (177Lu) oxodotreotide for treating unresectable or metastatic neuroendocrine tumours: MTA was split into 2 appraisals in 2017/18, with one part published last year (TA449) and one part (TA539) in August 2018.*						

Outputs	Measure	Target	Planned Q1 & Q2	Actual Q1 & Q2	Cumulative performance	RAG
Development and publication of guidance and evidence outputs (as specified in Business Plan)						
Publish up to 30 interventional procedures guidance	Publication within stated quarter	80%	23	21	91%	Green
Publish 4 diagnostics guidance	Publication within stated quarter	80%	2	2	100%	Green
Publish 3 highly specialised technologies guidance	Publication within stated year	100%	1	0	0%	Red
Notes: *Afamelanotide for treating erythropoietic protoporphyria ID927: Following receipt of an appeal against the guidance planned for publication, an appeal hearing was held on Monday 30 July 2018. Publication for final guidance is now to be confirmed.*						
Publish 8 medical technologies guidance	Publication within stated year	80%	2	1	50%	Amber
Notes: *Senza: Delayed for second consultation. Due to publish in November 2018.*						
Publish 34 medtech innovation briefings (MIBs)	Publication within stated year	80%	18	18	100%	Green
Submit advice to Ministers on up to 38 Patient Access Schemes	Publication within stated year	100%	22	30	136%	Green
Deliver up to 25 commissioning support programme topics to NHS England	Submission to NHS England Clinical Panel within stated quarter	80%	3	3	100%	Green
Publish 58 guidance surveillance reviews	Publication within stated quarter	80%	24	25	104%	Green
Publish up to 20 evidence summaries	Publication within year	80%	0	4	400%	Green
Deliver 10 quick guides for social care	Publication within year	100%	4	4	100%	Green

Outputs	Measure	Target	Planned Q1 & Q2	Actual Q1 & Q2	Cumulative performance	RAG
Development and publication of guidance and evidence outputs (as specified in Business Plan)						
Deliver 20 quality standards	Publication within stated quarter	80%	11	11	100%	Green
Deliver 1 indicator set	Publication within year	100%	1	0	0%	Red
Notes: *The 2018 NICE menu has been held back two months so that it reflects the findings of the national QOF Review. The QOF review published in July and the NICE menu published in October 2018.*						
Deliver 30 endorsement statements	Publication within stated quarter	80%	16	14	88%	Green
Deliver 50 shared learning examples	Publication within stated quarter	80%	20	22	110%	Green
Publish 12 monthly updates of the BNF and BNF C content	Publication within stated quarter	80%	6	6	100%	Green
Deliver a regular medicine awareness service (50 MAWs)	Publication to regular schedule	90%	26	26	100%	Green
Deliver 16 medicines optimisation key therapeutics topics	Publication within stated quarter	80%	0	0	N/A	Green
Notes: *No publications have been planned.*						
Deliver 25 medicines evidence commentaries	Publication within stated quarter	80%	13	13	100%	Green
Deliver 4 IAPT (Improving Access to Psychological Therapies) assessment briefings	Publication within stated quarter	80%	0	0	N/A	Green
Notes: *No publications have been planned.*						

Adoption and impact

Outputs	Measure	Target	Planned Q1 to Q2	Actual Q1 to Q2	Cumulative performance	RAG
Provision of support products for the effective implementation of guidance						
Provide adoption support products for up to 5 topics	Provide within year	80%	1	0	0%	**Red**
Notes: *Adoption support products publish alongside guidance. Senza MTG guidance is delayed for a second consultation and due to publish in November 2018.*						
Publish up to 96 resource impact products to support guidance	Publication within year	80%	40	37	93%	**Green**
Maintaining and developing recognition of the role of NICE						
Coverage of NICE in the media	% of positive coverage of NICE in the media resulting from active programme of media relations	80%	80%	80%	80%	**Green**

Operating efficiently

Outputs	Measure	Target	Planned Q1 to Q2	Cumulative performance	RAG
Delivering programmes and activities on budget					
Effective management of financial resources	Revenue spend	To operate within budget	2018/19 Quarter 2 year-to date (YTD) budget was £24.5m.	Net YTD spend for 2018/19 Quarter 2 was £24.1m. This was a net under spend of £0.4m and is mainly due to vacant posts.	Green
Effective management of non-exchequer income	Net income received from non-exchequer income sources measured against business plan targets	90%	The business plan income target was to receive £2.1m year-to-date (YTD) for Scientific Affairs programme, Office for Market Access, Intellectual Property income and research grants. Costs have been £0.2m lower in the Scientific Affairs programme, resulting in a revised income target of £1.9m.	Quarter 2 YTD income was £1.7m, equivalent to 90% of the revised income target. Research funding was slightly below target in quarter 1, however it is expected to achieve its target by year end.	Green
Produce the annual report and accounts within the statutory timeframe	Publications	100%	Lay before summer parliamentary recess.	2017-18 Annual accounts laid 10	Green

				July 2018 as planned.	

Outputs	Measure	Target	Cumulative performance	RAG
Maintaining and developing a skilled and motivated workforce				
Management of recruitment	Proportion of posts appointed to within 4 months of first advertisement	80%	97%	Green
Management of sickness absence	Quarterly sickness absence rate is lower than NHS average rate (3.7% Apr-Jun 2011) or general rate for all sectors (2.8%)	90%	100%	Green
Staff satisfaction	Proportion of staff reporting in staff survey that the Institute is a good, very good or excellent place to work (global job satisfaction index)	75%	95%	Green
Staff involvement	Hold monthly staff meetings	80%	83%	Green
Staff well-being	Implementation of NICE's quality standard for healthy workplaces: improving employee mental and physical health and wellbeing in respect of own staff	80% of quality statements	80%	Green
Sustainable development				
Recycled waste	% of total waste recycled	50%	99%	Green
Improving stakeholder satisfaction				
Improved satisfaction	Complaints fully responded to in 20 working days	80%	100%	Green
Improved satisfaction	Enquiries fully responded to in 18 working days	90%	93%	Green
Improved satisfaction	Number of Freedom of Information requests responded to within 20 working days	100%	97%	Amber
Notes: *60 FOI requests were received within the first two quarters of 2018-19. Two requests were responded to outside of the required timeframe. One was delayed due to the need for 3rd party advice on technology appraisal redactions and commercial sensitivity. The second was delayed due to senior staff availability, off-site storage retrieval and seeking legal advice.*				
Improved satisfaction	Parliamentary Questions contribution provided within requested timeframe	90%	100%	Green

Ensuring stakeholders have access to our websites as the main communication channel	Percentage of planned availability, not including scheduled out of hours maintenance	98%	99.97%	Green

Outputs	Measure	Target	Planned Q1 to Q2	Actual Q1 to Q2	Cumulative performance	RAG
Interest in opportunities for lay people to sit on our advisory reflected by ratio of applications to positions	2 to 1 (or greater) each quarter	100%	2 to 1	11.4:1	570%	Green

Outputs	Measure	Annual target	Cumulative performance	RAG
Improving efficiency and speed of outputs				
Speed of production	% STAs for all new drugs issuing an ACD or FAD within 6 months of the product being first licensed in the UK	90%	100%	Green
Speed of production	% of multiple technology appraisals from invitation to participate to ACD in 41 weeks, or where no ACD produced to FAD in 44 weeks	85%	N/A	Green
Notes: *No publications have been planned.*				
Speed of production	% of Appeal Panel decisions received within 3 weeks of the hearing	80%	100%	Green

RAG Status - Key

Green	= Greater than or equal to annual target
Amber	= Between 50 % and less than annual target
Red	= Less than 50% of annual target

November 2018

National Institute for Health and Care Excellence

Finance and workforce report

This report gives details of the financial position as at 30 September 2018 and an update on workforce developments.

The Board is asked to review the report.

Ben Bennett

Director, Business Planning and Resources

November 2018

Financial Position as at 30 September 2018

Summary

1. Table 1 summarises the financial position as at 30 September 2018. There is a full analysis in Appendix 1

Table 1 Financial Position at 30 September 2018

	Year to date (30 September 2018)				Estimated Outturn (31 March 2019)			
	Budget £m	Expenditure £m	Income £m	Variance £m	Budget £m	Expenditure £m	Income £m	Variance £m
Guidance & Advice	24.4	24.5	(0.5)	(0.5)	50.8	50.9	(0.9)	(0.8)
Corporate	6.5	6.9	(0.5)	(0.1)	13.1	13.9	(0.9)	(0.2)
Science Advice & Research	0.1	1.5	(1.3)	0.1	0.2	3.1	(2.5)	0.3
Other Income	(6.5)	0.0	(6.5)	0.0	(12.6)	0.0	(12.6)	0.0
Reserves	0.1	0.0	0.0	(0.1)	1.1	0.9	0.0	(0.2)
Grand Total	**24.7**	**32.9**	**(8.8)**	**(0.6)**	**52.6**	**68.7**	**(17.0)**	**(0.9)**

2. Table 1 above shows a total under spend of £0.6m (2%) at the end of September 2018. This is primarily attributable to vacant posts.

3. The full-year forecast position is that the under spend will continue to increase to £0.9m, with further underspends on vacant posts expected.

4. The capital budget of £0.5m is currently underspent, with less than £0.1m actual and committed spend during the first half of the year. The Manchester office space is being reviewed and some capital spend may be incurred on improvements but this has yet to be committed.

5. Total half-year expenditure to 30 September 2018 was £32.9m and income recognised was £8.8m. Thus the net expenditure was £24.1m, which was £0.6m (2%) lower than the budget of £24.7m. The under spend comprised of:

    - £0.5m pay under spend arising from vacant posts across the Directorates.
    - £0.2m non pay under spend mainly due to lower than budgeted programme support costs.
    - Offset by income being £0.1m lower than anticipated.

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

Pay and resourcing

7. Total pay expenditure to 30 September 2018 was £17.5m, which was a £0.5m (3%) under spend against budget.

8. Key pay variances include a year to date under spend on staff of £113,000 (4%) in Health Technology Evaluation, £111,000 is the Centre for Guidelines (4%), £95,000 (4%) in Evidence Resources and £59,000 (4%) in Science Advice and Research.

9. During September 2018, the actual headcount was 612 wte against a budget of 680 wte, with vacant posts totalling 68wte (a 10% vacancy rate). The vacancy rate has been consistently around 10% for the first 6 months of the year, with overall headcount having fallen by 9 heads since 31 March 2018. Although 40 new starters have joined NICE in the first 6 months, 49 employees have left in the same period.

10. The underlying vacancy rate would normally be expected to be in the region of 5% of budgeted posts. It is anticipated that the current vacancy rate will reduce towards this level by the end of 2018/19, particularly as a number of external candidates have recently been appointed (but are yet to start) in new posts within the technology appraisals programme to increase capacity and to establish the commercial liaison unit. Further, the HR team are looking at ways to increase recruitment from external sources and also improve staff retention rates. Further details are provided in the mid-year review section of this report.

Non-Pay Expenditure

11. Total non-pay expenditure to 30 September 2018 was £15.4m, which was a £0.2m (1%) under spend against budget.

12. Key non pay variances include a year to date under spend of £122,000 in Science Advice and Research mainly due to lower than budgeted expenditure in NICE Scientific Advice on adviser fees and travel costs, plus an under spend of £76,000 in the Centre for Guidelines mainly due to lower than budgeted committee meeting costs.

13. The full year forecast outturn is an under spend of £0.6m against budget. This is mainly due to an expected increase in the existing under spends identified above and an uncommitted reserves balance of £249k.

Income

14. Total income recognised as at 30 September 2018 was £8.8m and is £0.1m below budget. This is mainly due to lower than anticipated income in Scientific Advice (£0.22m) and Science Policy and Research (£0.1m). However, this is partially offset by expenditure also being lower (£0.18m) than anticipated in these teams, resulting in a year to date net deficit of £0.14m in Science, Advice and Research.

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

16. Of total income, £6.6m relates to agreements we have in place with the devolved administrations (£1.0m), NHS England (£3.6m) and Health Education England (£2.0m) to use NICE services and products or fund programmes within the organisation.

17. The other income received relates to the Scientific Advice programme (£0.9m), subletting office space (£0.5m), receipts from research grants (£0.3m) and IP and copyright income (£0.1m). The remaining income (£0.4m) is for smaller and ad-hoc services spread across multiple programmes.

18. As at 30 September 2018 Scientific Advice generated a deficit of £0.1m after staff costs and other expenditure including a contribution to overheads. The full year projection is for Scientific Advice to be in deficit by £0.27m. The deficit is attributable to some one-off unplanned costs associated with long term sickness absence and the departure of the director. The disruption associated with these events has also resulted in lower than planned activity. The new director is now in-post and it is anticipated that activity growth will pick up again The full year forecast is for Scientific Advice income to be in line with that from 2017/18 (£1.9m).

Forecast Outturn

19. The current forecast is for the overall year-end outturn to be an under spend of £0.9m, consisting of £1.0m underlying underspends across all teams (mainly due to vacancies) and £0.2m uncommitted reserves. This is offset by a £0.3m forecast over spend in Science, Advice and Research due to lower than anticipated income in the Scientific Advice and Science Policy and Research programmes. This forecast is inclusive of assumptions made about successful recruitment to vacant positions and income generating teams achieving their planned targets.

20. There is a £1.1m reserves budget for 2018/19. The reserves balance is made up of budget made available from transferring savings associated with posts vacant at the start of the year (known as the part-year budget effect of vacancies).

21. On 21 August 2018 SMT approved £0.9m of non-recurrent expenditure to be committed against these reserves leaving £0.2m uncommitted. These expenditure items were reported to the Board at its last meeting in September. This expenditure has been included in the forecast expenditure in table 1. A significant proportion of this expenditure is yet to be incurred and as such the budget for all approved bids remains in central reserves. In the coming months this budget will be transferred to the relevant teams as and when expenditure is committed.

22. The approvals for expenditure from reserves included £25,000 for the Centre of Health Technology Evaluation (CHTE) to recruit support for setting up an early engagement function. This work has since been paused, but this budget is being repurposed to support updates to CHTE methods and process guides until March 2019.

Capital

23. The 2018/19 capital allocation is £0.5m. At present £6,500 has been utilised for the installation of a new CCTV system in the Manchester Office and there will also be expenditure associated with the installation of new sections of flooring (£12,000) in the Manchester Office. In addition to this IT hardware expenditure associated with increasing storage capabilities is expected to be capitalised in 2018/19.

24. The facilities team are in the process of reviewing the Manchester office space and will be presenting a paper of options for improvement. Some of this will be capital, although any resulting expenditure is likely to impact in the next financial year.

NICE2020 savings and business planning

25. Business planning and budget setting for 2019/20 is currently in progress as set out in the previous board report. This will continue for the rest of November, with the first draft of the business plan expected to be ready late in December. As part of the business planning and budget setting process teams will also be asked to identify potential resource implications and opportunity costs associated with supporting the NICE Pathways work.

Workforce

Resourcing

26. NICE advertised 95 vacancies over the first six months of the year, (Apr – Sept 18). Whilst not high volumes, we continue to face challenges to recruit the right people with the right skills in some key areas of the business.

27. In April 2018 we appointed a dedicated recruitment specialist to review our approach to recruitment.

28. As part of our review of recruitment, we have surveyed staff who are currently occupying hard-to-fill roles including technical analysts and software developers, to ask for input into improving our employer profile for these areas. As a result, several “personas” have been built which reflect the characteristics of a typical analyst or developer. These personas are now being used in our recruitment campaigns.

29. Alongside this, we are now advertising our vacancies in a more targeted way to ensure we are capturing the active and passive candidate markets. In particular, we are trialling two services to help us maximise our advertising budget:

    - ClickIQ increases the visibility of our advertisements across a variety of jobs boards including Glassdoor and Indeed, which is broadening our advertising reach.
    - Vonq have streamlined the media buying process. This is particularly relevant for the recruitment of specialised roles that are difficult to attract to, like developers and testers.

30. The new strategies are resulting in an increase in the number of recent successful campaigns, such as three senior analysts in CHTE, however we recognise we need to do more.

31. The HR team has also been supporting the selection process by providing personality and ability profiling for 58 candidates across 11 senior recruitment campaigns.

Policy updates

32. So far in 2018/19, HR has reviewed and implemented 6 new employment policies; sickness absence, time off work, flexible working, home working grievance, organisational change, time off for parents. The whistleblowing policy has been reviewed and will be implemented subject to approval by the Board elsewhere on this agenda. The introduction of these new policies will be supported by management guides, templates and a suite of internal management training, developed and delivered by HR business partners.

33. A new lone working policy was implemented in September by the facilities team. We recognise that there may be an increased risk to the health and safety of employees when working alone, whether that be at home, on NICE premises outside core hours or when travelling on NICE businesses. The policy has been established to identify risks and manage them accordingly.

34. The first topic in a series of 'mini-masterclass' management training has been delivered. To coincide with the introduction of a new sickness absence policy, the first topic covered long and short term absence and supporting employees in the workplace with long term conditions and disabilities. 157 managers across all directorates were trained. The feedback from these sessions was very positive and indicated a demand for more topics to be covered, which are planned.

Staff development

35. We have run five facilitated workshops supporting teams to work together more effectively using tools like Myers Briggs.

36. We now have an internal mental health first aid instructor and have scheduled 5 courses over the next twelve months (3 in Manchester and 2 in London), with 55 staff members already booked to attend.

37. This year's Guidelines International Network (G-I-N) conference was held in Manchester, and 30 NICE staff attended. The HR team ran 3 bespoke networking and presentation skills mini masterclasses to boost skills and confidence in advance of the conference.

38. NICE agreed to formally nominate one person for the Harkness fellowship in health care and policy practice, an international 12 month study programme based in New York. We received six applications for this.

39. We have appointed 9 apprentices in this financial year, with a further 5 in the pipeline, meaning we are making good progress towards our target of 15 new apprenticeships this year.

40. A review of our apprentice induction has been carried out, which has resulted in several improvements, including:

    - A one-to-one induction with the apprenticeships and training coordinator
    - A new apprenticeship network which allows NICE apprentices to meet monthly.
    - An apprenticeship forum on Learning Zone (our learning management system) to share resources and useful hints and tips.
    - Each new starter is now assigned an apprentice buddy to help them settle into the organisation. We aim to partner new starters with an apprentice who has completed the same qualification in the previous year.

Staff engagement

41. As requested by the Board we have analysed the staff survey results in more detail, specifically focussing on diversity and location of our staff. The key findings are:

    - Staff who are home-based and London-based are less likely to report they intend to be working for NICE in 12 months' time than our Manchester staff. They are also less likely to feel that the future of their job is secure. London and Manchester staff have similar opinions on the career framework for progressing within their current role. Home workers are less satisfied with this.
    - Staff in their 20s and 30s are less likely to report they intend to be working for NICE in 12 months' time than those who are aged 16-20 or 41 and over.
    - Staff in their 20s are generally satisfied with career development and progression opportunities at NICE, but older staff are less so.
    - Staff in the Manchester office are generally more satisfied with career development and progression opportunities than home workers and London staff.

42. The HR business partners are now supporting leaders in each directorate to develop action plans to address local issues. Organisation-wide issues are being addressed through the staff survey action plan.

Appendix 1 Summary of Financial Position

The table below is a summary of the financial position per centre and directorate as at 30 September 2018.

Centre / Directorate		Year to Date				Estimated Outturn			
		Budget £000s	Expenditure £000s	Variance £000s	Variance %	Budget £000s	Expenditure £000s	Variance £000s	Variance %
Centre for Guidelines	Pay	3,164	3,053	(111)	(4%)	6,468	6,337	(131)	(2%)
	Non pay	5,665	5,589	(76)	(1%)	11,969	11,861	(108)	(1%)
	Income	(312)	(312)	0	0%	(624)	(624)	0	0%
	Total	**8,517**	**8,330**	**(187)**	**(2%)**	**17,814**	**17,574**	**(239)**	**(1%)**
Centre for Health Technology Evaluation	Pay	3,960	3,846	(113)	(3%)	8,572	8,365	(207)	(2%)
	Non pay	1,699	1,707	8	0%	3,206	3,219	13	0%
	Income	0	(3)	(3)	--	0	(3)	(3)	--
	Total	**5,659**	**5,550**	**(109)**	**(2%)**	**11,778**	**11,581**	**(197)**	**(2%)**
Health and Social Care	Pay	3,676	3,668	(9)	0%	7,506	7,518	12	0%
	Non pay	1,195	1,218	23	2%	2,629	2,657	29	1%
	Income	0	(19)	(19)	--	0	(57)	(57)	--
	Total	**4,871**	**4,867**	**(5)**	**0%**	**10,135**	**10,118**	**(16)**	**0%**
Evidence Resources	Pay	2,472	2,377	(95)	(4%)	5,193	4,855	(337)	(6%)
	Non pay	3,003	3,043	39	1%	6,007	6,072	65	1%
	Income	(83)	(176)	(94)	(114%)	(135)	(246)	(111)	(82%)
	Total	**5,393**	**5,243**	**(149)**	**(3%)**	**11,064**	**10,681**	**(383)**	**(3%)**
Science Advice and Research	Pay	1,410	1,351	(59)	(4%)	2,831	2,754	(78)	(3%)
	Non pay	287	165	(122)	(42%)	572	345	(227)	(40%)
	Income	(1,619)	(1,302)	318	20%	(3,183)	(2,549)	634	20%
	Total	**77**	**214**	**137**	**n/a**	**220**	**549**	**329**	**n/a**
Subtotal Guidance and Advice		**24,517**	**24,204**	**(313)**	**(1%)**	**51,011**	**50,504**	**(507)**	**(1%)**

Centre / Directorate		Year to Date				Estimated Outturn			
		Budget £000s	Expenditure £000s	Variance £000s	Variance %	Budget £000s	Expenditure £000s	Variance £000s	Variance %
Communications	Pay	1,761	1,774	13	1%	3,590	3,591	1	0%
	Non pay	194	197	3	(1%)	369	371	2	1%
	Income	0	(1)	(1)	--	0	(1)	(1)	--
	Total	**1,955**	**1,969**	**14**	**1%**	**3,958**	**3,960**	**2**	**0%**
Business Planning and Resources	Pay	1,469	1,444	(25)	(2%)	2,944	2,958	13	0%
	Non pay	3,120	3,095	(25)	(1%)	6,253	6,197	(56)	(1%)
	Income	(439)	(477)	(38)	(9%)	(879)	(917)	(38)	(4%)
	Total	**4,150**	**4,062**	**(88)**	**(2%)**	**8,318**	**8,238**	**(80)**	**(1%)**
Subtotal Corporate		**6,105**	**6,031**	**(74)**	**(1%)**	**12,277**	**12,198**	**(78)**	**(1%)**
Depreciation	Non pay	425	370	(55)	-13%	850	740	(110)	(13%)
	Total	**425**	**370**	**(55)**	**-13%**	**850**	**740**	**(110)**	**(13%)**
Other Income	Income	(6,472)	(6,484)	(12)	0%	(12,619)	(12,608)	11	0%
	Total	**(6,472)**	**(6,484)**	**(12)**	**0%**	**(12,619)**	**(12,608)**	**11**	**(0%)**
Reserves	Non pay	135	0	(135)	(100%)	1,124	875	(249)	(22%)
	Total	**135**	**0**	**(135)**	**(100%)**	**1,124**	**875**	**(249)**	**(22%)**
NICE Grand Total	**Pay**	**17,911**	**17,512**	**(399)**	**(2%)**	**37,104**	**36,378**	**(725)**	**(2%)**
	Non pay	**15,724**	**15,384**	**(340)**	**(2%)**	**32,979**	**32,337**	**(642)**	**(2%)**
	Income	**(8,925)**	**(8,775)**	**150**	**2%**	**(17,440)**	**(17,006)**	**434**	**2%**
	Total	**24,710**	**24,121**	**(589)**	**(2%)**	**52,643**	**51,709**	**(934)**	**(2%)**

Appendix 2 Financial Statements

STATEMENT OF COMPREHENSIVE NET EXPENDITURE FOR THE PERIOD APRIL TO SEPTEMBER (6 months)

	30 Sept 2018 Total £000	30 Sept 2017 Total £000
Total operating income	**(8,775)**	(7,826)
Staff costs	**17,512**	16,265
Purchase of goods and services	**5,638**	6,047
Depreciation and impairment charges	**370**	396
Other operating expenditure	**9,376**	9,693
Total operating expenditure	**32,896**	32,401
Comprehensive net expenditure	**24,121**	24,575

The above statement shows the income and expenditure incurred during months April - September in each financial year only to aid comparison.

STATEMENT OF FINANCIAL POSITION AS AT 30 SEPTEMBER

	30 Sept 2018 Total £000	30 Sept 2017 Total £000
Non-Current assets		
Property, plant and equipment	**1,925**	2,205
Intangible assets	**129**	66
Total non-current assets	**2,054**	2,271
Current assets		
Trade and other receivables	**3,865**	7,108
Cash and cash equivalents	**3,492**	4,391
Total Current assets	**7,357**	11,499
Total Assets	**9,411**	13,770
Current liabilites		
Trade and other payables	**(2,808)**	(5,769)
Provisions for liabilities and charges	**(1,009)**	(1,283)
Total current liabilities	**(3,817)**	(7,052)
Total assets less current liabilities	**5,594**	6,718
Taxpayers' equity		
General fund - Segment 1 NICE	**4,556**	5,801
General fund - Segment 2 Scientific Advice (balance brought forward as at 31 March)	**1,038**	917
	5,594	6,718

The above statement shows the statement of financial position (also known as the balance sheet) as at 30 September in each financial year. It is a snapshot at that particular date and is not necessarily representative of the financial position at other points of the financial year or the position reported in the annual accounts.

November 2018

National Institute for Health and Care Excellence

NICE impact: antimicrobial resistance

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

The Board is asked to review the NICE impact antimicrobial resistance report.

Professor Gillian Leng

Deputy Chief Executive and Director, Health and Social Care Directorate

November 2018

Introduction

1. The attached report is the sixth of a series of NICE impact reports and its focus is antimicrobial resistance. The report reviews the uptake of NICE guidance in respect of primary care antimicrobial prescribing and the administration, prescribing, review and antimicrobial stewardship in secondary care, with a spotlight on sepsis.

2. This paper provides information about how the System Support for Implementation team is working with key partners to support the implementation of NICE antimicrobial stewardship and prescribing guidelines. It also provides information about the schedule for the topics of future impact reports and reports how NICE impact reports are promoted, focussing on activity and uptake for the NICE impact diabetes report.

Implementation

3. The antimicrobial resistance impact report highlights that whilst progress has been made across the system, there is still room for improvement. For example, while there has been an overall reduction in prescribing of antibiotics in primary care (down 11% between 2013 and 2017), there is still considerable variation across the regions; and there has been a 7.7% increase in secondary care antibiotic prescribing making the UK the 3rd highest across 23 European countries.

4. The System Support for Implementation team is working with key system partners such as PHE, HEE, NHS England and NHS Improvement to deliver a programme of work to support implementation of the antimicrobial stewardship and prescribing guidelines. Key forthcoming activities include :

    - Exploring the option of embedding the antimicrobial prescribing guideline visual summaries into primary and secondary care systems to enable easier access at the point of care.
    - Supporting the development and endorsement of partner implementation and educational resources including: PHE audit tools; Health Education England e-learning for health modules; and the 'Antimicrobial Stewardship Competencies for UK Undergraduate Healthcare Professional Education' framework produced by Cardiff University.
    - Strategic engagement with stakeholders such as the National Optimising Prescribing Working Group, NHS England's Regional Medicines Optimisation Committees, local pharmacy networks and community pharmacies, to encourage proactive and structured dissemination and implementation of NICE guidance.

5. The NICE indicators programme is currently exploring the development of antibiotic prescribing and antimicrobial stewardship indicators based on the related guidelines. Adding these to the NICE indicators menu will provide an opportunity for inclusion in national performance frameworks such as the quality and outcomes framework.

Future reports

6. The health and social care directorate SLT has considered the topics for future impact reports and following discussion the order has been changed. Sexual health has been brought forward ahead of mental health so that publication of the sexual health impact report can coincide with the publication of the sexual health Quality Standard.

7. Stroke has been included to replace respiratory as it was agreed that the respiratory impact report should reflect the NHS RightCare pathway. The publication date for the respiratory impact report will be confirmed when the publication date of the RightCare pathway is known. The table below details the changes.

Table 1 Schedule for future impact reports

Topic	Board Meeting
Sexual Health	30 January 2019
Mental Health	20 March 2019
Stroke	22 May 2019
Adult Social Care	17 July 2019

Promoting NICE impact reports: diabetes

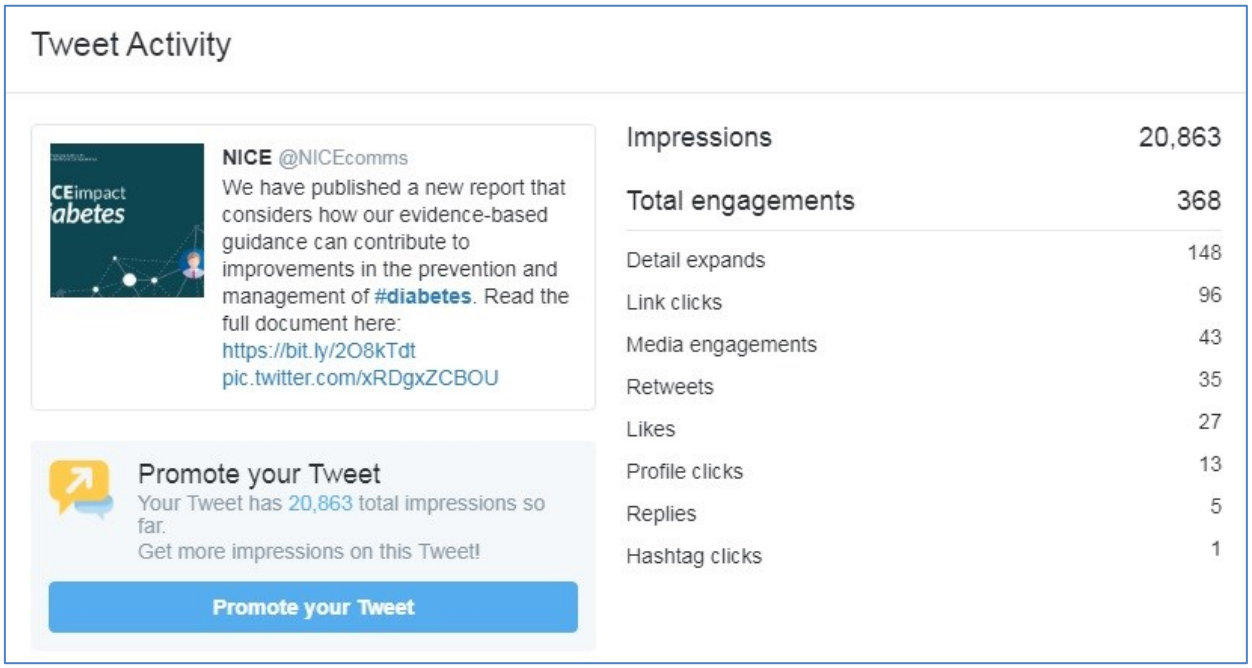
8. At its last meeting Board members asked for an update on the latest engagement and communication activities carried out to promote the most recent NICE impact report on diabetes. The report published on the NICE website on 21 September 2018 in PDF format. The following is a summary of the various activities and channels used to raise awareness of the report and the important issues it covers amongst our stakeholders.

Social media

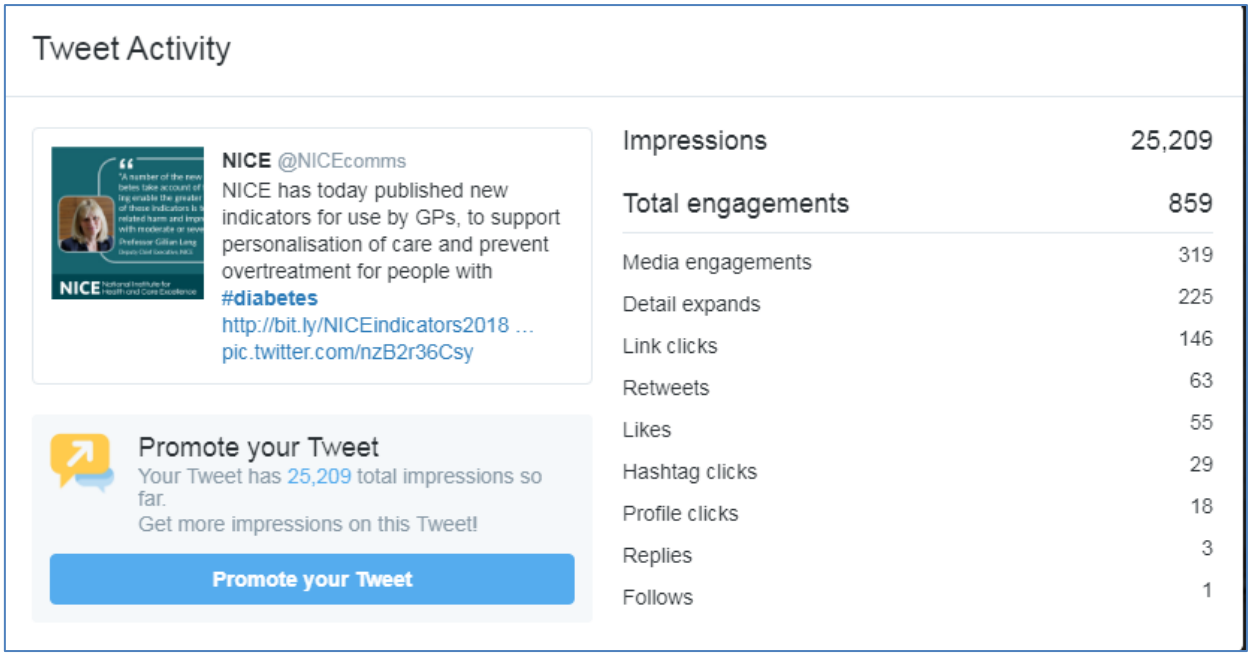
9. For publication, we promoted the diabetes impact report via the social media channels below. Following publication, we continue to use social media to promote the report, linking it into relevant initiatives, such as latest NICE indicators for general practice.

Twitter

10. For the tweets that follow, the engagement rate was about 1.7% which is considered very high by industry standards. According to Google: "An engagement rate between 0.09% and 0.33% is considered to be high, where an influencer would expect 9 - 33 reactions for every 1000 followers on Twitter. An engagement rate between 0.33% and 1% is considered to be very high, with expected reactions to be between 33 and 100 for every 1000 Twitter followers."



View the post here.



View the post here

Facebook

View the post here

NICE newsletters

11. We highlighted the diabetes impact report, as well as a National Health Execututive blog by Gill Leng on the report in the August editions of our newsletters to stakeholders: NICE News (25,213 subscribers) and Update for Primary Care (12,405 Subscribers). NICE News subscribers demonstrated the most interest in the report. Mail chimp statistics showed that it was downloaded 205 times and received 6% of all clicks.

Working with partners and key stakeholder organisations.

12. We worked closely with partners and key stakeholder organisations' to encourage them to spread the word about the diabetes impact report through their networks and communication channels. Below are some examples of the activities that have been/will be carried out as a result of this work:

    - Communications colleagues at key partner/stakeholder organisations' shared the report via social media/website/e-news bulletins. These included: Diabetes UK, NHS Digital, Royal College of Physicians, NHS improvement, Diabetes inpatient specialist nurse UK Group; Association of Children's Diabetes Clinicians; National Children Young People's

Diabetes Network and other relevant patient/professional organisations, groups and networks.

- National Health Executive (NHE), published a blog by Gill Leng: How are we faring in the fight against diabetes? This forms part of a series of blogs that NHE is publishing on our impact reports. So far we have covered cancer, maternity, cardiovascular disease and falls and fragility fractures.
- Diabetes UK provided the commentary for the impact report and agreed to include an announcement about it in its professional magazine, Diabetes Update, which will publish at the end of November. This will be circulated to over 40,000 health care professional with a key role in caring for and educating those living with diabetes.
- The Association of British Clinical Dialectologists also agreed to include an announcement about the report in the Chairman's news section of the British Journal of Diabetes (BJD) in December. This goes out to hospital diabetologists, endocrinologists, general physicians, surgeons, general practitioners and other professionals with a special interest in diabetes.

Events

13. Our events team continue to promote our impact reports at relevant events, exhibitions and speaking engagements. This includes promoting the reports to delegates on the NICE stand and asking NICE speakers to mention them in relevant presentations. Paul Chrisp will be highlighting the diabetes impact report in his key note speech: Excellence across the care pathway: NICE and diabetes at the Diabetes Professional Care Conference on 15 November.

Promoting upcoming reports

14. The communications team will continue to use each impact report as a theme to promote NICE's work more generally. It is an embedded part of our strategic approach to external communications. The next NICE impact report will be on AMR and is due to publish on 23 November (tbc). The team will be working together to promote all of NICE's AMR work, including the AMR impact report throughout the month of November. This will include a Facebook Live, which focuses on antimicrobial resistance.

NICE National Institute for Health and Care Excellence

NICEimpact *antimicrobial resistance*

NICEimpact *antimicrobial resistance*

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

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

Antimicrobial resistance (AMR) poses a significant threat to public health. Antimicrobial-resistant infections result in at least 700,000 deaths worldwide each year.

This report focuses on how NICE's evidence based guidance can change prescribing practice to help slow the emergence of AMR and ensure that antimicrobials remain effective treatments for managing infections.

Antimicrobials in primary care p6

Prescribing of antimicrobials in primary care in England has reduced in recent years. This section highlights NICE guidance that provides primary care with the tools they need to further reduce inappropriate antibiotic prescribing.

Antimicrobial stewardship in secondary care p11

Prescribing of antimicrobials in hospitals in England has risen overall since 2013. This section reviews the uptake of recommendations from NICE's guidance on antimicrobial stewardship, including a focus on the timely review of antimicrobial prescribing.

Spotlight on sepsis p14

Sepsis is a leading cause of avoidable death in people of all ages. This section looks at the the uptake of NICE's recommendations for people with suspected sepsis in hospital, including the timely recording of vital signs and the prompt administration of antibiotics.

Commentary p17

Professor Mike Sharland and Professor Peter Wilson review recent achievements and consider NICE's role in combating antimicrobial resistance.

Why focus on antimicrobial resistance?

Medicines used to treat infections are called antimicrobials. Antibiotics are antimicrobials that are widely used for treating a range of bacterial infections such as chest and urinary tract infections. They are also used to help prevent infection in some people who may be at higher risk of getting an infection, such as those having surgery or receiving cancer treatment.

Widespread use of antimicrobials has been linked to microbes such as bacteria and viruses changing and becoming resistant to treatment. This means that the antimicrobials we have no longer stop all microbes causing the infection. Some survive to cause long lasting and severe infections. This is known as antimicrobial resistance (AMR).

The Chief Medical Officer (CMO) Dame Sally Davies advocates globally on AMR. The CMO report on the threat of antimicrobial resistance was published in 2013. The report highlighted encouraging the development of new antibiotics and looking after the current supply of antibiotics. This means using better hygiene measures to prevent infections, prescribing fewer antibiotics and making sure that antibiotics are only used when needed.

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 our partners in the system, such as The Department of Health and Social Care (DHSC), NHS England and Public Health England (PHE).

AMR is increasing, with few new antimicrobial medicines coming to market. NICE is working in collaboration with DHSC, NHS England and industry to explore **new funding models** for innovative antimicrobials that do not link payment to the volume of antimicrobials prescribed. Such models have the potential to provide much needed incentives for the development of new antimicrobials. The appropriate use of existing antimicrobials remains vitally important.

NICE first published guidance on antibiotic use in 2008. This guideline, on **self-limiting respiratory tract infections**, provides practical strategies for prescribing in primary care. Since then NICE has published a suite of guidance, quality standards and advice products on **antibiotic use**. Our guidelines and quality standard on **antimicrobial stewardship** aim to change prescribing practice to help slow the emergence of AMR and ensure that antimicrobials remain an effective treatment for infection.

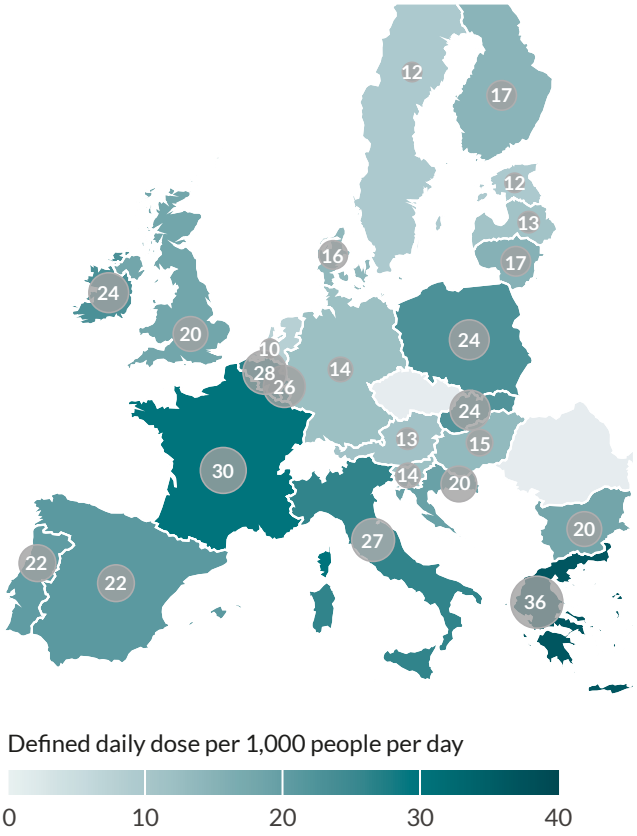
DHSC's **UK Five Year Antimicrobial Resistance Strategy** outlines approaches to slowing the development and spread of AMR. Since the strategy was launched in 2013, significant progress has been made to tackle the threat of AMR. Data from PHE's **English surveillance programme for antimicrobial utilisation and resistance** (ESPAUR) reports show that prescribing behaviours are gradually changing.

In England, total prescribing of antibiotics in all settings, measured using defined daily dose per day, reduced by 4.5% between 2013 and 2017, although prescribing increased in secondary care.

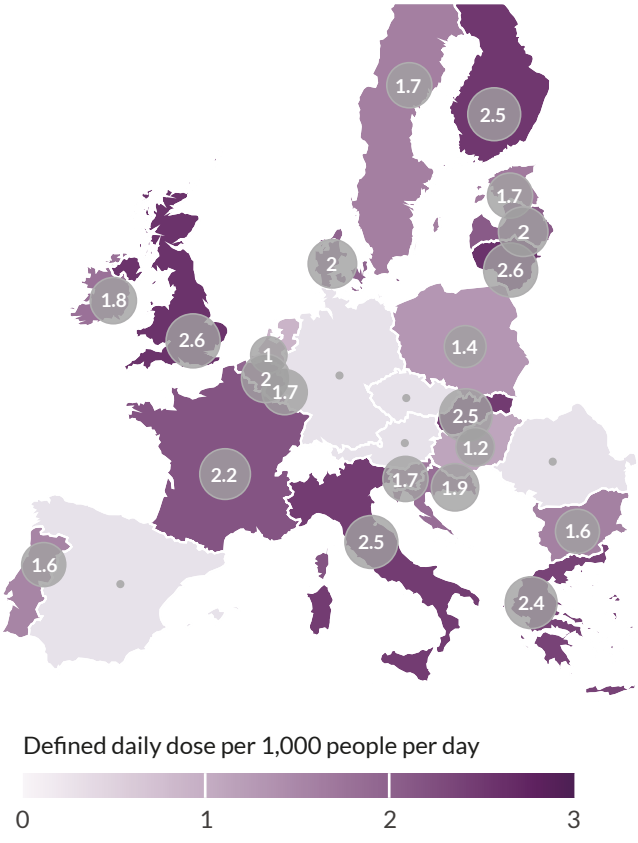
Prescribing of antibiotics in England reduced by 4.5% overall between 2013 and 2017

Data from the European Centre for Disease Prevention and Control show that, when compared to other European countries, the UK ranks in the middle for antibiotic prescribing in primary care. However for prescribing of antibiotics in hospitals, the UK prescribes the third highest out of the 23 European countries with data.

Primary care antimicrobial use in Europe, 2016. Defined daily dose per 1,000 people per day.



Hospital antimicrobial use in Europe, 2016. Defined daily dose per 1,000 people per day.



The 2018 ESPAUR report provides an update on the burden of antimicrobial resistance. Data show that the proportion of bacteria resistant to antibiotics remained largely stable from 2013 to 2017, but that the total number of infections resistant to key antibiotics increased from 12,250 in 2013 to 16,504 in 2017, a rise of 35%.

For example, the number of cases of *Escherichia coli* (*E. coli*), the most common bloodstream infection, increased from 33,497 in 2013 to 41,287 in 2017, a rise of around 23%. The ESPAUR report estimates that, for *E. coli*, there was an increase in the number of infections resistant to the broad spectrum antibiotics piperacillin/tazobactam and third-generation cephalosporins.

Surveillance data show that the number of bloodstream infections increased between 2013 and 2017

While progress has been made and total prescribing has reduced, AMR remains one of healthcare's biggest challenges. To help prevent the development of current and future bacterial resistance and resistant infections, it is important to use antibiotics according to the principles of antimicrobial stewardship as recommended by NICE. This includes prescribing antibiotics only when they are needed and reviewing the continued need for them.

We routinely collect data which give us information about the uptake of NICE guidance. To produce this report, we have worked with national partners to select data which tell us how our guidance might be making a difference in priority areas of antimicrobial stewardship and infectious diseases. These data also highlight areas where there remains room for improvement.

'Over the last few years, we have managed to reduce antibiotic prescribing in England. But we've still got a long way to go. We need to equip prescribers with the right tools to move away from an over-reliance on antibiotics. Your guidance will help with this.'
Dame Sally Davies, Chief Medical Officer

Antibiotics in primary care

The prescribing of antibiotics in primary care has been successfully reduced by about 11% between 2013 and 2017, but there is still more to do.

In England around **three quarters** of all antibiotic prescribing takes place in primary care. To minimise the development of antimicrobial resistance (AMR) it is important to prescribe antibiotics only when they are necessary.

Antibiotics are often assumed to be a quick fix when feeling unwell and many people ask their GP for them. However, antibiotics are inappropriate for self-limiting mild bacterial infections and viral infections such as colds. NICE and our partners in the healthcare system are working to reduce the level of inappropriate prescribing by producing guidance and toolkits along with using incentives to support safe and effective prescribing.

NICE's antimicrobial stewardship guidelines on **changing risk-related behaviours in the general population** and **systems and processes for effective antimicrobial medicine use** aim to make people aware of how to correctly use antimicrobial medicines, outline the dangers associated with their overuse and misuse, and aim to change prescribing practice to help slow the emergence of AMR.

1m

fewer antibiotics were dispensed in 2017/18 than in 2016/17

Prescribing of antibiotics in primary care has reduced in recent years but there is still more to do. NICE's suite of antimicrobial prescribing guidelines on **managing common infections** aim to provide clear guidance about when to use antimicrobials to minimise AMR.

Antibiotic prescribing in a primary care centre

NICE's guideline on **prescribing antibiotics for self-limiting respiratory tract infections** provides practical strategies for prescribing, including identifying when immediate antibiotics are needed and when to offer a back-up (delayed) prescription or reassurance alone. One primary care centre, Churchill Medical Centre in Surrey, developed and implemented a programme based on the guideline, which they described in a NICE **shared learning example**.

The practice introduced a consistent set of messages based on NICE's guidance. These were presented in the form of leaflets, posters, waiting room messages, summaries of evidence and short positive messages to patients that clinicians could give with confidence. This made sure that clinicians, staff and patients had access to the best available evidence to manage common respiratory tract infections effectively. The practice showed a 15% reduction in antibiotic prescribing for respiratory tract infections within 3 months.

Antibiotic prescribing in primary care

Narrow spectrum antibiotics are more specific and act only against certain bacteria, giving a more targeted approach.

Broad spectrum antibiotics act against lots of different types of bacteria and should be reserved for treating more serious infections as they are more likely to contribute to antimicrobial resistance.

Antibiotic prescribing and antibiotic resistance are inextricably linked. The UK Five Year Antimicrobial Resistance Strategy states that 'indiscriminate or inappropriate use of antibiotics is a key driver in the spread of antibiotic resistance'. Most antibiotic prescribing takes place in primary care and so, alongside NICE guidance, incentives have been put in place to encourage appropriate prescribing in primary care.

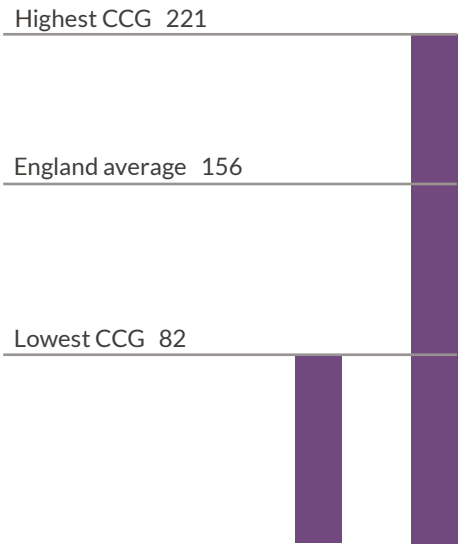
Since 2015, NHS England's Quality Premium has included a focus on improving appropriate antibiotic prescribing. This payment is intended to reward CCGs for improvements in the quality of the services that they commission. To achieve the antibiotic prescribing element of the payment, each CCG has been required to reduce the number of antibiotics prescribed and the percentage of those prescriptions which are for broad spectrum antibiotics.

By the start of 2018, over 80% of CCGs had reduced their antibiotic prescribing levels to below the 2013 England average

Both of these measures have seen improvement since the UK Five Year Antimicrobial Resistance Strategy was published in 2013. Data from Public Health England (PHE)'s AMR local indicators show that, between 2013 and 2017, total antibiotic prescribing in primary care decreased by around 11%. In the first quarter of 2018, 82% of CCGs had reduced their levels of prescribing to below the England average for the same quarter in 2013.

Antibiotic items prescribed in primary care per 1,000 people, England

Antibiotic items prescribed per 1,000 people, 2017



However there remains wide variation in the prescribing of antibiotics in different areas of England, suggesting that there is still room for improvement in many areas.

As well as reducing overall prescribing, it is important to prescribe the appropriate antibiotic. Broad-spectrum antibiotics, such as co-amoxiclav, quinolones and cephalosporins, should be reserved for treating more serious infections as they are more likely to contribute to antimicrobial resistance.

Data from PHE's AMR local indicators show that the median proportion of broad-spectrum antibiotics as a proportion of all antibiotic items reduced from over 11% in 2013 to under 9% in 2017. In March 2018, the prescribing of broad spectrum antibiotics as a proportion of all antibiotic prescribing in primary care was at or below 10% in over 85% of CCGs.

The TARGET toolkit

Public Health England, the Royal College of General Practitioners and the Antimicrobial Stewardship in Primary Care Group have produced the **Treat Antibiotics Responsibly, Guidance, Education, Tools (TARGET)** toolkit. This helps influence prescribers' and patients' personal attitudes, social norms and perceived barriers to responsible antibiotic prescribing.

A TARGET patient leaflet on treating respiratory tract infection has been endorsed by NICE. It supports the implementation of recommendations in the NICE guidelines on **processes for antimicrobial stewardship**, **behaviour change for antimicrobial stewardship** and **antibiotic prescribing for respiratory tract infections**.

Managing common infections

A **study** led by researchers from PHE's National Infection Service found that, in England between 2013 and 2015, as many as 23% of all antibiotic prescriptions in GP practices may have been inappropriate. The study identified that sore throat, cough, sinusitis, ear infection and urinary tract infections were the conditions most associated with inappropriate prescribing of antibiotics.

To drive further improvement, NHS England has maintained the focus on reducing antibiotic prescribing in the 2018/19 Quality Premium. To help prescribers meet these targets and reduce the risk of AMR, NICE's new **suite of evidence-based antimicrobial prescribing guidelines** make recommendations for appropriate prescribing for common infections, the choice of antibiotic, dosage and course length.

Upper respiratory tract infections

In October 2017 NICE published its first managing common infections guideline, on acute sinusitis. The guideline recommends that antibiotics should not be offered to people presenting with acute sinusitis symptoms of around 10 days or less. The NICE guideline on otitis media (ear infection) says that in most cases infections last up to a week, and that most children get better in 3 days without antibiotics. Serious complications are rare.

Acute sinusitis is usually triggered by a viral infection such as a common cold and most people will get better without treatment, regardless of cause

The evidence reviewed during the acute sore throat guideline development found that most sore throats will get better without antibiotics. However, research suggests antibiotics were prescribed in 60% of cases. Instead of prescribing antibiotics, NICE advises people to manage their symptoms themselves with self-care, for example, treating pain with paracetamol or ibuprofen if appropriate.

Urinary tract infections (UTIs)

A suite of guidelines support antibiotic prescribing for UTIs. UTIs are common, with a recently published study showing that, over a 10-year period, around 1 in 5 older adults will have at least one UTI clinically diagnosed in primary care. Although the majority of UTIs will require antibiotic treatment, it is important to use the right antibiotic, at the right dose, for the right length of time.

Our lower UTI guideline advises healthcare professionals to ask people about the severity and regularity of their symptoms before prescribing antibiotics. This includes asking about the steps they have taken to manage the UTI themselves, for example taking painkillers. It may also involve asking the person for a urine sample, and using the results to identify which antibiotic is likely to work most effectively.

'Having the NICE guidance to share with patients helps with those difficult conversations where patient expectations include antibiotics for self limiting ailments. It's nice to have the guidance and evidence behind you.' GP, Herefordshire

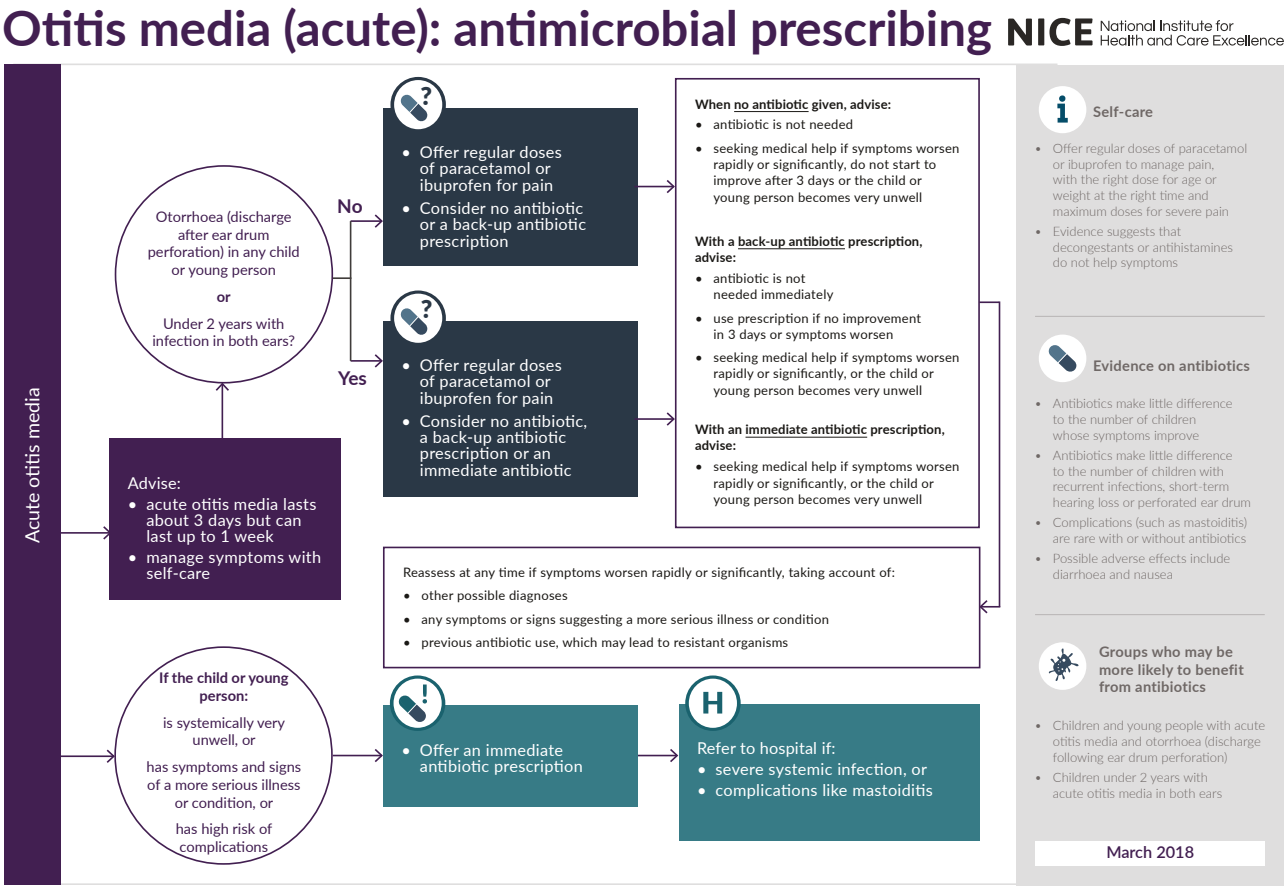
Health Education England *are working to promote awareness of antimicrobial resistance. They encourage those prescribing, dispensing and administrating antibiotics to do so responsibly and with an understanding of antimicrobial resistance. They also advise ensuring that these principles are included in curricula for human medicine, nursing, pharmacy, dentistry and other professionals when preventing, managing and controlling infection.*

Data from the **2017 ESPAUR** report indicate that around half of people with *E. coli* infection had a UTI that was thought to have been the underlying source of the invasive infection. Testing of samples from community and acute settings showed that around 3% were resistant to nitrofurantoin while over a third were resistant to trimethoprim. The 2018/19 **Quality Premium** incentivises CCGs for reducing inappropriate antibiotic prescribing for UTI in primary care, focusing on a reduction in the prescribing of trimethoprim to people aged 70 or older.

Supporting decision making

The managing common infections suite of guidance include a visual summary, which is an overview of the guideline recommendations, and a prescribing table. This aims to support decision making alongside the healthcare professional's own clinical judgement.

Visual summary from otitis media (acute): antimicrobial prescribing guideline



Antimicrobial stewardship in secondary care

Antimicrobial stewardship aims to change prescribing practice to help slow the emergence of antimicrobial resistance and ensure that antimicrobials remain an effective management for infection.

Unlike in primary care, the overall use of antibiotics in hospital has been rising in recent years. To minimise antimicrobial resistance it is important to prescribe antimicrobials only when they are necessary.

NICE's guideline on antimicrobial stewardship (AMS) aims to improve appropriate antimicrobial use through organisational or healthcare systemwide approaches. The guideline recommends antimicrobial stewardship programmes and interventions to promote and monitor appropriate antimicrobial use, preserving their future effectiveness.

In April 2015, NHS England launched a national programme to reduce inappropriate antibiotic prescribing, with incentive funding for hospitals. The payments form part of the Commissioning for Quality and Innovation (CQUIN) scheme that rewards quality improvement.

Antibiotic prescribing in secondary care

Data from Public Health England (PHE)'s English surveillance programme for antimicrobial utilisation and resistance (ESPAUR) report 2018 show that, when using hospital admissions as a measure of hospital activity, between 2013 and 2017 secondary care antibiotic prescribing increased by 7.7%.

As well as a focus on overall prescribing, it is important to prescribe the appropriate antibiotic, preserving some antibiotics for the most serious infections. Between 2013 and 2017 carbapenem use in secondary care remained stable overall while colistin use increased. The shortage of piperacillin/tazobactam saw its use decline by 37% between 2016 and 2017. However, when measured using defined daily dose the total use of alternative antibiotics to piperacillin/tazobactam increased by a greater amount. Combination therapy of the antibiotic substitutes is likely to have contributed to the increase in overall use.

7.7%

increase in antibiotic prescribing per hospital admission between 2013 and 2017

In 2017/18, 23% of NHS acute trusts met their CQUIN objectives to reduce total antibiotic prescribing, 75% met their objectives to reduce piperacillin/tazobactam prescribing and 49% met their objectives to reduce carbapenem prescribing. However, since many acute trusts did not meet their objectives, there is still room for improvement in this area.

Antimicrobial stewardship teams

NICE's AMS guideline recommends that organisations establishing AMS teams should ensure that the team has core members including an antimicrobial pharmacist and a medical microbiologist. A survey carried out by PHE as part of the 2017 ESPAUR report demonstrated that all AMS committees included an antimicrobial pharmacist and microbiologist. The survey also showed that the NICE AMS guideline was discussed by 93% of trust AMS committees and 83% had completed the NICE AMS **baseline assessment tool**.

NICE says AMS teams should review prescribing and resistance data and identify ways of feeding this information back to prescribers in all care settings. Most respondents (91%) had accessed the AMR local indicators data via the **PHE Fingertips tool** and the majority (71%) had shared this data with their AMS committee. However only one-third had shared the data with their trust board and just 5% reported sharing it with front-line clinical staff.

Antimicrobial review

PHE's **start smart – then focus** toolkit provides an outline of evidence-based antimicrobial stewardship in the secondary healthcare setting and supports the NICE antimicrobial stewardship guideline. It identifies the steps prescribers should take to make sure that antibiotics are appropriate when starting treatment. The tool then outlines how treatment should be focused and reviewed, in line with NICE guidance.

Reducing the number of infections reduces the need to prescribe antibiotics. NICE has published a **suite of guidance** *which covers preventing and controlling healthcare associated infections. These are infections in hospitals that develop because of treatment or from being in a healthcare setting.*

NICE's recommendations cover monitoring, responsibilities, and policies and procedures in secondary care organisations to reduce the risk of infection in patients, staff and visitors.

93%

of acute trust AMS committees discussed the NICE AMS guideline

The NICE quality standard on antimicrobial stewardship highlights that it is best practice to take appropriate microbiological samples before antibiotics are used in hospital. Where it is appropriate to prescribe antibiotics before the type of infection is confirmed, such as when sepsis is suspected, microbiological samples should be taken before administering the antimicrobial and, when the results are available, used to review the antimicrobial prescription.

NICE recommends that people in hospital who are prescribed an antimicrobial have a microbiological sample taken and their treatment reviewed when the results are available

For some infections, people need to have an antimicrobial given by injection directly into their bloodstream (an intravenous antimicrobial). NICE's AMS guideline recommends that healthcare professionals should consider reviewing these prescriptions after 48 to 72 hours. They should check whether antimicrobial treatment is still needed and, if it is, whether it can now be taken orally.

Part of the national CQUIN indicators for acute care providers is to ensure that prescriptions are reviewed within 72 hours of starting an antibiotic. Data from ESPAUR show the proportion of antibiotic prescriptions reviewed within 72 hours was over 90% in 2017/18.

Antibiotic review in neonatal care

NICE's quality standard on neonatal infection states that newborn babies who start antibiotic treatment for possible early-onset neonatal infection should have their need for it reassessed at 36 hours. To deliver this, the quality statement says that service providers should have systems in place for blood culture results to be returned within 36 hours of samples being taken.

A study published in the Journal of Hospital Infection surveyed microbiological laboratories in the UK to identify barriers to implementing the guideline. The survey showed that fewer than half of the laboratories in England had a system to automatically report negative blood culture results to neonatal units at 36 hours, including out of hours. These results suggest there is room for improvement in this area.

Spotlight on sepsis

Sepsis is a common cause of serious illness and death, with an estimated 123,000 cases in England each year and 37,000 deaths.

Sepsis is a clinical syndrome caused by the body's immune and coagulation systems being switched on by an infection. It is a life-threatening condition that is characterised by low blood pressure despite adequate fluid replacement, and organ dysfunction or failure.

Sepsis is a leading cause of avoidable death in people of all ages and is difficult to diagnose with certainty. Although people with sepsis may have a history of infection, fever is not present in all cases. The signs and symptoms of sepsis can be non-specific and can be missed if clinicians do not think 'could this be sepsis?'.

Sepsis is a life-threatening condition that is difficult to diagnose

In 2016 NICE published guidance on the recognition, diagnosis and early management of sepsis. The guideline recommends that healthcare professionals should consider using an early warning score to assess people with suspected sepsis in acute hospital settings. NICE did not find enough evidence during guideline development to inform a recommendation for the use of any specific scoring system. NICE supports the 2017 implementation advice published by NHS England on the National Early Warning Score as a pragmatic approach in hospital settings.

In addition to guidance on sepsis, NICE has also produced guidance on the care of acutely ill patients in hospital, the assessment and initial management of fever in under 5s, meningitis (bacterial) and meningococcal septicaemia in under 16s, neutropenic sepsis, antibiotics for the prevention and treatment of neonatal infection, and pneumonia in adults.

Sepsis care in hospital

The Royal College of Emergency Medicine (RCEM) severe sepsis and septic shock clinical audit 2016/17 reported on sepsis care in hospitals in England. NICE recommends that temperature, heart rate, respiratory rate, blood pressure, level of consciousness and oxygen saturation should be assessed in people with suspected sepsis. The audit reported that these vital signs were recorded on arrival in the emergency department in around 90% of cases.

Where healthcare professionals decide a person is at high risk of life-threatening illness from sepsis, NICE recommends that they should have antibiotics administered no more than an hour after being identified as high risk. For people at high risk of severe illness or death from sepsis, the clinical benefits of having the first dose of intravenous antibiotics within an hour outweigh any risks associated with possible antimicrobial resistance.

The RCEM audit reported that, in 2016/17, 41% of people identified as high risk had antibiotics administered within 1 hour. This is an increase from 28% in 2011/12.

Proportion of people in hospital identified at high sepsis risk who were given antibiotics within 1 hour

NICE recommends that people at high risk should also receive extra fluids through a drip or injection (intravenous fluids) if needed, within an hour of arriving at hospital. Early intervention with intravenous fluids can help reverse septic shock and restore cardiovascular stability for people who are at high risk of severe illness or death. The RCEM audit reported that the first intravenous crystalloid fluid bolus was given within 1 hour in 40% of cases. An additional 27% of people were given this within 4 hours.

'Harry arrived at the hospital and was immediately taken to the paediatric department. He was transferred to the children's high dependency unit and started on 2 different antibiotics and treated for meningitis as the possible cause. On day 3 he was given gentamicin which helped to rid him of Sepsis after 5 full days in hospital. I cannot thank the doctors and staff enough for their care which ultimately saved Harry's life.' Jordan, a young father, whose 5 week old baby Harry developed sepsis

For people with suspected sepsis, NICE recommends giving oxygen to achieve a target saturation of 94 to 98% for adults. The RCEM audit reported that oxygen was initiated to maintain the required level before leaving the emergency department in 58% of cases. This measure has also improved, from 47% in 2013/14 and 51% in 2011/12.

The NICE quality standard on sepsis highlights that people who have been stratified as at low risk of severe illness or death from sepsis should be given information about

symptoms to monitor and how to access medical care. This is because sepsis cannot always be ruled out for people who have been assessed as being at low risk. They need to know which symptoms to look out for and how to access medical care urgently if these symptoms develop.

Information on symptoms and how to access medical care should be given to people assessed at low risk of developing sepsis

However the RCEM audit reported that, in 2016/17, just 26% of people at low risk or their relatives were provided with information. There appears to be room for improvement in the delivery of this element of care.

Sepsis antibiotic review

NICE works with a community of **medicines and prescribing associates** to support and promote high quality, safe, cost-effective prescribing and medicines optimisation in their local health economies. One of these associates supported the work of Frimley Health NHS Foundation Trust antimicrobial stewardship team.

In the financial year 2017/18 the trust achieved its target for the review of antibiotic prescriptions for sepsis within 72 hours. This increased from 82% in quarter 1 to 91% by quarter 4, exceeding the CQUIN target of 90%.

The Trust identified reasons for non-achievement of antibiotic review, including that the review was not undertaken by a senior clinician or did not detail an antibiotic plan.

Following the review of antibiotics, over the course of the financial year the decision to continue current antibiotics decreased from 68% in quarter 1 to 35% by quarter 4. In the same period the proportion who switched from intravenous to oral antibiotic at review increased from 6% to 14% and the proportion that stopped antibiotics at review increased from 17% to 22%.

Commentary

Mike Sharland, Peter Wilson, September 2018

Professor Mike Sharland is chair of the Advisory Committee on Antimicrobial Prescribing, Resistance and Healthcare Associated Infection.

Professor Peter Wilson is a member of the Advisory Committee on Antimicrobial Prescribing, Resistance and Healthcare Associated Infection.

The challenge of multiresistant bacterial infections in the UK is considerable and the prospect of untreatable infections is becoming a reality. The appearance of these infections is mirroring a pattern seen in other European countries. The main defence is infection control including antimicrobial control and stewardship.

NICE guidance has a central role in promoting and ensuring best clinical practice. Compliance with its recommendations is the standard and it is non-compliance that needs explanation and justification. Incentives in terms of Quality Premium and CQUIN are important in helping to deliver compliance with best practice. This report demonstrates some of the considerable successes already achieved.

In primary care broad spectrum antibiotic use has been reduced, exceeding the expected targets and alleviating pressures for emergence of antimicrobial resistance. There have been many previous attempts to reduce patient expectation and unnecessary prescription of antibiotics for likely viral respiratory infections. Finally these moves are gaining momentum in the range of guidelines for appropriate prescribing when treating common infections (p8).

Rising levels of bacteremia due to *Escherichia coli* have been a concern and resulted in major campaigns to improve catheter care, early diagnosis and appropriate antibiotic treatment of urinary infections in both primary and secondary care. Whether these are succeeding is not yet clear. However, new NICE guidance on treatment of urinary infection is intended to ensure that the choice of antibiotic in both lower and upper urinary infection limits the risk of bacteremia (p9).

It contains an example of a visual summary and prescribing table to help the prescriber to ensure the decision to use an antimicrobial is evidence-based and likely to be effective (p10).

In secondary care the complexity of treatment and improvements in survival of elderly and cancer patients has resulted in greater needs for broader spectrum antimicrobial use. Antibiotic usage has been rising for several years. Hence delivering a reduction in total antibiotic use, and of the very broad spectrum carbapenems in particular, has proved difficult.

The need to choose the most appropriate antibiotic at the time of diagnosis is not adequately supported by clinical or diagnostic studies. More National Institute for Health Research supported projects are required to improve targeting treatment to the causative organisms and instituting additional infection control precautions. NICE guidance on treatment of health care acquired infection aims to improve the appropriate choice and use of antibiotic according to the risk of antimicrobial resistance in the healthcare setting (p12).

Combining effective early treatment and stewardship goals is a pressing need. Ensuring an empirical antibiotic is of sufficiently broad spectrum to be effective against all likely pathogens can work against the need to narrow the spectrum to avoid resistance emerging.

Encouraging the prescriber to de-escalate from an effective but very broad spectrum agent before the patient has fully recovered can be difficult. NICE guidance promotes rational prescribing through taking of microbiological specimens and the review of antimicrobial prescriptions at 48–72 hours.

The different pressures make developing strategy difficult but the impressive record in this country suggests the correct paths will be found to halt the progress of these threats to the nation's health.

We would like to thank Professor Mike Sharland and Professor Peter Wilson, for their input. We would also like to thank the Sepsis Trust for their contributions to this report.

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National Institute for Health and Care Excellence

Workforce Strategy 2018-21

The current workforce strategy covers the three year period to the end of 2018. A formal review of the strategy is therefore due.

The Board is asked to review and approve the refreshed strategy for 2018-21.

Ben Bennett

Director, Business Planning and Resources

November 2018

Introduction

1. This current workforce strategy covers the three year period to the end of 2018. A review of the strategy is therefore due and has been carried out by assessing progress against current objectives in the context of the strategic workforce challenges that the organisation now faces.

2. This document sets out a strategic framework for our approach to recruiting, supporting and developing our workforce to help meet these challenges.

3. To enable managers to do this effectively we need to recruit and develop high quality, appropriately skilled staff and provide an environment that encourages continuous improvement and embraces change. We need to ensure we have the right people processes in place that support and encourage excellence, develops talent and promotes equality and diversity in the workforce. We also need to ensure everyone understands our expectations of each other and what they should expect in return.

4. This needs to be underpinned by strong leadership, training and development opportunities, meaningful staff engagement and policies that promote health and well-being. We also need to think strategically about workforce planning and creating a talent pipeline for the future.

Developing the strategy

5. The strategy has been developed in conjunction with senior staff and the SMT, taking into account the business challenges they face. Their views about how these challenges could be addressed have been incorporated into this strategy.

6. The views and ideas of our staff side partners, UNISON, were obtained. We explored the direction we might take on the working environment, equality and diversity and health and well-being. The results of recent staff surveys were also reviewed and key themes arising from them were considered.

Operating Context

7. New science, innovative technologies and a changing political and economic context are combining to create opportunities and challenges for everyone involved in the health and care system. NICE has a unique role in bringing together patients, innovators and the NHS, to deliver improvements in outcomes and the effective use of resources.

8. NICE is responsible for producing guidance, standards and indicators, together with other information and advice products and services. The type of work we do means that we come under public and political scrutiny. What we do has to be

based in evidence and developed in conjunction with our stakeholders. The nature of what we do and the approach we take to our work, requires a particular set of skills and behaviours from a workforce that is unique in the English health and care system.

9. Over the past three years NICE has had to manage a stepped reduction in its Grant-in-Aid funding from the Department of Health and Social Care. The final stage of this overall 30% reduction will be in 2019/20. This has been managed through the implementation of a strategic savings programme, which has required some significant management of change programmes that have had an impact on the workforce, both in terms of changing roles as well as some redundancies.

10. The key final stage in the savings programme will be the introduction of a new funding model for our technology evaluation work which will involve recovering the costs of appraisals from the manufacturers of the technologies. This is unlikely to result in any reduction to the headcount. Activity is likely to increase but there will be increased emphasis on achieving efficiencies as there will be increased scrutiny of the costs of the appraisals. The model will also bring an expectation that we can be more agile in our response to fluctuations in demand for appraisals. There are some significant workforce issues associated with this change. The efficiency challenge may require new ways of working and we will continue to face the challenge of recruiting, retaining and developing staff. Being in a position to respond to fluctuations in demand may require more flexible arrangements for engaging and deploying the workforce.

11. As well as the new cost recovery model for appraisals other areas of activity will become more dependent on non-exchequer sources of income including more commercial sources with similar workforce challenges.

12. Consideration is also being given to establishing a charitable Foundation. The Foundation's objects would be aligned to our public task, but with the ability to operate more commercially. It would involve the transfer of the Science Advice and Research programmes together with the staff who are directly employed in these programmes. As well as the task of managing the transfer under TUPE the NICE HR function would, at least in the short to medium term, provide services to the Foundation.

13. We are also considering a far-reaching change in the way NICE develops and presents its advice. This project is in the context of a need to continue to evolve and be more responsive to the needs of the health and care system. Digital technologies are revolutionising the way we work and we must be able adapt the way we present our guidelines and products that is helpful to the user.

14. The first stage is to develop and test a proof of concept, which will require regular engagement with our main audiences. Once we are clear about the design and content of the new pathways, we will consider what this means for the way we work and the processes we use. This will require input from staff at all levels of the organisation to help shape the model for the future.

15. The lease on the London office comes to an end in December 2020 and it is proposed to relocate the London staff by September 2020. This is likely to be to Stratford. No changes to the workforce will occur as a result of the move, but the implications of the transfer for existing staff will need to be considered. There are no plans for changes to the office in Manchester, in the short to medium term.

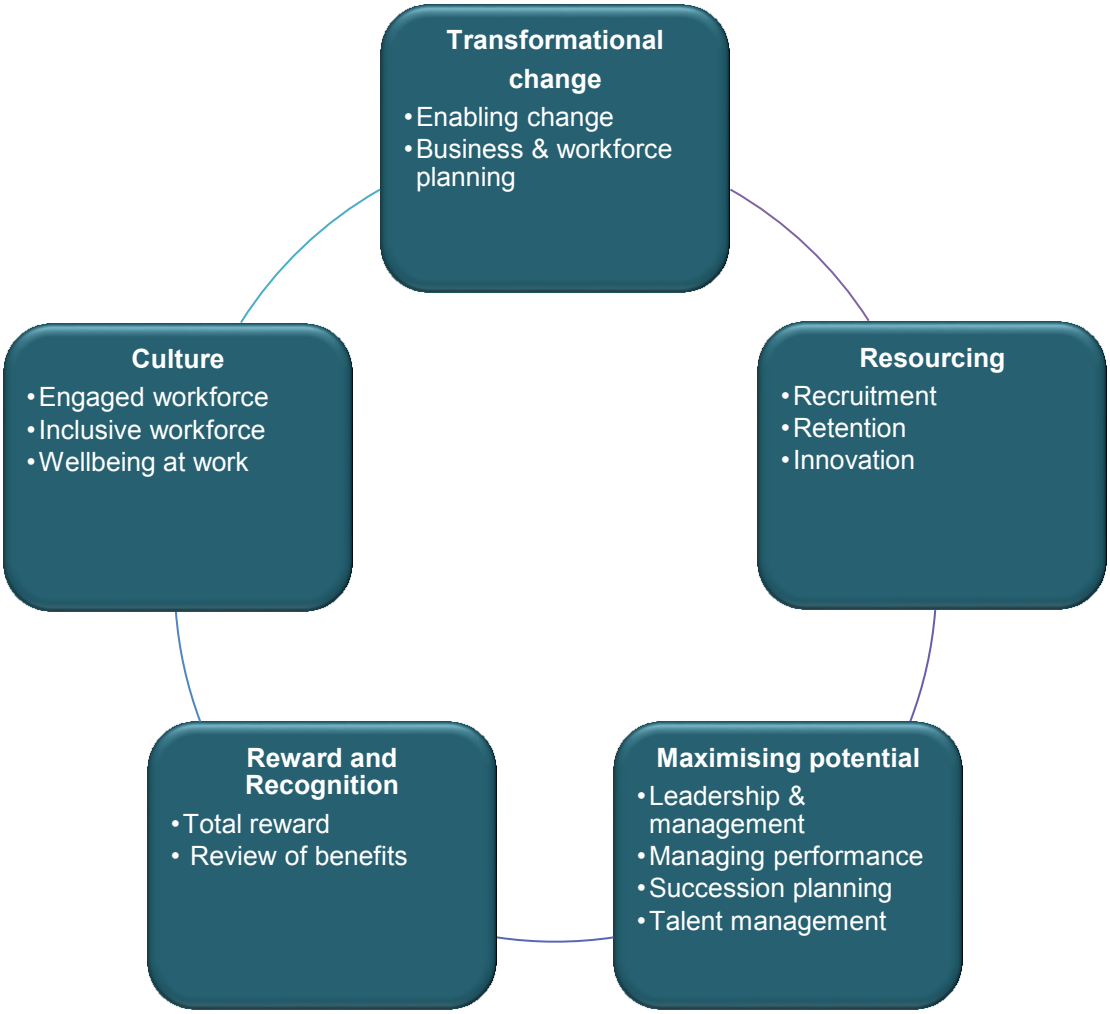
16. In the context of these strategic challenges, our workforce strategy needs to be robust enough to manage short term change but flexible enough to cope with longer term developments.

Workforce Vision

17. We want people to see NICE as an employer of first choice. Our ambition is to retain and develop a workforce which is a proud advocate of NICE's purposes and that is committed to the behaviours that underpin our success.

18. To enable this vision, our strategy is built around five key themes:

- Transformational change
- Resourcing
- Maximising potential
- Reward and recognition
- Culture



Transformational Change

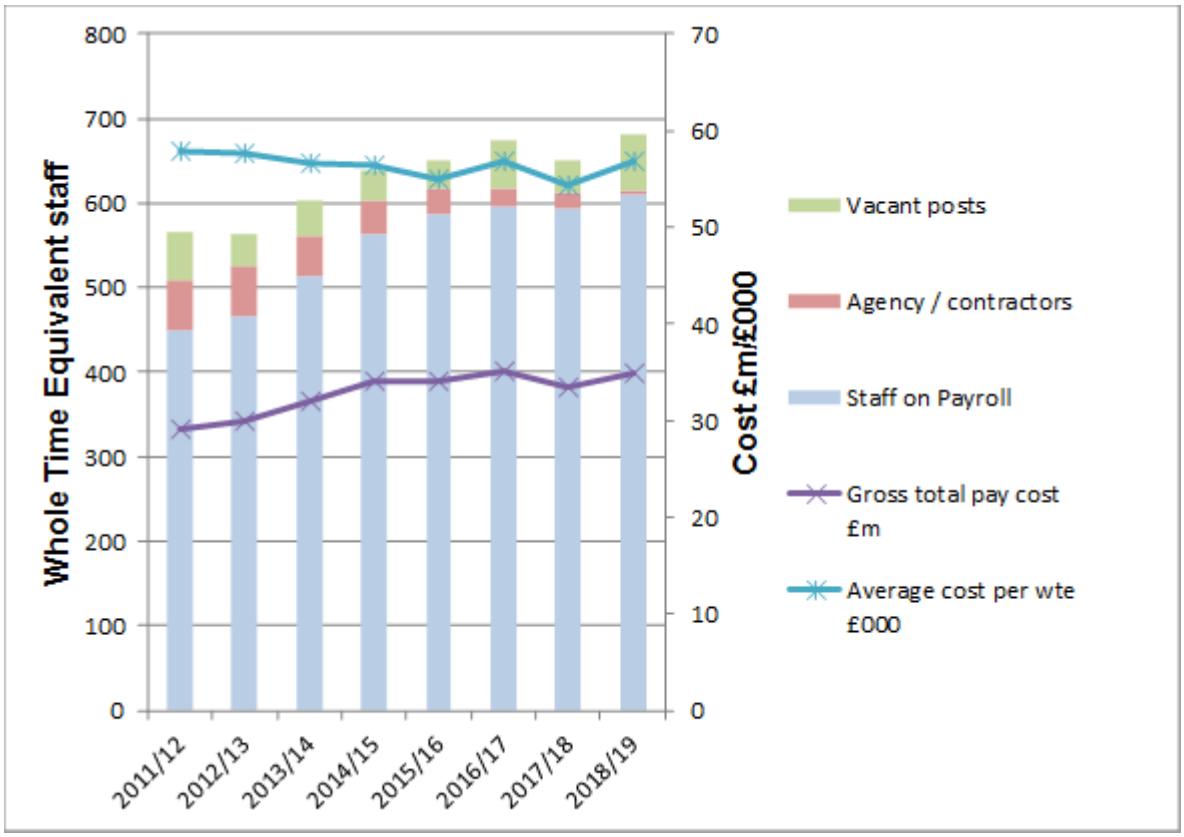
Business and Workforce Planning

19. Chart 1 shows the change, since 2011/12 in a series of metrics that describe our workforce: staff in post on the payroll, from agencies, contractors and the remaining unfilled vacancies, the total expenditure on pay in each year in £m and the average cost per whole time equivalent (wte) in £000s. The 2018/19 figures are based on current actuals projected to the end of the year.

20. The dip in headcount in 2017/18 resulted from the management of change exercises that took place in 2016 and 2017. A combination of redundancies and restricting recruitment led to a reduction in headcount in the first half of 2017/18 which lowered the average wte.

21. Wte assumptions for this year are based on the average for April – Sept 18.

Chart 1: Cost and Size of workforce



22. In the last 5 years, overall pay costs have increased by £5m and non-pay costs have dropped by £5m, illustrating most savings schemes have targeted non-pay costs. In that time, the pay budget has risen from 45% to 55% of the total budget.

23. This strategy does not attempt to anticipate the projected overall dimensions of the workforce over the next 3 years as there are too many unknowns at the moment. The working assumption is a broadly static workforce in terms of numbers, although the skill mix requirements and individual team sizes may change.

24. We also need to ensure that emphasis is given to maximising productivity through different ways of working, use of technology or other innovation which may allow managers to consider changes to existing staff resources. This will require closer attention to issues such as skill mix, not only now but for the future.

25. Another area that we will review is our approach to strategic workforce planning. This has historically been driven by the budgeting process and business planning. Our current managers have varying levels of experience of strategic workforce planning and we will therefore:

- develop a more sophisticated approach to workforce planning and ensure that it becomes a standard part of the business planning cycle;
- equip our managers with the skills to undertake effective workforce planning.

Enabling Change

26. NICE is a dynamic and constantly evolving organisation. It is likely that the nature of the change in the future is going to be different and more challenging. For the successful evolution of our organisation we need to foster a working culture that embraces change and enables it to happen efficiently. To enable us to do this we will:

- help our staff to understand the drivers of change; why change is increasingly likely in today's climate; and strategies to support themselves and their teams during periods of uncertainty;
- ensure that we have policies that enable change to happen quickly whilst ensuring that staff are treated fairly and equitably throughout;
- ensure that managers are trained to carry out changes effectively;
- in any change programme, seek to ensure that staff are engaged in the process; through effective regular communications.

Resourcing

Recruitment and talent acquisition

27. Currently, the UK employment market presents particular challenges to employers. Despite the economic uncertainty associated with Brexit there is near full employment and after many years of mostly static or real terms reduction in wages there is overall real terms growth in wages. There are roles that we have always found it difficult to recruit to but we are currently experiencing difficulty in attracting suitable applications for roles that historically we have found it easy to recruit to.

28. In April 2018 we appointed a dedicated Recruitment Specialist to review our approach to recruitment and talent acquisition. Whilst we are starting to see some improvements, we continue to face challenges to recruit the right people with the right skills in some key areas.

29. Because of the relative scarcity of the types of skill we require, it is always likely that our own workforce will be a significant source of suitable applicants and we need to do more to 'grow our own', whilst at the same time creating an external talent pipeline.

30. Recognising the future demands more flexible resourcing solutions, recruitment and talent acquisition will need to be a key focus over the coming three years and will require a step up of our resourcing efforts. We will do this by:

- using the most up to date recruitment practices, the development of our careers site and innovative approaches to finding key skills and talent;
- developing an annual workforce plan focusing on centre and directorate needs;
- developing our employer brand and value proposition to further enhance our overall recruitment standing;
- creating 'on-brand' content (video, blogs, images) that helps bring our employer brand to life and identify and create the right platforms (careers site, blogging site, You-Tube, social media channels) to present and promote our content to highly targeted audiences;
- looking to extend our advertising reach beyond the currently used (NHS jobs) with better branded targeted recruitment campaigns and more use of technology and social media, tapping into the passive job seeker market;
- taking a more proactive approach to target key audiences, engaging and developing networks with local universities and creating a platform to build a talent pipeline;
- identifying opportunities to pilot a 'graduate programme' for hard to appoint roles and continue to drive our apprentice strategy and identify ways in which usage of the apprentice levy can be maximised;
- improving the quality and presentation of recruitment materials and develop engaging materials regarding career opportunities within NICE in order to promote the wide range of jobs in the organisation;
- improving the training for managers and those sitting on recruitment panels and introducing a range of selection tools to ensure we recruit people with the right skills;
- continuing to refine and enhance recruitment processes to improve both the hiring manager and candidate experience.

Retention

31. Our staff turnover rate has been just below 10% for a number of years, which is slightly lower than most public sector employers. This level of turnover is generally considered to be reasonable and healthy. It is a rate that ensures refreshment of the talent pool without destabilising the organisation.

32. We have a good track record of retaining our staff once they have been recruited. Almost half of our current workforce has been with us for five years or more. It is important however that we monitor our turnover rates and regularly

review levels of turnover by role type and location. We will also better utilise the information gathered from exit surveys to ensure we understand why people are leaving. By feeding this intelligence into the resourcing and retention strategies we will be better placed to plan ahead for what we need and to take into account labour market trends that we have noted.

33. In developing our retention strategies we will:

- Consult employees – we will ensure wherever possible that employees have a 'voice' through consultative bodies, regular appraisals, staff surveys and grievance systems;
- Be flexible – we will continue to offer flexible working to staff wherever possible, recognising that an employee that is supported to balance their work and domestic arrangements is likely to be more committed to their employment;
- Treat people fairly – we will commit to treating staff fairly and reasonably and we will work hard to foster an environment of trust, respect and dignity at work;
- Review our current exit process – ensure we maximise the opportunity to learn from those who choose to leave.

Maximising potential

Developing our employees

34. We recognise that to achieve our organisational goals we will need appropriately competent staff who are clear about what is required of them and are engaged and motivated to do it well.

35. Career progression inside NICE, has been key area of concern in the Staff Survey and we want this strategy to help address it, by:

- reviewing the induction and on-boarding process so that employees are aware of development opportunities and how they can support their own personal development within NICE;
- using the appraisal process to have 'talent conversations' that seek to understand and manage people's career aspirations and where promotions are not feasible internally, to look for sideways moves and/or other opportunities for development;
- mapping out career paths for key roles; including exploring how we grow our own talent via apprenticeships and pilot a graduate programme for niche, hard to appoint roles;
- explore ways to share knowledge across NICE through action learning groups, cross-team project work, job shadowing and secondments;

- continuing to offer external development opportunities through sponsorship of professional qualifications, attendance at conferences, placements on external programmes such as the DHSC Policy School and the Harkness Fellowship;
- continuing to offer coaching and mentoring opportunities;
- reviewing our soft skills and first line management development opportunities.

Developing our leaders

36. The challenges we face will require excellent leadership and people management skills. To achieve the challenges ahead we will:-

- define our expectations of what is expected of a manager at NICE and ensure that we have programmes in place to develop skills and knowledge where gaps are identified;
- review our leadership development offering to ensure it remains fit for purpose and continues to meet the organisational requirements;
- continue to invest in the external leadership development programmes such as with the Health Care Leaders Scheme;
- develop a common approach to talent management and succession planning for our senior teams;
- support our leaders to build their mental agility and resilience to deal with constant change in our fast moving digital world.

Managing performance

37. Managing performance has a significant role in ensuring the successful achievement of our organisational goals. We need to make sure that our staff are clear about what is expected of them. We need to provide them with the right environment and tools to do the job and ensure that they have the skills and support to achieve their work objectives.

38. We need managers who can create the right performance environment, understanding the resources available and able to build positive relationships with individuals based on clear expectations, trust and empowerment.

39. In order to achieve this we will:-

- review and update our appraisal and performance managements tools, policies and procedures;
- develop a competency based framework that is fit for the types of roles we have against which managers can measure performance;

- provide training to line managers to enhance their confidence and capability in managing performance;
- review our induction to ensure that it is fit for purpose and serves as a solid foundation for ensuring staff get the best start in their new role;
- support line managers to better utilise the probationary period to review performance and suitability for the role;
- maximise our use of technology to reduce the administration burden for managers, increasing the number of automated processes, particularly those necessary to manage people;
- provide regular, meaningful management information to help managers make informed decisions about performance.

Reward and recognition

40. Pay costs constitute 55% of the total budget. NICE offers a comprehensive and attractive total employment package but we have not always promoted this in a consistent and coherent way to both our existing staff and our potential applicants.

41. Pay is not usually the key motivator for staff engagement and performance. Our staff survey results tell us that, generally, most people feel fairly rewarded, and we know that many of our staff value our ethos and our flexibility more than their salary. However we will:-

- ensure that we are effectively communicating the full remuneration, benefits package through the use of the total rewards statements;
- ensure we market, communicate and continue to explore and develop other non-financial rewards such as flexible working arrangements;
- review our current benefits package and explore whether we can expand that offering in areas such as buying additional leave, ensuring that they are affordable and sustainable in the long term;
- consider ways to recognise excellence and those employees going the extra mile, and consider how we celebrate and share successes.

Culture

Creating the right environment

42. We want to create a supportive working environment that enables everyone to deliver on their full potential.

43. We want our employees to feel part of the organisation's future and are invested in its success. For this to happen we need engaged staff who understand what the challenges are, what is required of them and how their contributions are valued.

44. To achieve this we will:-

- ensure that individual objectives support the organisation's business plan and help with personal development;
- ensure that line managers have the necessary skills to properly listen to, motivate and empower their staff and get the best out of them;
- ensure that employees have a voice in the organisation through regular two way discussions, team meetings, the monthly all staff meetings, updates through Your Week at NICE and other communication channels, and through engagement with staff representatives and unions;
- develop a statement of behaviours that describes how people who work at NICE engage with each other and with people outside the organisation, to create a positive and supportive working environment;
- monitor engagement scores via the employee survey.

Creating an Inclusive workforce

45. We are committed to valuing staff and the differences between individuals, and aim to create a supportive and respectful workplace environment in which all staff will be treated fairly, with equality of opportunity for all.

46. We will develop strategies and plans to support the development and sustainability of an inclusive and diverse workforce by continually self-assessing, to provide a working environment where:

- we ensure staff understand what we mean by diversity and inclusion, through training and policies;
- we showcase our commitment to diversity and inclusion to our staff, candidates and our stakeholders through initiatives such as Time to Change, Stonewall Diversity Champions and Disability Confident;
- we continue to monitor gender pay and where possible identify action plans;
- managers are accountable for their decisions and their practice aligns with the initiatives for equality and diversity with support through training;
- we continue to look for examples of best practice in other organisations and where appropriate replicate within NICE.

Well-being at work

47. NICE recognises the importance of supporting and promoting the health and well-being of its employees. Externally, we promote employee health and wellbeing through a range of guidance which have direct recommendations for employers and naturally these recommendations will form the framework for our own health and well-being strategies.

48. We will develop strategies and plans that support improved workplace health and well-being and enable staff to be productive at work, improve morale, reduce absenteeism and turnover and enhance loyalty to the organisation.

49. In line with NICE guidance we will provide a safe working environment where:-

- the SMT and Board are committed to the health and wellbeing agenda;
- good line management encourages creativity, builds supportive relationships with staff, ensures that employees are motivated to fulfil their goals and fosters a spirit of teamwork and commitment;
- employees are able to influence the wellbeing actions and provide support for initiatives;
- managers have a good awareness of mental health matters and are able to identify and respond with sensitivity to employees' emotional concerns, and symptoms of mental health problems;
- staff are supported in general health matters including increased physical activity, healthy weight management, smoking cessation and general health improvement.

Conclusion

50. We have developed this workforce strategy to articulate our vision of what needs to be done and to set out a plan for how we aim to achieve it. We will develop action plans under each of the five key areas of delivery and we will regularly update the SMT on progress against these plans.

51. We are viewing this as a dynamic process, NICE will continue to change and develop over time and so too therefore will our workforce strategies need to develop to respond to these changes. We need to view this strategy therefore and the work that will arise from it as fluid, subject to adaptation and consequently a continuous work in progress.

Decision

52. The Board is asked to review and approve the refreshed workforce strategy for 2018- 21.

November 2018

National Institute for Health and Care Excellence

Whistleblowing Policy

The Whistleblowing Policy was due for review in September 2018. The revised policy was approved by the Audit and Risk Committee on the 26th September 2018 and is presented to the Board for final sign off.

The Board is asked to approve the Whistleblowing policy.

Ben Bennett

Director, Business Planning and Resources

November 2018

Whistleblowing Policy

Introduction

1. The policy was due for review in September 2018.

2. The revised policy was developed in partnership with Unison and the Joint Consultative Committee and Senior Management Team.

3. The revised policy was reviewed and approved by the Audit and Risk Committee on 26 September 2018 and is presented to the Board for final sign off.

Background

4. The current policy was used for the first time in December 2017 and highlighted a number of areas for improvement which have been incorporated in its routine review.

5. The investigation and outcome process has been clarified in the new policy so that employees and managers accessing it are clearer on the stages in the process and how confidentiality will be handled.

6. The distinction between a complaint that should be managed using the Grievance Policy and a concern that should be managed using the Whistleblowing Policy has also been clarified.

7. The new policy is based on the NHS Improvement model policy for NHS Organisations, which was commissioned by NHS England and developed following the Francis Report. A benchmarking exercise with other ALB's indicated that this model policy is commonly used.

Decision

8. The Board is asked to note and approve the revised Whistleblowing Policy.

Whistleblowing Policy

Responsible Officer	Director of Business Planning & Resources
Author	Human Resources Team
Date effective from	
Date last amended	
Review date	

Contents

Responsibilities

Managers

1. To be familiar with the Whistleblowing policy and associated NICE Guides so that the policy is applied consistently and fairly within their area of responsibility.

2. To ensure that all concerns brought to their attention are taken seriously and handled in line with this policy

Employees

3. To ensure that they are aware of the location of the policy.

Equality Statement

4. An Equality Analysis has been carried out on this policy and can be obtained from HR.

Whistleblowing

5. NICE recognises that from time to time you may have concerns about what is happening at work. It is really important that you speak up about a concern, and are confident that we will listen. Usually these concerns are easily resolved. However, if your concern is about risk, malpractice or wrongdoing, it can be difficult to know what to do. This policy enables and supports you to raise your concerns and applies to all employees; volunteers, agency workers, and third parties.

Who should I raise my concern with?

6. If you have tried to raise your concerns informally with the appropriate manager but you still feel that the matter has not be satisfactorily addressed, or you feel the matter is very serious, you should contact the Chief Executive directly. Support is available from management, human resources or recognised trade union if you feel reporting the matter is the appropriate step to take, and if you feel you need that additional support or guidance.

7. The Chair of the Audit and Risk Committee oversees this policy. If you believe it is not appropriate to approach the Chief Executive, you have already and you still consider the matter to be unresolved, you should contact the Chair of the Audit and Risk Committee. The Chair is listed on the Board and Committees page of NICE's website and they can be contacted via the outlook address book.

What concerns can I raise under this policy?

8. Qualifying disclosures are disclosures of information where you reasonably believe that one or more of the following matters is either happening, has taken place, or is likely to happen in the future and you think the risk, malpractice or wrongdoing is harming individuals, the work we do, or service we deliver and you genuinely and reasonably believe their disclosure to be in the public interest. Examples could include:

- A criminal offence
- A breach of a legal obligation
- A miscarriage of justice
- A danger to the health and safety of any individual
- Damage to the environment
- A deliberate attempt to conceal any of the above.

9. If you are a member of a professional body e.g. Doctor, Pharmacist, Nurse etc. you may have a professional duty to report a concern in line with your professional code of conduct.

10. Your concern is probably best pursued under NICE's grievance policy if:

- You feel that you have personally been poorly treated
- You feel there has been breach of your employment rights, contract or terms and conditions
- You are seeking redress or justice for yourself
- You will probably be expected to be able to prove your case during the process

Feeling safe and confident to raise your concern

11. If in doubt, raise it. Do not wait for proof; raise it while it is still a concern. If you raise a genuine concern, you will not be at risk of losing your job or suffering any detriment (such as reprisal or victimisation). It does not matter if you turn out to be mistaken as long as you are genuinely troubled. NICE will not tolerate the harassment or victimisation of anyone raising a genuine issue. Nor will we tolerate any attempt to bully you into not raising any such concern.

12. If you raise a whistle blowing concern, and do so by following the procedure outlined in this policy, you are entitled to legal protection from detrimental treatment as a 'whistle-blower' under the Public Interest Disclosure Act 1998.

13. If you feel that you are being bullied, or subjected to harassment, because of raising a concern you should raise it under NICE's Bullying and Harassment Policy.

14. If you are not sure about which policy can help you with your particular situation or you need advice on how to proceed, contact the Human Resources team or refer to the NICE guides on the 'Raising concerns' NICE space page.

Confidentiality

15. NICE hopes that you will feel comfortable raising your concern openly, but we also appreciate that you may want to raise it confidentially. This means that while you are willing for your identity to be known to the person you report your concern to, you do not want anyone else to know your identity. Therefore, we will keep your identity confidential, if that is what you want, unless required to disclose it by law (for example, by the police). You can choose to raise your concern anonymously, without giving anyone your name, but that may make it more difficult for us to investigate thoroughly and give you feedback on the outcome, or provide you with support during the process.

16. All conversations, either informal or formal, meetings, witness statements, investigations etc, must be kept confidential by all parties involved. We appreciate that this can sometimes be difficult when working in a small team or close environment; however, so that the issue raised can be brought to a

swift conclusion and everyone feels able to move on, confidentiality must be maintained.

How should I raise my concern?

17. If you are raising your concern verbally, the person to whom the matter is reported will ask you to provide a written summary of your concern.

18. To ensure that the person you are raising the concern with knows which policy you are referring to, advise them that you believe your concern is under the whistle blowing policy. If you are unsure, you or the person you are raising the concern with can seek advice from Human resources.

19. If you wish the matter to be dealt with in confidence you should request this when you raise your concern. While the matter may be raised in confidence and while every effort will be made to maintain this, nevertheless complete confidentiality may not always be possible. If the situation arises where we are not able to resolve the concern without revealing your identity, we will discuss with you how we can proceed.

20. If you have a personal interest in the matter, you must inform the appropriate person at the time of raising your concern.

Advice and support

21. While it is hoped this policy provides the reassurance you need to raise concerns internally, we recognise there may be circumstances where you may need support, advice and guidance on raising a concern.

22. Information can be found on the Whistleblowing NICE space page, from the Human Resources department or on the NHS and Social Care Whistleblowing helpline, on 08000 724725 or https://speakup.direct/ which provides:

- The Free confidential advice to NHS/social care employees that witness wrong doing and are unsure whether or how to raise their concern.
- Advice and support to managers or those responsible for policy development and best practice.

- Advice on how to respond to whistle blowing concerns that have been raised.

23. The Employee Assistance Programme is a telephone based resource, offering you confidential information available 24 hours a day, 365 days a year. This service provides specialist information and counselling services including finance, emotional issues, and law, education, health, work and family matters. Information on how to access this service is available on NICE space.

Investigating concerns

24. Where you have been unable to resolve the matter quickly and informally with your manager, we will initially assess what action should be taken. This may involve an informal review by the appropriate manager or a proportionate formal investigation by someone independent to the concern you are raising. We will tell you who is handling the matter, how you can contact them and whether your further assistance may be needed.

25. We may decide that your concern would be better looked at under another process; for example, our process for dealing with bullying and harassment. If so, we will discuss that with you.

26. You may, if you wish, be accompanied by a recognised trade union representative or work colleague at any meeting you attend to discuss the concern.

Feedback

27. We will provide you with updates on the progress of the investigation into your concern. While the purpose of this policy is to enable us to investigate possible malpractice and take appropriate steps to deal with it, we will give you as much feedback as we properly can. If requested, we will confirm our response in writing. However, we may not be able to tell you any precise action taken where this would infringe our duty of confidence to someone else.

If a matter is raised about you

28. If somebody raises a concern that may involve you, you will be asked to participate openly and honestly in any initial fact-finding or formal investigation. In some circumstances, if the person raising the concern does not wish their identity to be revealed, you must respect their decision. Should they be required to reveal their identity for example for legal reasons, full discussions will take place with that individual and with you to ensure confidentiality is maintained.

29. Sometimes, we receive concerns anonymously. This is discouraged for the reason outlined above; however, we would ask that you participate in any fact-finding or formal investigation in the normal way.

30. If a concern is made against you, we will ensure that you are treated with dignity and respect, and ensure that you receive the necessary support.

Learning from your concern

31. The focus of any investigation will be on improving the service we provide and work we do. Where an investigation takes place, a report with recommendations will be produced. Where it identifies improvements that can be made, these will be owned by the appropriate Director and will be tracked to ensure necessary changes are made, and are working effectively. The Director will provide regular updates to the Board as to how any recommendations are being implemented. Lessons will be shared with teams across the organisation, or more widely if appropriate.

32. The Audit Committee will be given high level information about all concerns raised by our employees through this policy and what we are doing to address any problems.

National Institute for Health and Care Excellence

NICE Pathways

This paper is designed to provide the Board with an overview of the pathways project, focussing on the initial pilot phase. It builds on earlier discussions with the Board about how we will take forward the work, and asks the Board for formal approval.

The Board is asked to approve the pilot.

Professor Gillian Leng

Deputy Chief Executive and Director, Health and Social Care Directorate

November 2018

Initiating the Pathways pilot

Introduction

1. At the NICE board meeting in July 2018, an initial vision for NICE's future way of working was discussed and agreed: "Our work will be driven by pathways that reflect the way prevention, treatment and care are organised and delivered. These pathways will be the way we prepare and present advice to our users on effectiveness, safety and value for money. The pathways will enable links to be made across topics and within topics, and allow users to access underpinning evidence and practical support".

2. This vision will build on our existing experience with pathways, and the guidance development project. It will take into account user feedback about the need to be able to access information from NICE more quickly, and build in ongoing feedback.

3. The aim of this paper is to provide the board with more information about the rationale for change and detail of the pathways pilot, to seek formal approval to take this forward.

Rationale for change

4. NICE has 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.

5. This feedback tells us that our work is highly valued by the majority of the stakeholders and that our guidance is seen by many as the gold standard. However we have been able to identify a number of common and interrelated themes across stakeholder groups that indicate we can do better in certain areas. These views have informed the ideas behind the pathways pilot.

6. The main themes that have emerged from stakeholder feedback are that our products need to be more accessible, and presented and structured in a way that makes them easier to use.

Accessibility

7. Difficulty in finding guidance and other products on the website is a recurring theme coming up in nearly every engagement we have with our stakeholders. 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 clunky and difficult to navigate.

8. The extensive number of products offered by NICE is a theme often reported from the Field Team's engagement with stakeholders. The amount of different products (guidelines, quality standards, evidence summaries) all on the same topic mean that people are unsure how the products relate to each other and what they should do with each one.

9. 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 used directly in clinical systems, with no or minimal translation.

Structure and presentation of guidance and advice products

10. Many stakeholders tell us that our recommendations are more easily understood when presented in a multi-layered approach rather than in a traditional block of text. We also receive many enquiries about sequencing - how our guidance connects together. We have numerous examples of questions around how technology appraisals fit together, and also how they are used in different clinical situations.

11. Users generally like the concept of 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.

12. 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.

13. 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 algorithm versions of NICE guidelines because they find the guidelines too difficult to follow and need to simplify them for local use.

Maintaining the currency of our advice

14. In addition to the feedback from users about the design and presentation of our advice and guidance, we are also aware that we have limited 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.

Phases of work

15. The project will be split into several phases, beginning with a pilot to test the proof of concept, and ending with a transformation phase where NICE's work is all reconfigured into the new presentation and we will reorganise the way we work if needed.

The pilot phase

16. The principal aim of the pilot is to generate a 'proof of concept' pathway and test the approach with end users. We need to be confident that our vision for a pathway approach has the support of our users and commissioners before taking it forward. As part of this process, we need to determine if and how existing NICE outputs can be integrated into the scope of the pathway content, how a new committee will sequence drugs and other technologies within the pathway, and test the approach for generating and updating recommendations.

17. During this phase, we will refine and prioritise the objectives and expected benefits of the pathways vision. We will test the proof of concept against these.

Product design and digital development phase

17. If the feedback from the proof of concept is positive, the aim of this phase will be to design the digital product to deliver the pathways concept developed in the pilot phase. We will adopt a user-needs driven methodology to produce the digital architecture that will support the future pathways product.

18. An associated strand of work will determine the impact of the new pathways product on the NICE website as a whole. This may entail having a separate corporate website, or microsite, and a separate interface to manage stakeholder engagement and run consultations. We will also need a system for listing drug and medical technology (medtech) guidance, with links to underpinning information.

19. This work will be led by the digital services team, in partnership with the NICE communications team and inform the wider work on the process review.

Process review and organisational design phase

20. The aim of this phase is to determine what changes we need to make in our internal processes to take forward this work, and to plan for any organisational development required as a result. This phase will link closely with the digital work, and will be crucial to ensuring we can deliver the required internal benefits.

21. It is likely that the approach to developing the new pathways output will be different from the current model of working within NICE. This strand of the project will therefore be crucial to ensure we are clear about future requirements, and to help us transition from the current way of working. It will need to address the following:

- Current capacity within NICE and within our external guideline centres, including skills and resources, and how teams currently work.
- An estimate of the skills and resources needed for the future, including how the teams might best be configured. This will need to include a gap analysis and strategic workforce plan showing what training might be required and where we might have new requirements.
- What changes to our existing processes are required, and whether any manuals require updating and consultation with stakeholders. This might include our approach to surveillance of new research and new data, and the way we manage our committees.
- Alignment with other ongoing transformation programmes within NICE, including the Centre for Health Technology Evaluation 2020 project, and the health data analytics initiative.
- A plan for transitioning to the new way of working, including support for management of change if required.

Transformation phase

22. The aim of this phase is to roll out and implement new ways of working, and to convert agreed elements of our back catalogue to the new product.

23. This phase will require careful planning and support to transition the organisation from one way of working to another, including from HR and the digital team. Ideally it would happen in phases, perhaps with the construction of pathways as the first priority to create a visual output for the end user. The detail will be worked out in the process review and design phase.

Detail of the pilot phase

Overall approach to building the proof of concept

24. The overall approach to developing the proof of concept will be an iterative one, in which we gradually build up an understanding of a pathway content in conjunction with stakeholders and end users. We will develop a range of visuals which will capture the scope and level of detail of the content, and visualise specific components such as the drug sequencing algorithms. These visuals will be used to test the concept with users and stakeholders.

25. Type II diabetes has been selected as the pilot topic as it represents a broad pathway, covering prevention, treatment and care, and because it is a priority area for the NHS. There is a range of underpinning guidelines that are at least 2 years since publication, meaning some updating may be required, and there are many related medtech and technology appraisal outputs to position in the pathway.

26. A Pathways Advisory Committee is being established to inform the development of the pathways approach, including the visuals, and to determine how such advisory committees should operate in the future. This will include understanding the implications for our future processes of producing advice that is directly integrated into the pathways presentation. The first meeting of the committee is scheduled for the end of November, with subsequent meetings on a monthly basis. Terms of reference for the Pathways Committee are given in the appendix, including detail of the issues they will be addressing.

27. Staff and stakeholders are being involved at all stages of the pilot work, so they have the opportunity to shape the future solution.

28. The proof of concept visuals need to provide enough of the vision for audiences to understand future aims and functionality of the new approach, but it won't be a complete product. The digital services team will support the visualisation of the concept with interactive displays where suitable.

29. The proof of concept process will help prepare for the Government Digital Service (GDS) assessment, which will be required in the product design and digital development phase.

Stakeholders and audience engagement in the pilot phase

30. Our stakeholders are well known to us and have always played an important role in our work. We have tended to categorise stakeholders in the following way, and we will engage with all of these groups during the pilot:

- People who use our guidance - health and care professionals but also the public, patients and carers, who are not typically a key targeted stakeholder group although our guidance and advice are ultimately for their benefit. Health and care professionals have traditionally been the main channel through which the public learn about and benefit from our work.

- Organisations who fund our guidance – commissioners, managers, providers (CCGs, DHSC, NHSE, NHSI), influencers, regulators and partners such as Royal Colleges, PHE, HEE, CQC, and industry (ABPI, ABHI). There is also an important group, in the context of the pilot, of 'digital stakeholders', particularly those who provide online decision support systems for clinicians.

31. We will gather views from our users throughout the pilot project via our insights and user engagement teams.

32. For regular engagement with selected stakeholders, we are establishing an External Reference Group. This group will provide feedback and specialist input into the proof of concept, and will hopefully act as advocates of the project in the longer term. We will also meet regularly with clinical system providers, initially as part of the External Reference Group, and then in more detail as required.

Key questions for the pilot phase

34. By the end of the pilot phase, there are a number of questions we will need to have answered before taking forward the project.

Questions for people who use our guidance

35. With our core audiences, we will explain and illustrate the scope of pathways and how it is different. The most important overarching question for our users will be whether the pathways approach is a better way for NICE to deliver the advice they need.

36. There will be some more specific questions related to the amount of detail required, and the need to provide key features of information, such as levels of evidence, new or updated recommendations, and where funding requirements are in place. We will test whether the general style, approach and level of detail in the pathways material resonates with them.

Questions for organisation who fund our guidance

36. By the end of the pilot phase, we will need to confirm that our commissioners (DHSC and NHS England) are content with the following changes listed below. If not, do any of the products, in addition to technology appraisals, need to be retained as stand alone? It is likely that we will propose:

- Technology evaluation outputs (including medtech) have specific individual documentation, as now, but with the products also sequenced in the pathway and listed separately

- Guidelines presented are only available as pathways, and will be routinely and rapidly updated. Any new topics will therefore be referred as pathways
- Other advisory products will all be contained within the pathway, including resource impact statements, shared decision aids and shared learning.

37. Through engagement with clinical system providers, we also need to be clear about how the NICE product needs to link to external systems. It is never possible to be completely 'future proof', but we need to take into account future requirements as far as possible.

Resource requirements

Staff time

38. The project is being overseen by a steering group, with membership from senior staff across NICE. The pilot also has support from a core team led by Gillian Leng with support from the Programme Director for service transformation and a senior pharmacist. Also part of the core team will be a programme manager, a clinical fellow, and senior HR and finance team members. They will be supported by a guideline development team from the Centre for Guidelines, re-allocated to work on the pathways work. User-engagement and editorial resources will also be allocated. Other teams may be involved in specific tasks. Key elements of the work will include:

    - Servicing the committee, including providing papers, arranging meetings and organising expenses.
    - Documenting the outline pathway as described by the committee and considering how information should be structured, for consideration with our audiences
    - Suggesting information from existing NICE products to be included in the outline pathway for consideration by the committee
    - Providing information on NICE recommended drugs and technologies for sequencing and inclusion in the pathway
    - Providing information on new evidence and potential technologies for consideration by the committee, with a view to potential updating and/or new guidance development
    - Pulling all the information together and preparing information for sign off.

Financial considerations

39. Underspend for 2018/19 is being used to employ a programme manager, which will need to carry on into the next financial year. Underspend is also being used for background digital development work, and for editorial support.

40. Internal staff have been identified across all work programmes to support the pilot work, which means that some areas of work for 2019/20 may have to be deprioritised to ensure we have sufficient capacity for the pilot. This is being considered as part of the business planning cycle, and any opportunity costs will be brought to the board for discussion. This includes the release of one slot in the guidelines programme. Indicative costs are included in the table below.

	2018/19	2019/20
Internal staff time (opportunity costs of stopping activity)	£0	£0.6-1.0m
Additional resource (includes a programme manager, external consultancy for org design and additional staff)	£0.25m	£0.6-1.1m
Digital design	£0	£1.5m
	2018/19	**2019/20**

Timeline for completion of the pilot

41. The following table provides a high level timeline for the pilot project.

Plans presented to the Board at the November meeting for approval	November 2018
Presentation of aims to key stakeholders to identify any significant issues	November 2018
Pathways Committee holds first meeting to produce an outline pathway	November 2018
Proof of concept visuals available for review by Committee	March 2019
Investment in making the visuals more interactive may start, if appropriate	March 2019
Proof of concept review by SMT and Board	April 2019

Proof of concept visuals launched and available for audience review, to explain the scope of pathways and how it is different	NICE conference 2019
User engagement and stakeholder feedback continue as the product design phase starts in earnest	June – Sept 2019
Report produced to scope the digital product design and development phase, to feed into business planning for 2020/21.	September 2019

Appendix: Pathways pilot committee terms of reference

General

1. The committee will operate as an advisory committee to NICE's Board for the purposes of determining a new approach to our work.

2. The committee will advise NICE on how best to achieve NICE's vision that: 'Our work will be driven by pathways that reflect the way prevention, treatment and care are organised and delivered. These pathways will be the way we prepare and present advice to our users on effectiveness, safety and value for money. The pathways will enable links to be made across topics and within topics, and allow users to access underpinning evidence and practical support'.

3. The committee will advise NICE on:

- an 'end to end' pathway for diabetes, beginning with prevention and symptom recognition, and concluding with end of life as appropriate
- how to include other conditions commonly associated with diabetes (multimorbidities) into the pathway
- some new pathway content, and also how the pathway output will be used in practice
- whether and how relevant information from all existing NICE products should be embedded into the pathway
- the sequence in the pathway of all approved drugs, therapies and medtech, on an ongoing basis
- identification of preference sensitive decision points to aid shared decision making
- how to factor in case finding and possible demand on services
- surveillance of new evidence, including consideration of new medical technologies
- development of review questions to fill key gaps in the pathway
- how to identify best practice in areas where research evidence is absent, weak or equivocal, including through analysis of real world data
- the effectiveness, and cost effectiveness of interventions, actions and measures to improve the health and social care of the public, resulting in the update of published guideline recommendations in areas where there is new evidence
- whether technology recommendations in the pathway should be updated

- opportunities and challenges that may be faced in implementing the recommendations that might require additional resources or implementation efforts at a local level
- new topics that should be included in the pathway
- the establishment of new processes and methods to embed new ways of working
- the place of new and updated recommendations within published NICE guidance, to ensure implementation.

4. The committee will throughout pathway development and maintenance:

- develop a pathway for the relevant audiences in accordance with the agreed vision
- provide feedback on the prototype pathway visuals
- submit its recommendations to NICE's Guidance Executive, which will have powers delegated by the Board to consider and approve the pathway and any new recommendations
- be accountable to the NICE director (or delegated senior member of the NICE team) responsible for the pathway
- be collectively responsible for the pathway and any new recommendations
- acknowledge that the intellectual property of content arising from the pathway development process belongs to NICE
- follow NICE's equality policy and take account of socioeconomic factors and their influence on health and ill health
- adhere to NICE's principles on social value judgements.

5. Individual committee members will:

- declare all relevant interests, sign a declaration of interest form and inform NICE of any additions or changes to declared interests throughout the development process, in accordance with the declaration of interests policy for NICE advisory committees
- sign a confidentiality agreement with NICE relating to any information designated confidential by NICE, such as academic or commercial-in-confidence material or sensitive personal data.

Membership

6. Committee members will be appointed by NICE, and committee membership will reflect both the spread of interests and expertise required for the business of the committee and NICE's values of equality and diversity.

7. The chair and members of the committee will be selected to draw on appropriate expertise for the purposes of the pilot. On completion of the pilot, any new committees established to embed the work into practice will be appointed in accordance with NICE's policy on recruitment and selection to advisory bodies.

8. Committee members will be drawn from the NHS, local government, the academic community and other areas, as appropriate, as agreed by NICE staff with responsibility for the programme. They will include practitioners, commissioners and providers, people using services, their family members and carers, and advocates, and members from relevant industries.

9. The committee will have a minimum of 7 voting members with additional members agreed on a topic-by-topic basis according to need. The committee will have a chair. All committee members are selected for their expertise and not as representatives of their organisations.

10. Expert witnesses may be invited to attend and advise the committee on specific topics and can be drawn from a wide range of areas as appropriate. They are invited to present their evidence in the form of expert testimony and are asked to provide a written paper, or to agree a summary of their evidence recorded by NICE staff. They also help the committee to consider and interpret the evidence, but they are not members of the committee so they should not be involved in the final decisions or influence the wording of the recommendations. Expert witnesses have no voting rights and do not count towards the quorum.

AUDIT & RISK COMMITTEE

Unconfirmed minutes of the meeting held on 26 September 2018 at the NICE London Office

Present

Dr Rima Makarem	Non-Executive Director (Chair)
Professor Sheena Asthana	Non-Executive Director
Professor Tim Irish	Non-Executive Director (by telephone)

In attendance

Andrew Dillon	Chief Executive
Gill Leng	Deputy Chief Executive (item 5.2)
Ben Bennett	Director - Business Planning and Resources
Meindert Boysen	Director - Centre for Health Technology Evaluation
David Coombs	Associate Director - Corporate Office
Barney Wilkinson	Associate Director - Procurement & IT
Catherine Wilkinson	Associate Director - Finance & Estates
Jane Lynn	Senior Financial Accountant
Elaine Repton	Governance Manager: risk assurance (minutes)
Andrew Jackson	National Audit Office
Andrew Ferguson	National Audit Office
Niki Parker	Government Internal Audit Agency
David Wright	DHSC, NICE Sponsor Team

Apologies for absence

1. Apologies for absence were received from Elaine Inglesby-Burke and Jane Newton.

Declarations of interest

2. Rima Makarem declared that she will be a Non-Executive Director and Chair of the Audit Committee at the House of Commons Commission from 1 October 2018.

Minutes of the last meeting

3. The minutes of the meeting held on 20 June 2018 were agreed as a correct record.

Action Log

4. The Committee reviewed the action log noting that most actions were now completed with the exception of two reports to be presented to the Committee in November (business continuity planning and cyber security). The date for the internal audit review of the NICE Foundation preparations will be confirmed

once there is greater clarity on the DHSC's position on the proposal to establish the Foundation.

RISK MANAGEMENT

5. The Committee reviewed the strategic and business risk registers, noting the updated mitigating controls and future planned actions.

Strategic risks 2018-20

6. The Committee members commented that they felt the strategic objectives could be better connected.

7. It was queried whether risk 2 was too biased towards NICE's investment in health technologies and failed to sufficiently recognise the health and social care sector, in line with the Government's policy challenges. It was suggested that there could be a better balance of NICE's strategic ambitions with more emphasis on health and social care.

8. The Committee also suggested that the mitigations in risks 1 and 5 be amended to make the distinction that risk 1 relates to engaging with national partners in support of NHS England's 10 year plan, whilst risk 5 relates to NICE's role in supporting the life sciences industry and the Accelerated Access Review. The Committee felt this clarity would be helpful.

ACTION: AD

Business risks 2018/19

9. The Committee commented that it was not clear for some risks how the target scores will be achieved, and by when. It was requested that those risks which were light on future actions be re-visited and dates included where specific action is planned. It was accepted that some risks will always exist and therefore will never be closed and as such will continue to be monitored.

ACTION: SMT / ER

10. The Committee sought assurance that NICE had not become complacent by working with the same external academic centres and partners without properly quality checking outputs and continually testing the market. Barney Wilkinson confirmed that contracts were evenly spread across a number of centres and highlighted that performance monitoring, assessing quality assurance and reviewing value for money, were key responsibilities of contract managers.

11. Subject to the request for additional actions to be included to reach target scores, the business risk register was noted. The recommended removal of three risks and inclusion of two new risks was agreed.

WHISTLEBLOWING

Whistleblowing policy

12. Ben Bennett presented a revised whistleblowing policy for approval, highlighting the sections that had been updated. The revised version provided

clarity on the investigation and outcome process, the legal protection available to whistle blowers, and a distinction between using the whistleblowing policy as opposed to the grievance policy.

13. The Committee asked how the policy would be cascaded to all staff. Ben Bennett explained the various communication channels which the HR Team would use to ensure maximum staff awareness.

14. The revised whistleblowing policy was agreed.

Report on whistleblowing case

15. Gill Leng joined the meeting to present the report on the whistleblowing case explaining the background to the complaint, which she subsequently investigated in late 2017/early 2018. The allegations, the process followed, conclusions reached and actions agreed from the case were discussed in detail, including how the whistle blower was treated during and after the investigation process.

16. It was queried whether action could have been taken earlier to prevent the complaint escalating as it did. The Officers accepted that the individual's concerns should have been escalated earlier and that this was a key learning point from the case.

17. The Committee discussed the need for an open culture at NICE in which staff feel empowered to raise concerns and feel confident that they will be listened to. This avoids issues escalating into a formal process. Gill Leng gave assurance that there were various opportunities for staff to give feedback through the staff survey, the Chief Executive's all staff meetings and weekly communications updates. Other initiatives were discussed for SMT to consider such as a designated feedback email inbox and a communications campaign for a "speak up week". It was noted that the new HR Workforce Strategy, due to be presented to the Board in November, could be used to address any organisational cultural issues and ensure staff are comfortable raising concerns.

18. The Committee queried why so many people involved in the management of the External Assessment Centre (EAC) contracts were unaware of the issues that the complainant raised. It was accepted that the case had highlighted the need to strengthen contract management skills to ensure responsibility for performance monitoring, oversight of contract delivery and VFM indicators, were clear. It was noted that the Senior Management Team has discussed this and the other recommendations from the investigation.

19. In relation to future contract management, the Committee asked whether a regular performance report should be reviewed by SMT, and if there were plans to train staff in contract management skills. It was confirmed that the SMT does receive regular updates on the performance of NICE's largest contracts. In terms of staff training and continuous learning, it was noted that consideration was being given to inviting the more experienced programme directors to share their knowledge with other teams.

20. The report on the whistle blowing case was noted.

EAC contract management

21. Following on from the preceding agenda item, Meindert Boysen explained the structure and future management responsibilities of the new EAC contracts which have been developed jointly with finance and procurement colleagues following the issues raised by the whistle blowing case.

22. The Committee sought clarification of the process for allocating work between the EACs and how quality, performance and VFM would be monitored. It was noted that a new EAC Operations Group had been constituted with responsibility for the governance and oversight of contract management, including the allocation of work, the quality of outputs, expenditure and budget performance.

23. The report was noted.

INTERNAL AUDIT

Update report

24. The Committee noted progress against the internal audit plan for 2018/19. One review has been completed in quarter 2 with two reviews planned for quarter 3.

Non-staff expenses review

25. Niki Parker presented the findings of the internal audit review of non-staff expenses which received a moderate assurance level and made eight recommendations for improvement.

26. The Committee discussed the reasons for non-compliance with the policy and the rationale for the finance team checking 100% of claim forms before processing payments, despite two previous checks having been completed within the project teams. Catherine Wilkinson explained that the error rate was high therefore it was easier for her team to check claim forms rather than process payments and then have to try to recover the money from individuals if mistakes are subsequently identified.

27. The audit had established that there was not a common understanding of how the policy should be applied and that different teams had adopted their own approach. There was also an element of staff feeling they needed to keep committee members 'happy', and sometimes processed claims that were not fully compliant with the policy. The Committee agreed that compliance with the policy was essential and that senior managers should ensure their teams are adequately trained to apply the policy rigorously. It was suggested that SMT should consider monitoring compliance by way of a simple performance dashboard. Consideration might also be given to linking the policy to the disciplinary policy, if non-compliance continues.

ACTION: SMT

28. The Committee noted that a revised non-staff reimbursement policy had recently been launched and that the Finance and Public Involvement Teams were supporting project teams and lay members by providing guidance and assistance where needed. Additionally, the policy roll out would be enhanced by senior management support within teams. The audit recommendations were accepted.

29. The internal audit report was noted.

EXTERNAL AUDIT

Update report

30. Andrew Jackson confirmed that the certification of NICE's 2017/18 financial statements were completed in timescale, without issue and subsequently signed by the Comptroller & Auditor General.

31. The Committee were advised of the NAO's decision to contract out the detailed work of the financial audit of the NICE accounts to EY, one of its framework contractors. Andrew Jackson and Andrew Ferguson would continue to support the Committee and attend future meetings.

32. The Chair requested that the Committee receives a report in November on the impact of IFRS 9 and 15 on this year's accounts, as well as next year's implementation of IFRS 16 (Leases), and how they will be dealt with in the year end statements. Catherine Wilkinson agreed to include a section in the next financial accounting report.

ACTION: CW

CONTRACTS & IT

Waivers report

33. The Committee noted the schedule of contract waivers that had been approved since 1 April 2018. Barney Wilkinson drew attention to contract reference 1215, (HealthTech Connect), advising that a further contract waiver will be reported in November following NHS England's request for further work to be undertaken on the software to comply with GDPR.

34. The waivers report was noted.

FINANCE

Financial accounting performance

35. Catherine Wilkinson presented the financial accounting performance report as at 30 August 2018. The Committee noted the positive performance in most areas, with the exception of payments receivable from NHS England (NHSE), which were still being delayed due to NHSE failing to provide purchase order numbers. The position will continue to be monitored and the Committee will be updated at each meeting.

36. The financial accounting performance report was noted.

CORPORATE OFFICE

Use of the NICE Seal

37. The NICE seal had not been used since the last meeting.

Annual complaints report 2017/18

38. The Committee reviewed the annual complaints report for 2017/18 noting that six complaints were considered under the general complaints policy. No complaints have been escalated to the Parliamentary and Health Service Ombudsman.

39. The report was noted.

Internal audit recommendations log

40. The Committee noted progress against internal audit actions that had passed their original implementation date, and those which were now recommended for closure. The one high level recommendation outstanding regarding signed contracts of employment, was expected to be completed by December 2018.

Committee annual plan 2018/19

41. The Committee noted its annual plan for 2018/19.

42. The NAO requested that submission of their audit planning report be moved to January 2019.

ACTION: ER

OTHER BUSINESS

43. There were no further items of business raised.

FUTURE MEETING DATES

44. The Committee confirmed its meetings in 2018/19 would take place on:

- 28 November 2018
- 12 December 2018 (NEDs training session)
- 23 January 2019 (at 10.00am)
- 24 April 2019
- 19 June 2019 (at 9.30am)
- 4 September 2019

The Chair declared the meeting closed at 4.25 pm.

National Institute for Health and Care Excellence

NICE Charter

This report gives details of proposed updates for the NICE Charter.

The Board is asked to consider the updated NICE Charter detailed in Annex 1, and to approve the newly updated version for publication on the NICE website.

Jane Gizbert

Director, Communications

November 2018

Introduction

1. The NICE Charter was first published on the NICE website in 2013. NICE was asked by the Department of Health to produce a Charter document which outlines in simple terms who we are, what we do and how we work.

2. The Department of Health requested that the Charter should be updated every three years, and as such it was updated and approved by the Board in November 2016.

3. At that time, the Board requested to review the Charter on an annual basis.

Proposed updates and changes to the NICE Charter for 2018

4. An updated version of the NICE Charter can be seen in Annex 1 of this paper. Changes being suggested to the Charter for 2018 are:

    - The addition of a reference to our Medtech Innovation Briefings (paragraph 4)
    - The removal of references to our smartphone apps, in advance of their forthcoming retirement (paragraphs 10 and 42)
    - The updating of paragraph 15 to reflect language used in the Health and Social Care Act to describe how NICE recommendations reflect the broad balance between the benefits and costs of health and social care provision in England
    - A short paragraph on the citizens' council has been replaced with a reference to the new NICE principles, which are about to go out to public consultation
    - An additional paragraph inserted in the section on "How our guidance is used" to explain the work NICE undertakes to measure the uptake and impact of our guidance (paragraph 39)
    - Details about our different digital channels moved from the 'Who we are and what we do' section into the 'Access to our guidance' section for consistency (paragraph 42)
    - Updating the name of the Department of Health and Social Care throughout
    - Adding new points to the section on 'Working with healthcare industries' to cover: the new HealthTech Connect service (paragraph 29); our work with the Accelerated Access Collaborative (paragraph 31); and our work with NHS England on the Cancer Drugs Fund (paragraph 34).

5. The current version of the Charter, published in 2017, is available on the NICE website at www.nice.org.uk/about/who-we-are or on request.

Decision

6. The Board is asked to consider the updated Charter and approve for publication on the NICE website.

National Institute for Health and Care Excellence

November 2018.

Annex 1: the NICE Charter incorporating all updates for 2018

NICE Charter 2018

Who we are and what we do

1. The National Institute for Health and Care Excellence (NICE) is the independent organisation responsible for providing evidence-based guidance on health and social care. NICE guidance, standards and other resources help health, public health and social care professionals deliver the best possible care within the resources available.

2. NICE is at the heart of the health and social care system. We work closely with local and national organisations including NHS England, the Care Quality Commission, Public Health England, NHS Improvement, and Health Education England. Together we encourage and support a quality- and safety-focused approach, in which commissioners and providers use NICE guidance and other NICE-accredited sources to improve outcomes.

3. NICE guidelines make evidence-based recommendations on a wide range of topics in health, public health and social care. Our guidelines recommend the most effective ways to: prevent and manage specific conditions; to improve health and manage medicines in different settings; to provide social care to adults and children; to plan services and interventions to improve the health of communities; and to provide integrated health and social care services that meet the needs of patients and people who use services.

4. Our recommendations about the use of new medicines, medical technologies and diagnostics identify the most clinically- and cost-effective treatments available. We work openly and transparently with the pharmaceutical and medical technology industries to evaluate their products, facilitating access to the NHS market for those products which are found to offer the best value for patients, and making a clear case for their adoption in the NHS. We also prepare advice on new heath technologies in Medtech Innovation Briefings.

5. NICE quality standards are a key component of the drive to develop an outcomes-based approach to improving quality and consistency of care. They identify priority areas for quality improvement, and contain a set of statements and measures to enable organisations to assess the quality of care they are providing or commissioning.

6. Our quality standards, along with other NICE products, underpin the menu of indicators that NICE produces each year. NICE Indicators are used nationally and locally to help the NHS to measure the delivery of safe, effective, and cost-effective care and services. NICE indicators measure the quality of care a person receives and the impact it has on their health – and they focus on where improvements can be made. The NICE indicator menu comprises both

indicators for Clinical Commissioning Groups and indicators for general practice.

7. Our support for organisations committed to improving the quality of care is accompanied by a responsibility to ensure careful and targeted use of finite resources. NICE enables the NHS, local government and social care providers make the best use of resources by setting out the case for investment and disinvestment through our guidance programmes and other advice. Our position is to work with system partners to realise the benefits of appropriate care and spending on the right things. This includes identifying specific recommendations that can save money, to enable conversations at a patient and population level on appropriate treatments and interventions.

8. All of our guidance, quality standards and other advice products are independent and authoritative. They are based on the best available evidence and set out the best ways to prevent, diagnose and treat disease and ill health, promote healthy living, and care for vulnerable people.

9. We are committed to an environmentally sustainable health and care system. We continue to seek ways to support commissioners and providers to assess and reduce the environmental impact of implementing NICE's recommendations.

10. Our guidance, advice and quality standards are made available in a variety of formats to ensure they are easily accessible to users through the NICE website and NICE Pathways.

11. Our online NICE Evidence service provides a portal for easy access to evidence, accredited guidance and other products in health and social care. We commission evidence-based resources such as the British National Formulary on behalf of the health service, which can be accessed digitally from NICE Evidence via the NICE website.

12. Our guidance and other products are for the NHS, local authorities, social care organisations, charities and anyone with a responsibility for commissioning or providing healthcare, public health or social care services. Following our recommendations can help these organisations to reduce variations in practice across the country.

13. NICE is committed to operating within the budget available to us through securing income opportunities, finding cost improvements and by effectively managing our resources.

How we work

14. We are internationally recognised for the rigorous processes we use to produce our recommendations and for the quality and accuracy of our products. All NICE guidance, quality standards and other products are developed to a high standard, as close as possible to the point at which it is

needed, in accordance with a set of core principles that underpin all of our work:

Evidence

15. All NICE recommendations are based on the best available evidence of what works, in terms of the broad balance between the benefits and costs of the provision of care services or of social care in England. We conduct and commission comprehensive reviews, drawing on published literature, to ensure that our advice is based on the most up-to-date evidence available.

Expert input

16. Every piece of NICE guidance and every quality standard is developed by an independent committee of experts, which includes lay members and representatives from clinical practice, public health, social care and where appropriate, from industry.

Public involvement

17. All of our committees include at least two lay members: patients, carers, service users or the general public. The expertise, insight and input of these lay members is essential to the development of all NICE guidance and advice, and helps us to make sure that our work reflects the needs and priorities of those who will be affected by them.

Independence, genuine consultation and transparency

18. All NICE committees are independent and unbiased. Once a topic has been referred to us by the Department of Health and Social Care, or NHS England, neither organisation has any more influence over the final guidance than any other stakeholder. All of our guidance, quality standards and other products are developed independently of government influence. We have a consultation process, which allows individuals, patient groups, professional and statutory bodies, commissioners, charities and industry to comment on our recommendations throughout the development of our guidance and quality standards. We also have a formal appeal process for final recommendations in our technology appraisals and highly specialised technologies guidance.

Review

19. Once published, all NICE guidance is regularly considered for review, and updated in light of new evidence, if necessary.

Methodological developments

20. Our independent advisory committees use a wealth of scientific methodology to help underpin and inform their decisions and recommendations. This includes internationally recognised scientific methods for evaluating and comparing the benefits and costs of different forms of practice.

21. Our independent advisory committees typically assess value for money by calculating the additional 'Quality Adjusted Life Years' (QALYs) that new treatments and other health technologies offer compared to standard practice. QALYs show the benefits that a treatment provides in terms of length of life, and quality of life, over the life of the patient. They are calculated by estimating the number of years a new treatment will provide benefit and, using fractions of a scale of 0-1, what change in quality of life it will provide.

    QALYs rely on quality of life measures used in clinical trials or from other sources which assess things like how well patients can carry out the activities of daily life with and without the treatment, and how the treatment will affect their pain levels and mental wellbeing.

    The number of extra QALYs a new treatment brings is then set against the cost of the new treatment to get a 'cost per QALY.' We usually recommend new treatments up to £20,000 per QALY but in special cases we can recommend up to £30,000 per QALY – and for treatments that extend life at the end of life, we can go as high as £50,000 per QALY.

    Where it concerns a technology that is selected for our highly specialised technologies programme, we apply a starting point of £100,000 per QALY and can go up to £300,000 per QALY, depending on the level of additional gain in QALYs achieved by the technology versus the comparator.

22. The science that the committees use when making their recommendations is constantly evolving. To make sure that NICE stays at the forefront of this challenging field, our Science Policy and Research team oversees a range of research activities that are undertaken across NICE to ensure that our processes, methods and policies remain up-to-date and fit for purpose.

How we involve people

23. All of our guidance, quality standards, and other products are developed taking into account the opinions and views of the people who will be affected by them, including patients, carers and members of the public, as well as health and social care professionals, NHS organisations, industry, social care businesses and local government.

24. Our consultation process allows a range of individuals and organisations to comment on our recommendations throughout the development of our guidance and quality standards. Our guidance is created by independent and unbiased advisory committees that include a diverse range of experts from surgeons and midwives, to health economists and social workers, as well as patients or carers or other members of the public.

25. In the case of our technology appraisals and highly specialised technologies guidance, in which we make recommendations about the use of new drugs and technologies within the NHS, we work with manufacturers to ensure that evidence they submit on the effectiveness of their products is the most appropriate to enable an evaluation to be undertaken.

26. We value the input of patients, carers and the general public in the development of our guidance and other products. By involving the people for whom the guidance will be relevant, we put the needs and preferences of patients and the public at the heart of our work. Our Public Involvement Programme supports individual patients, carers and members of the public, as well as voluntary, charitable and community organisations involved with NICE's work.

Working with the healthcare industries

27. Much of what NICE does has an impact on the healthcare industries that supply the NHS. We are very conscious of the responsibility we carry when we advise the NHS on the use of health technologies and we know that what we say about new technologies is often taken into account in health systems elsewhere in the world. For these reasons we regard the relationship we have with industry and individual companies as having equal importance with our other stakeholders and we will continue to work with the industry associations and companies in this country and abroad to build mutual respect and trust.

28. NICE digital services hosts *UK Pharmascan*, a horizon scanning database for information on new medicines in development which can be accessed by national horizon scanning organisations to support NHS budget and service planning to enable the faster uptake of new medicines across the NHS.

29. HealthTech Connect is also hosted by NICE and provides a service to companies NHS England and the Academic Health Science Networks by allowing emerging medical device, diagnostic and digital products to be identified for NICE outputs or NHS England commissioning policies.

30. The NICE Office for Market Access (OMA) works with drugs, devices and diagnostics companies on a fee-for-service basis. OMA gives any commercial stakeholders access to a dedicated team at NICE, offering tailored support to help them optimise their products' journey through NICE and the rest of the pathway to market.

31. The Accelerated Access Collaborative (AAC) Secretariat is hosted by NICE and operates on behalf of the Office for Life Sciences. The AAC is a unique partnership that brings together key partners from healthcare landscape organisations and industry to deliver the world-leading innovations that will transform patient outcomes. The AAC has two core objectives: for the NHS to be one of the most pro-innovation healthcare systems in the world, and for it to be seen as such by patients and industry; and for innovation to be delivered at a price that industry and the NHS think is affordable and fair.

32. Our fee-for-service Scientific Advice programme allows life sciences companies to better prepare to present their case for adoption of their products in the event that they need to engage in one of our evaluative programmes.

33. We operate the Patient Access Scheme Liaison Unit (PASLU) to review and evaluate proposed Patient Access Schemes that pharmaceutical

manufacturers plan to submit to NHS England. Patient Access Schemes involve innovative pricing agreements designed to improve cost effectiveness and facilitate patient access to specific drugs or technologies. PASLU advises NHS England on the feasibility of proposed Patient Access Schemes.

34. We work in partnership with NHS England to operate the Cancer Drugs Fund. The Fund provides a fast-track route for access to the most promising cancer treatments even when there is significant clinical uncertainty. It also allows speedier access to clinically- and cost-effective treatments that have been recommended by NICE, with treatments becoming available within the NHS before the NICE appraisal is completed.

How our guidance is used

35. Different types of NICE guidance have a different status within the NHS, public health and social care. Our technology appraisals and highly specialised technologies guidance are unique because the NHS in England is legally obliged to fund and resource medicines and treatments recommended through our technology appraisal programme. The legal status of these programmes is reinforced in the NHS Constitution, which states that patients have the right to drugs and treatments that have been recommended by NICE for use in the NHS, if the the doctor responsible for the patient's care says they are clinically appropriate.

36. None of our other guidance and products is subject to the same legal obligations as our technology appraisals and highly specialised technologies guidance. Nevertheless, health and social care professionals are actively encouraged to follow our recommendations to help them deliver the highest quality care. Of course, our recommendations are not intended to replace the professional expertise and clinical judgement of health professionals, as they discuss treatment options with their patients.

37. We are aware that NICE guidance sometimes recommends changes in practice which the NHS, local government and social care providers may find difficult to implement, especially when faced with limited resources and differing local budget priorities. We work with partners at a national level to help local organisations by providing a programme of implementation support to put our guidance into practice locally.

38. Our guidance is relevant to charities, voluntary and community organisations, residential care homes, private sector employers, patients, carers, service users and the public as well as the NHS and local government. We do our best to provide support for all these groups to put our recommendations into practice locally.

39. We measure the use of NICE guidance and publish impact reports showing how our recommendations have been used in practice to improve outcomes in priority areas. Our impact reports are based on publically available data and other sources showing the uptake of our work.

Communicating about our guidance, standards and other resources

40. Our guidance, quality standards and other advice products are disseminated and communicated clearly to those responsible for putting them into practice. We also raise awareness about our broader role among those who use the NHS and social care and to members of the public whose health is influenced by our public health guidance.

41. Through our audience insights work we ensure that the views and expectations of NICE's audiences are systematically gathered and interpreted. We deliver a full suite of multi-channel communications activities, telling the story of NICE's work and role through our website, social and traditional media, speaking engagements, exhibitions and conferences, internal platforms, public affairs and stakeholder engagement. We provide a timely, responsive service to direct enquiries from health and care professionals, patient groups, charities, parliamentarians and members of the public.

Access to our guidance

42. We use a number of innovative ways to help all users access all of our products including NICE Pathways and NICE Evidence. Website improvements and new digital developments are user-led and strive to maintain high standards of accessibility.

43. Patients, people using services, carers and the public can also use NICE guidance and other products as a guide to the high quality care they should expect to receive.

Putting our guidance and standards into practice

44. NICE guidance and advice can both drive and enable the design and delivery of services provided by the health and care system. When used effectively, NICE resources can support local improvement initiatives, improve outcomes and reduce variation.

45. We deliver a substantial programme of support to encourage improvement and change in practice. For example: we work with third party organisations to motivate individuals to adopt NICE guidance and standards; we facilitate the availability of support tools which make following our guidance more straightforward at a local level; we provide a suite of online educational modules; and we also have a team of regional implementation consultants and prescribing advisors who provide practical support and advice to our audiences on a local level.

46. NICE is committed to supporting commissioners and providers, local authorities and organisations in the wider public and voluntary sector to make the best use of their money, setting out the case for investment and disinvestment through our guidance programmes and our other advice.

47. We have a collection of cost-saving resources on our website which can help commissioners and providers make sure they are spending money on the right things. We are committed to promoting the provision of appropriate care, and supporting the health and care system to stop ineffective care and treatments.

48. Our guideline manual sets out NICE's commitment only to recommend new treatments or interventions with an increased cost implication if they are underpinned by a solid evidence base and robust economic analysis.

National Institute for Health and Care Excellence

Technology appraisal and highly specialised technologies appeals report

The Board has requested to receive a report on the appeals received against the final draft recommendations for technology appraisals (TA) and highly specialised technologies (HST) evaluations.

The main purpose of the report is to provide assurance to the Board that the appeals programme is compliant with the regulations, and the processes and systems to support the management of appeals are being properly maintained. It presents trends from appeals in recent years, and learning points from appeals in 2017-18.

The report also notes changes in the TA and/or HST processes and their potential impact on the receipt of appeals.

The Board is asked to note the report.

Ben Bennett

Business Planning and Resources Director

November 2018

Background

1. NICE has a responsibility to ensure the management of appeals against the final draft recommendations for technology appraisal (TA) meets the statutory requirements.

2. In April 2013, regulations (Health and Social Care Information Centre Regulations) came in force extending the remit of appeals to highly specialised technologies (HST). The regulations also brought changes to the grounds of appeal and the appeal panel composition, and confirmed the arrangements for holding an appeal. NICE's published appeals process guide operationalises the regulations and sets out how the appeals process will operate.

3. Appeals can only be submitted by consultee organisations and must be submitted within the appeal period, 15 working days following the final draft guidance being issued to consultees and commentators. Appeals must be submitted under one or more of the two strictly limited grounds of appeal.

4. The grounds of appeal are:

    - Ground 1. In making the assessment that preceded the recommendation, NICE has -

        a. failed to act fairly

        b. exceeded its powers

    - Ground 2. The recommendation is unreasonable in the light of the evidence submitted to NICE.

5. In line with the regulations, the composition of the appeal panel must consist of members appointed by NICE whose appointment has been agreed by the Secretary of State for Health and Social Care and contain a majority of members who are not non-executive directors or employees of NICE. The chair must be an external member who is engaged in the provision of healthcare in the health services or someone who has experience in representing patients or carers or who is a patient or carer.

6. Each appeal panel responsible for hearing the appeal consists of five members:

    - chair of the appeal panel
    - one non-executive director of NICE
    - one health service representative
    - one representative of the life sciences industry, and
    - one patient representative.

7. DAC Beachcroft provide legal advice throughout the process, and attend each appeal hearing to advise the panel.

8. The appeals process is administered by the corporate office team.

Technology appraisal and highly specialised technologies appeals

9. The Vice Chair of NICE, Dr Rosie Benneyworth, is responsible for determining the arguability and validity of each of the appeal points lodged, deciding if an appeal will be held, and writing to the appellants with the outcome of this scrutiny process. The Vice Chair is not selected to sit on an appeal panel to maintain their independence from the appeal panel decision-making.

10. Appeals can proceed to either an oral appeal hearing or written appeal however oral appeal hearings are more common. Oral appeal hearings are open to all interested parties, members of the public and press to observe. Written appeals, introduced in 2008, are usually agreed where there are discrete appeal points, largely matters of factual interpretation, and no more than two appellants.

11. Occasionally appeals are rejected at scrutiny if all the points do not meet the grounds of appeal. It is also possible for an appeal to be cancelled due to NICE or the appellant requesting to withdraw the proposed guidance or their appeal, respectively.

Number of appeals received

12. There have been 516 technology appraisals (TA) and 7 highly specialised technology (HST) evaluations published as at 31 March 2018. Within this time 113 appeals were received against 104 pieces of technology appraisal guidance and 2 pieces of highly specialised technologies guidance. Nine pieces of technology appraisal guidance received a second appeal following the first appeal being upheld and the final draft guidance returning to committee for further consideration. To date, the second appeal in each case has resulted in an 'appeal dismissed' outcome.

13. Table 1 below summarises the total number of appeals received since 2000 against the total number of TA and HST guidance publications. It also provides a breakdown for each of the last 5 years.

Table 1 Summary of appeals received against TA/HST guidance publication

Summary of appeals received	March 2000 - March 2018	2013-14	2014-15	2015-16	2016-17	2017-18
Oral appeals	89	2	2	6	2	5
Written appeals	3	0	0	0	0	0
Rejected appeals	16	0	1	1	0	1
Cancelled appeals	5	1	0	1	0	1
Total (Appeals)	113	3	3	8	2	7

TA/HST guidance publications	March 2000 - March 2018	2013-14	2014-15	2015-16	2016-17	2017-18
TA	516	31	30	47	53	76
HST	7	0	1	1	2	3
Percentage of guidance publications subject to appeal	22%	10%	10%	17%	4%	10%

14. Since 2013, there has been a steady increase in the number of TA and HST guidance publications, over which time the proportion of guidance with a positive recommendation (including optimised) has remained at approximately 80%. The number of appeals has not increased in line with the increased number of guidance publications, and as shown above, the rate of appeals has reduced relative to volume of guidance publications. Note that the proportion of TA guidance with a commercial arrangement has increased significantly over this period, using options provided under the Pharmaceutical Price Regulation Scheme and the new Cancer Drugs Fund.

15. To date, a majority of the appeals received have resulted in an oral appeal hearing. Across the five year period there have not been any written appeals. The last written appeal took place in 2010.

16. The cancelled appeal in 2013-14 was at the request of NICE to retract the final appraisal determination (FAD) and in 2015-16 and 2017-18 at the request of the appellant.

Grounds of appeal

17. An appellant can submit more than one appeal point under a particular ground. Table 2 presents the proportion of appeals received resulting in a valid appeal (oral or written) or rejected appeal following the scrutiny stage. A large proportion of valid and rejected appeal points are submitted under ground two with the appellant challenging the reasonableness of the recommendations in light of the evidence submitted.

18. Appeal points received under ground 1b, NICE has acted outside its remit or unlawfully, are less frequent. Due to the nature of these appeals, which usually revolve around points of law, more involvement from the appeal panel's legal representative is needed.

Table 2 Grounds of appeal - resulting in a valid (oral/written) or rejected appeal

	March 2000 - March 2018		2013-14		2014-15		2015-16		2016-17		2017-18	
	V	R	V	R	V	R	V	R	V	R	V	R
Ground 1a: NICE has failed to act fairly	76	12	2	0	2	1	4	0	1	0	5	0
Ground 1b: NICE has exceeded its powers	32	6	0	0	0	0	0	0	1	0	1	0
Ground 2: The recommendation is unreasonable in the light of the evidence submitted to NICE	87	15	2	0	1	0	6	1	2	0	5	1
Total	195	33	4	0	3	1	10	1	4	0	11	1

Note: valid appeals (V) and rejected appeals (R)

Outcome of appeals

19. The appeal panel aim to issue their written decision to NICE within 15 working days of the appeal hearing. The health service representative is responsible for writing up the appeal panel's decision. The health service representative receives no direct payment for writing the appeal decision or attending the appeal however their employer is reimbursed for their time commitment.

20. In 2017-18, two appeal panel decisions were received outside of this timeframe as more time was needed by the panel to finalise the write-up. On both occasions this delay did not impact the anticipated appeal decision publication date.

21. There are three outcomes to an appeal:

    - Appeal dismissed - all points are dismissed and the appeal panel does not request changes to the final draft guidance.
    - Appeal upheld - at least one point has been upheld and it is necessary for the final draft guidance to be returned to the advisory committee.
    - Appeals panel requests changes to the final draft guidance but no further consideration by the committee

22. Across the last 18 years overall, slightly more appeals have been upheld than dismissed. However, in 2017-18, 3 appeals were dismissed and 2 upheld.

23. Table 3 below summarises the appeal outcome to date with year on year comparison from 2013-14 to 2017-18.

Table 3 Summary of appeal panel decisions

Outcome of appeals	March 2000 - March 2018	2013-14	2014-15	2015-16	2016-17	2017-18
Dismissed: Final guidance published	33	0	0	1	0	3
Upheld: Final draft guidance returned to committee	36	1	2	4	2	2
Request changes to final draft guidance but no further consideration by the committee	23	1	0	1	0	0
Total	92	2	2	6	2	5

24. Table 4 summarises the outcome of an appeal according to the grounds of appeal. It shows, for example, of the 76 valid appeal points lodged relating to procedural unfairness (ground 1a), 27 resulted in an upheld appeal, 24 resulted in a dismissed appeal and 9 required amendments to the final draft guidance prior to guidance publication.

25. There was little variation between the proportion of all appeals received and appeals confirmed as valid by the Vice Chair at scrutiny. The percentage was consistent across the grounds of appeal.

26. Where the appeal panel has requested the wording be amended in the final draft guidance prior to publication this is most commonly for ground 2 appeal points.

Table 4 Appeal points received and their appeal outcome to date

Grounds of appeal	All appeals	Appeals oral/ written	Appeals upheld	Appeals dismissed	Appeals request change
Ground 1a: NICE has failed to act fairly	90	76	25	40	11
Ground 1b: NICE has exceeded its powers	37	32	2	26	4
Ground 2: The recommendation is unreasonable in the light of the evidence submitted to NICE	103	87	26	40	21

Appeals in 2017-18

27. The 7 appeals received in 2017-18 are summarised below.

Table 5 Summary of appeals in 2017-18

Topic	TA/HST	Committee outcome	Type of appeal	Appeal outcome
Hypophosphatasia (paediatric-onset) - asfotase alfa (1st line) [ID758]	HST	Not recommended for routine commissioning	Appeal cancelled	N/A
Lysosomal acid lipase deficiency - sebelipase alfa [ID737] (1st HST appeal	HST	Optimised recommendation	Oral appeal - 25 April 2017	Upheld
Obesity, overweight with risk factors - naltrexone-bupropion (prolonged release) [ID757]	TA	Not recommended for routine commissioning	Oral appeal - 27 October 2017	Dismissed
Leukaemia (acute lymphoblastic, relapsed, adults) - inotuzumab ozogamicin [ID893]	TA	Not recommended for routine commissioning	Oral appeal - 3 November 2017	Upheld

Topic	TA/HST	Committee outcome	Type of appeal	Appeal outcome
Idiopathic pulmonary fibrosis - pirfenidone (review of TA282) [ID837]	TA	Optimised recommendation	Oral appeal - 1 December 2017	Dismissed
Breast cancer (early) - intrabeam targeted intraoperative radiotherapy [ID618]	TA	Not recommended for routine commissioning but recommended only using machines that are already available where data can be collected on their use	Oral appeal - 8 December 2017	Dismissed
Multiple myeloma (relapsed, refractory) - daratumumab (after proteasome inhibitor and immunomodulatory agent) [ID933]	TA	Recommended within Cancer Drug Fund	Rejected appeal	N/A

28. The corporate office and Vice Chair reflect on each appeal hearing to identify any learning for the management of future appeals. This is informed by feedback from those involved in the appeal hearing and their own observations.

29. The main learning from 2017-18 relates to declaring and managing interests.

    - Following an objection from one of the appellants about the historic involvement of the appeal panel chair with the original appraisal of the technology in 2013, it was necessary to annul an appeal hearing before it issued its decision and convene a fresh panel to hear the appeal. In response, the process to scrutinise declared interests has been strengthened, with additional steps now in place.
    - Secondly, concerns raised by public attendees during and after another appeal hearing highlighted the need to clarify the position regarding the interests of those attending a hearing to represent appellants. The Board considered this issue and agreed that appellants' representatives would not have to make a declaration of interest. This is because these attendees will have a clear interest in the technology that is subject of the

appeal, often as the manufacturer, or bodies advocating the technology, and so NICE's policy cannot meaningfully be applied to these individuals.

30. In addition, one of the appeals raised issues regarding the role of NICE's guidance executive (GE) in relation to the appeals process. The appeal, and subsequent legal advice received by NICE, provided a useful reminder on the respective roles of the appeal panel, GE, and appraisal committees; and the status of appeal panel decisions.

31. The annual appeals training day (discussed further below) provides further opportunity for the panel's legal adviser, appeal panel, and senior management from CHTE to collectively reflect on the learning from appeals, both from the perspective of the TA/HST programmes and the appeals process.

Appeal Panel membership

Appointments and resignations

32. At 31 March 2018, 19 people had been approved by the Secretary of State for Health and Social Care to hear appeals (in addition to the NICE Non-Executive Directors):

    - 4 appeal panel chairs: 3 lay representatives, and 1 health service representative
    - 7 industry representatives
    - 5 health service representatives (must be engaged in the provision of healthcare in the NHS or public health service, and holding an active registration with the appropriate professional body, including for doctors, a licence to practise)
    - 3 lay representatives.

33. Information on these appeal panel members is available on the NICE website.

34. In line with NICE's policy and procedure for the recruitment to advisory bodies, appeal panel members serve up to 10 years in total (made up of individual terms of no more than 4 years).

35. In 2017-18 five new appointments were approved by the Secretary of State for Health and Social Care:

    - Appeal Panel Chair (1 post)
    - Lay representatives (2 posts)
    - Health service representatives (2 posts)

36. One proposed appointment of a health service representative who worked in the Welsh NHS was declined by the Department of Health and Social Care (DHSC) lawyers due to a clause in the regulations stipulating health service representatives must be engaged in the provision of health care in the health services in England. The DHSC has since released a consultation to amend this clause in the regulations to enable NICE to recruit health service representatives from across the UK. The DHSC's response to this consultation is awaited.

37. Four members tendered their resignation from the appeal panel due to personal circumstances either following completion or towards the end of their first term.

Training and induction

38. All new members are required to attend a half-day induction, and observe an appeal hearing as a silent observer prior to sitting on a panel for the first time. As a silent observer they are required to declare any interests; they will receive the appeal papers, and observe the appeal panel pre-appeal meeting, the appeal hearing, and debrief meeting on the day of the appeal. They are unable to participate in the discussions or ask questions at the appeal hearing. As appeals are infrequent, experienced panel members not selected to sit on a panel can also volunteer to be a silent observer to support their learning and development.

39. Appeal Panel training days have been held annually since 2010 at the NICE offices. The day is chaired by the Vice Chair and all panel members, including the Non-Executive Directors, are encouraged to attend.

40. The day usually includes:

    - Overview of past appeals and its legal context presented by the appeal panel's legal adviser
    - Developments in the TA or HST programmes presented by a member of CHTE
    - Training suggestions raised by panel members
    - Learning/reflections on appeals from CHTE
    - Learning/reflections from the appeal panel led by Appeal Panel Chairs.

41. At the October 2018 training day Leukaemia Care gave a presentation on their experience as a patient group appellant at the hearing for the appeal against the FAD for inotuzumab ozogamicin for treating relapsed or refractory B-cell acute lymphoblastic leukaemia held in November 2017.

Declaring and managing interests

42. The appeal panel members adhere to NICE's policy on declaring and managing interests for NICE advisory committees. Assurances are in place at key stages within the appeals process to ensure declarations are properly managed:

    - During the pre-appeal planning stage while checking appeal panel availability. All potential conflicts (prior to panel selection) are checked by the corporate office associate director.
    - Once the appeal panel is confirmed by the Chair a reminder is sent to the panel asking that declaration forms are returned
    - Prior to the distribution of the appeal papers
    - Prior to the appeal hearing, following the completion of the register of interests
    - At the hearing, the appeal panel and NICE representatives declare any interests.

43. As noted above, NICE’s policy on declaring interests does not apply to those representing the appellants.

Engagement with the Vice Chair and Corporate Office

44. The Vice Chair holds regular 4-6 weekly meetings with the corporate office to receive an update on current and potential appeals, panel recruitment, and discuss any emerging issues and propose mitigation. The Vice Chair has also begun six monthly meetings with the appeal panel chairs. The first meeting was held in April 2018, with a second held in September 2018. This seeks to strengthen the process of sharing learning from appeal hearings.

Changes in TA/HST programmes

45. In March 2017 the NICE Board approved changes to the arrangements for evaluating and funding drugs and other health technologies assessed through NICE's TA and HST programme, following a joint consultation with NHS England.

46. The introduction of a quality adjusted life years (QALY) weight gain as a measure of value was added to the HST methodology, which progressively advantages treatments that offer greater QALY gain. The £100,000 per QALY limit for automatic application of the funding directive is retained but the HST Evaluation Committee has discretion to apply the QALY weight in defined circumstances.

47. The revised statement of the methods and processes for the evaluation of highly specialised technologies was approved by the Board at its meeting in April 2017. The new arrangements were implemented for all topics initiated after 1 April 2017 and therefore did not impact the appeal hearing against the HST evaluation, sebelipase alfa for treating lysosomal acid lipase deficiency, held on 25 April 2017.

48. The introduction of a budget impact threshold of £20m and the fast track appraisal process were approved for the technology appraisal programme.

49. The budget impact threshold allows more flexibility in the adoption of technologies into the NHS which are cost effective but high in budget impact. If the budget impact exceeds the threshold in any of the first three years, a commercial negotiation is triggered with NHS England. In the event that NHS England intend to apply for a variation to the funding requirement they are required to do so no later than the end of the FAD consideration period or appeal period. The application and decision to vary the funding requirement is made by NICE's guidance executive, and not the appraisal committee. As a result, where appeals are submitted about this decision, a representative of guidance executive will need to attend any appeal hearing on behalf of NICE.

50. The new fast track appraisal offers a shorter process and is applied where NICE is confident that a reliable judgement about value for money can be made at an early stage in the appraisal. In addition, where a positive recommendation is made, a shorter period of deferred funding of 30 days rather than 90 days would be applied.

51. In April 2018, an updated version of the guide to the technology appraisal processes was published. Specific criteria when considering appraisals for the fast track process is outlined in section 2.4.31 and 2.4.32 of this guide.

52. The first technology considered for the new appraisal is likely to go to committee in 2018-19.

53. Due to these changes being newly introduced it is yet to be determined what impact they will have on the appeals programme.

Future considerations

54. The Department for Health and Social Care (DHSC) has recently consulted on proposed amendments to the regulations to allow NICE to charge companies for making technology appraisal and highly specialised technology recommendations relating to their products.

55. The consultation notes that the DHSC is considering the potential for broadening the scope of referrals to NICE which, if agreed between DHSC, NHS England, NICE and industry, could result in up to 20 additional technology appraisals per year. This has the potential to increase the number of appeals.

56. The impact of these proposals, and any further changes to the technology appraisal and highly specialised technologies programmes will continue to be monitored by the Vice Chair and the corporate office team, in order to identify any required actions. This may for example, include increasing the number of people approved by the Secretary of State to hear appeals, if it is felt likely that the number of appeals will increase, and ensuring the appeal panel members are briefed on the changes.

November 2018

National Institute for Health and Care Excellence

Board Chair and Vice Chair

The Institute's Standing Orders make provision for the appointment of a Vice Chair, and in 2016 the Board appointed Dr Rosie Benneyworth to this role. In summary, the role of the Vice Chair is to perform the Chair's duties when the substantive Chair is unable to discharge their responsibilities, including chairing the Board's meetings. In addition, the NICE Vice Chair has a central role in the technology appraisal and highly specialised technologies appeals process.

NICE's Chair, Sir David Haslam is currently undergoing medical treatment and therefore in line with the Standing Orders, Dr Rosie Benneyworth is temporarily carrying out the duties of the Chair. Given the temporary nature of these cover arrangements and the infrequency of appeals, it is proposed that Dr Benneyworth continues to undertake her duties in relation to the appeals process during this time.

The Standing Orders also state that if the Chair and Vice Chair are both absent, or are disqualified from participating, the remaining Board members present shall choose a Non-Executive Director to preside. To provide certainty in the event that Dr Benneyworth is unable to attend and chair a Board meeting during Sir David's absence, it is proposed that Professor Tim Irish (the Senior Independent Director) is designated as the Non-Executive who would chair the meeting.

The Board is asked to

- Agree that Dr Rosie Benneyworth will continue to undertake her duties in relation to the TA and HST appeals process while covering the Chair role
- Designate Professor Tim Irish as the Non-Executive who would be asked to chair a Board meeting during Sir David Haslam's absence should Dr Rosie Benneyworth be unable to preside.

Andrew Dillon

Chief Executive

November 2018

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.

Professor Gillian Leng, Director, Health and Social Care Directorate (Item 13)

Dr Paul Chrisp, Centre for Guidelines (Item 14)

Meindert Boysen, Director, Centre for Health Technology Evaluation (Item 15)

Jane Gizbert, Director, Communications (Item 16)

Alexia Tonnel, Director, Evidence Resources Directorate (Item 17)

November 2018

National Institute for Health and Care Excellence

Health and Social Care Directorate progress report

1. This report summarises performance against the business plan objectives for the Health and Social Care Directorate for September and October 2018. A summary is also provided for areas of work that have seen significant progress, and are felt to be of particular note for the Board.

Performance

2. The directorate successfully delivered a number of key products during September - October 2018 including: 4 medicines evidence commentaries; 1 indicator menu; the quarterly innovation scorecard and 3 quick guides for social care. Details of these publications are given in Appendix 1.

Delivery of products as set out in the business plan

3. The Chief Executive's Report details delivery of Quality Standards and Evidence Summaries, and any variation to plan. Information on the other products is outlined below.

4. The following additional products were delivered during September and October. These are all on target, ahead of schedule or within the tolerance indicated in the NICE Business Plan Balanced Score Card at 31 October 2018:

    - 9 weekly medicines awareness services bulletins.
    - 5 shared learning examples.
    - 6 endorsement statements.
    - 3 quick guides for social care.
    - 4 medicines evidence commentaries.
    - 11 resource impact products to support all guidance.
    - 1 indicator menu.

5. Budget impact tests were completed within 10 days for company submissions received where all information was complete.

Engagement with the local and national system

6. The team has continued to actively engage across the health and care system to ensure advice from NICE informs local, regional and national work. An update on key engagement metrics set at the beginning of the year is provided in Appendix 2. Additional detail is provided below.

Healthcare Sector - National

7. NICE leads have made contact with NHS England (NHSE) leads for all 15 work streams underpinning the NHS Long term plan.

8. There has been active alignment of work programmes with CQC GP inspection team, including CQC predictive modelling work stream and NICE's refresh of patient and service user experience quality standards.

Healthcare Sector - Regional

9. We have developed further STP resources and supported the use of NICE guidance and quality standards with STPs/ICS. We also produced a briefing describing key NICE resources that can support AHSNs to deliver their strategies. These outlined NICE's offer for practical support, including HealthTech Connect and the META tool.

10. We presented and supported a workshop for the North East and Yorkshire and Humber (Y&H) Mental Health Transformation and Sustainability network, resulting in the identification of several examples for shared learning case studies. Events have also been delivered in London and the South East.

11. In addition, the team contributed to 2 mental health network events in the Midlands, presenting on mental health resources focusing on dementia. Good practice examples from the region were shared, such as the Northamptonshire depression pathway.

12. We facilitated an event between Getting It Right First Time (GIRFT) and NICE Managers network in the North East and Y&H to promote NICE products to help reduce unwarranted variation in care and improved outcomes.

Public Health Sector - National

13. We are contributing to a new quality framework for public health, which offers an opportunity to demonstrate where NICE guidance and standards support improvements in public health. This will sit alongside Quality Matters for social care and a shared commitment to quality for the NHS. The main audience will be public health teams in local government.

14. We have submitted 3 abstracts to Public Health England's (PHE) Cardiovascular Disease Prevention Conference 2019.

Public Health Sector - Regional

15. We contributed to PHE West Midlands Oral Health Network event, providing an overview of how NICE guidance and associated resources can support improvements in the oral health of people living in care homes.

Social Care Sector - National

16. We ran two workshops at the British Association of Social Workers (BASW) annual conference on the use of NICE resources to support social work practice, and presented at the annual Research in Practice (RiP) Link Officers event on links between NICE and RiP in the context of transitions guidance and practice.

17. We also ran a workshop on the use of NICE guidance and standards to support scrutiny of health and social care in local areas at the Centre for Public Scrutiny (CfPS) national conference. Now working with the CfPS to develop a resource for scrutiny members to highlight NICE resources available and how they can be used by local scrutiny committees.

18. We hosted a joint presentation with Skills for Care (SfC) at the Care Show, focusing on NICE and SfC resources to support better medicines management in social care

Social Care Sector - Regional

19. We contributed to social care provider networks across all the regions with a focus on Managing medicines in care homes, and Managing medicines for adults receiving social care in the community. Although all were aware of and using the guidance, there was a low awareness of available tools and resources to support implementation.

20. We have developed a set of metrics for quality assurance of domiciliary care providers across the 33 London boroughs, in conjunction with London ADASS (the Association of Directors of Adult Social Services). A similar set of metrics for care homes has been piloted and is now being rolled out.

21. We also supported 5 events for SfC Registered Manager Networks and contributed to a regional conference in the South West.

Support for the digital IAPT programme

22. Four notifications have been received, 1 IAPT (Improving Access to Psychological Therapies) assessment briefing (IAB) is due to be published by January 2019, and another in March 2019. The NICE IAPT Expert Panel and NHSE Working Group have agreed to amend the eligibility criteria to allow more technologies to be assessed. NHSE have agreed a revised delivery target of 14 IABs in 3 years.

Implementation of the public involvement review

23. To promote ideas about evidence generated by and from patients, carers and people who use services, we have been exploring how other organisations' work might be useful and we have hosted two technical forums with:

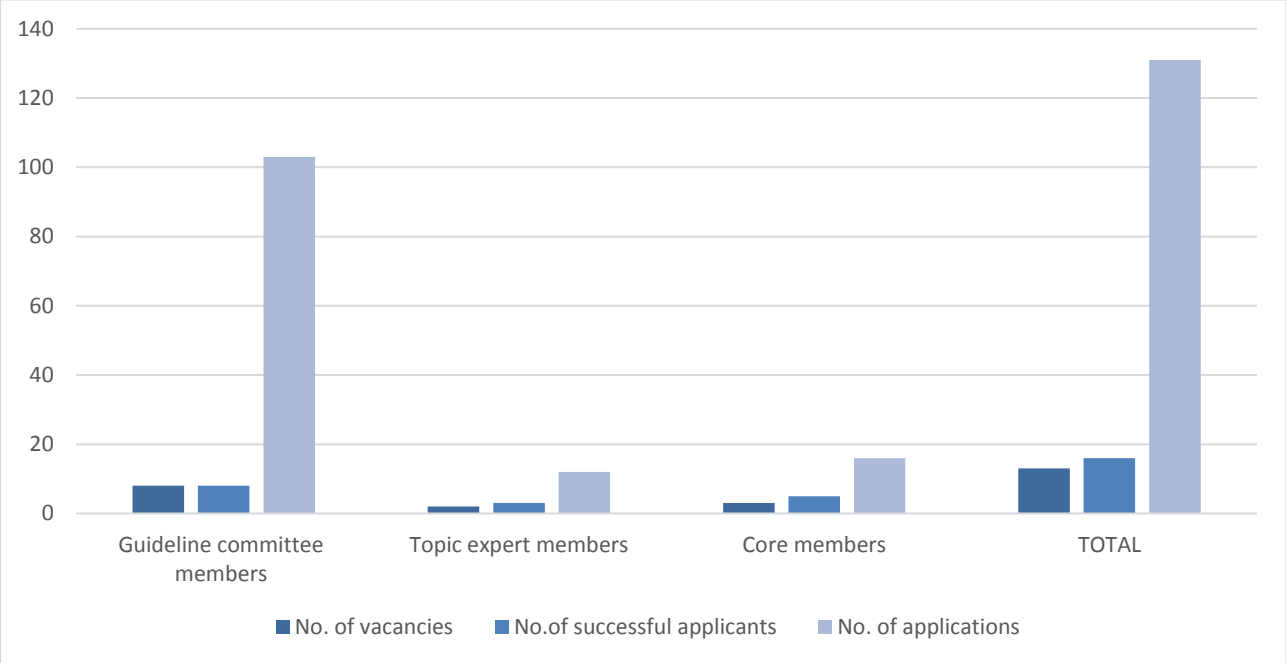
    - Macmillan Cancer Support to explore the evidence resources they and their academic partners (Southampton and Birmingham Universities) are developing that could be used by NICE.
    - The Winton Centre for Risk and Evidence Communication to determine how we could better communicate issues of risk, to illustrate uncertainties in any evidence-base and to support shared decision-making.

24. We are also piloting ways of obtaining feedback from committee members on the value of lay contributions to their decision-making.

25. PIP and Centre for Guidelines have agreed a number of pilot projects to ensure the voice of patients and the public can shape our guidelines as early as possible in development.

Recruitment of lay people to NICE committees

Figure 1 Patient & public committee member recruitment for the period September 2018 to October 2018



26. Overall, the ratio of applications to vacancies was 10:1; the target being 2:1 or greater, with 131 applications for 13 vacancies.

27. We had 93 applications for the lay member roles on the ME/CFS guideline committee. Earlier in the year we recruited 2 people for the sleep disordered breathing guideline topic. The committee requested an additional lay member with obesity related apnoea in a second round of recruitment. There were no suitable applicants but the committee will consider identifying a relevant expert witness later in development.

28. We recruited more core lay members than expected to the technology appraisal committee (4 instead of 2) and more specialist lay members to the Diagnostic Assessment Committee for kidney function tests (3 rather than 2). In addition 16 people were invited experts for NICE's committees, the Commissioning Support Programme and our Scientific Advice programme, and 1 person was invited to join QSAC committees as a specialist member.

Notable issues and developments

29. This section includes significant developments or issues that occurred between September 2018 and October 2018.

Indicator Programme

30. Members of the Quality and Leadership Programme published a paper in the New England Journal of Medicine (Minchin, Roland and Richardson et al. 2018) on the impact of removing pay-for-performance incentives on the quality of care delivered in general practice. This was in conjunction with academics from the universities of Dundee (Professor Guthrie) and Cambridge (Professor Roland).

31. NICE published new indicators to be used by negotiators to inform the content of the 2019/20 Quality and Outcomes Framework (QOF). The new indicators for people with diabetes included a number that used routinely collected frailty data to stratify the indicators, and this is the first time that NICE has used stratification to refine QOF indicators. The feedback from @NICEcomms was positive with 61 retweets and 51 likes.

32. The indicator team are in the process of updating the indicator process guide. The scope of the update is being overseen by an advisory group that includes representatives from NHSE, PHE, the Healthcare Quality Improvement Partnership (HQIP) and the King's Fund. The update will reflect upon the recent Review of the QOF in England (NHS England, 2018) while also drawing on contemporary literature around indicator assurance. We anticipate a first draft of the updated guide will be out for public consultation in quarter 4 of 2018/19.

Managing the resource impact of guidelines

33. The Guideline Resource and Implementation Panel (GRIP) held its fourth meeting in September. This national group is tasked with considering new guidelines that might have significant resource impact on the health and care system, and agreeing how this might be supported. The guidelines recently discussed included the abdominal aortic aneurysm (AAA), chronic obstructive pulmonary disease (COPD) and cerebral palsy. Consideration was given to the impact on use of resources along with workforce implications.

Healthcare data and analytics

34. The infrastructure to enable NICE to embed routine consideration and analysis of healthcare data into our programmes is now in place. We have recruited two members of staff to the new Healthcare data and analytics team, who will start in post in November. A cross-NICE steering group responsible for high level coordination of NICE's activities associated with real world data has been established, and will provide strategic support to the new team. September saw the first meeting of an external reference group constituted to provide expert input into the programme. Next steps include finalising a definition and principles of use of healthcare data and analytics, and work will begin to confirm processes and methods across NICE's programmes.

Supporting allied health professionals

35. The field team delivered the first 2 of 4 national webinars for allied health professionals (AHPs). The webinars are produced in collaboration with NHS England and NHS Improvement, and support AHPs to understand NICE's role and how to use NICE guidance, standards and implementation support resources to evaluate and improve the quality and efficiency of their services.

36. The live webinars were recorded and made available after the event. To date 1,000 people registered to view webinar 1 'An AHP's introduction to NICE', and 383 joined the live event. The evaluation and feedback from both webinars has been extremely positive. Many people have posted positive and supporting comments on Twitter during and after each webinar.

National Improvement and Leadership Development (NILD)

37. NICE attended the recent NILD Board and presented on the outcomes from the quality improvement round table event. The Board discussed the importance of the long term plan being clear about quality improvement approaches to achieve the work stream ambitions. A quality improvement narrative has been drafted and a task and finish sub group of the NILD Board has been convened to consider actions required to improve quality improvement capability building across the

NHS. An action plan is in development and a second meeting of the sub group is planned for after the publication of the NHS long term plan.

Appendix 1: Publications-September / October 2018

The table below provides a list of guidance and advice produced in September and October 2018 by the Health and Social Care Directorate which are not detailed elsewhere. This includes adoption support products (ASP), decision support tools (DST); IAPT assessment briefings (IAB), medicines evidence commentaries (MEC) and social care quick guides (SCQG).

Guidance title	Publication date	Product
Eczema in children: new study finds no evidence of benefit from emollient bath additives	October 2018	MEC
The risk of MRSA and C difficile in people with documented 'penicillin allergy'	September 2018	MEC
New MHRA drug safety advice: June to August 2018	September 2018	MEC
Asthma: quadrupling the dose of inhaled corticosteroids reduces the number of severe asthma exacerbations	September 2018	MEC
What to expect during assessment and care planning	September 2018	SCQG
Arranging services for people with a learning disability and behaviour that challenges	September 2018	SCQG
Promoting independence through intermediate care	October 2018	SCQG

Appendix 2: Strategic Engagement Metrics

Health Sector 2018-19

National

Organisation(s)	Strategic Metric	Progress Against Target	Progress Update
NHS England (NHSE) NHS Improvement (NHSI)	A set of tangible outcomes for delivery during 2018/19 is approved at the NICE, NHSE and NHSI, NQB quality improvement round table event	→	Event took place 28 June 2018, action plan developed.
NHS Improvement	100% alignment of 2018/19 GIRFT reports with NICE guidance, standards and indicators	→	4 reports to date (100% compliance): April - GIRFT cranial neurosurgery report May - GIRFT urology surgery report Aug - GIRFT oral and maxillofacial surgery report Oct - GIRFT national spinal report
NHS England NHS Improvement Health Education England (HEE)	Where available, NICE guidance and advice is embedded in policies and incentives to decommission low value interventions	→	Consultation ended 28/09/18.
Care Quality Commission (CQC)	NICE Quality Standard statements are in the checklists developed by CQC in their 12 mental health care areas	Complete	Checklists completed for the 12 CQC mental health core service frameworks and uploaded onto the CQC intranet site for inspectors.

Regional / Local

Academic Health Science Networks (AHSNs)	NICE guidance, quality standards or indicators are shown to have supported quality improvements in 4 AHSNs	↑	8 examples identified to date.
Sustainability & Transformation Partnerships (STPs)	NICE guidance and quality standards are shown to have supported 11 STP programmes of work	↑	28 examples identified to date.
Mental Health Networks (Sustainability & Transformation Partnerships)	Four mental health STP networks/ mental health networks are supported to increase their use of NICE guidance and quality standards to improve commissioning and provision of mental health services	↑	11 supported to date.

Public Health Sector 2018-19

National

Organisation(s)	Strategic Metric	Progress Against Target	Progress Update
Public Health England	Maintain references to NICE guidance and quality standards in 80% of Public Health England publications where relevant	→	A review of all PHE publications completed for quarter 1 with over 80% of relevant publications referencing NICE.
NHS England	NHS England embed relevant NICE guidance and standards in their framework for NHS Employers around health and wellbeing in the workplace	Complete	
British Heart Foundation NHS England Public Health England	The draft UK CVD prevention audit and decision making tool published during 2018/19 includes NICE's CVD related indicators, guidelines and quality standards	→	Initial work on identifying potential indicators for inclusion in the audit has taken place, at this stage all of the areas for audit are underpinned by NICE guidance and where available make use of existing NICE indicators.
Local Government Association	3 themed publications issued by the Local Government Association reference NICE	→	October 2018: 'Sector-led improvement in public health: progress and potential' references NICE and provides a link to NICE audit and assessment tools.

Regional / Local

Public Health England	7 examples of the NICE field team (and NICE Medicines Implementation Consultants as appropriate) working jointly with PHE regions/centres and other system partners to support Local Authority and STP/ICS use of NICE guidance and quality standards in meeting public health priorities	↑	11 examples identified to date.

Social Care Sector 2018-19

National

Organisation(s)	Strategic Metric	Progress Against Target	Progress Update
Department of Health and Social Care (DHSC)	Inclusion of 3 quality standard measures within the Quality Matters data framework (priority 2)		CQC hosted a roundtable event on 20th Sept to discuss the focus of priority 2 for year 2 of Quality Matters, following the roundtable 3 actions have been identified which include the use of NICE quality standards to develop quality measures. NICE are supporting the CQC and SfC in delivering these actions.
Care Quality Commission (CQC)	10% of 'outstanding' social care inspection reports published in 2018/19 to reference NICE		26 'outstanding' reports published in the last month, 5 of these refer to NICE (19.23%). Since April 161 reports published of which 27 mention NICE, i.e. 16.77% over the whole period.
Department for Education (DfE)	1 piece of NICE guidance referenced within a DfE policy document		NICE has submitted evidence to two DFE reviews - Children in Need enquiry and SEND and disability enquiry. The final review reports have not yet been published.

Regional / Local

ADASS	Evidence of NICE guidance or quality standards being referenced in commissioning policies and contracts in 30 local authorities (20%)	Complete	35 examples identified from LAs across all regions.
Skills for Care	NICE features in 11 provider forum network events for social care providers (3 each region, 2 London) - joint delivery with Medicines Implementation Consultants, as appropriate		NICE has featured in 24 events to date.

 Above monthly target

 Meets monthly target

 Below monthly target (expected to reach target next month)

 Below monthly target (not expected to reach target next month)

November 2018

National Institute for Health and Care Excellence

Centre for Guidelines progress report

1. This report sets out the performance of the Centre for Guidelines against our business plan objectives during September and October 2018. It also highlights the outcome of a judicial review that challenged the use of an unlicensed treatment for age-related macular degeneration, consultation on a draft guideline on the management of abdominal aortic aneurysm, an update to our guideline on the diagnosis and management of myalgic encephalomyelitis/chronic fatigue syndrome (ME/CFS) and work commencing on a guideline on cannabis-based products for medicinal use.

Performance

2. Five guidelines were published during September and October 2018; 3 clinical guidelines, 1 public health guideline and 1 social care guideline. Performance on delivery of the guidelines is on track, any variations are reported in the Chief Executive's report.

3. Eight surveillance reviews were published during this reporting period, of which 2 were exceptional reviews. In response to stakeholder comments we are carrying out a second consultation on CG112 Sedation in under 19s which has delayed publication of the surveillance report. All other deliverables are on track.

4. The updated Guidelines Development Manual was published on 31 October. It will be implemented in all new guidelines being developed from 1 January 2019.

5. Quarter 2 review meetings with both internal and external guidance developers and contractors are either complete or in progress. All contractors remain within budget and are on target to complete agreed deliverables.

6. The print format BNF and BNFC 2018 are complete and are currently in delivery to prescribers across the UK. The BNF sub-contract to print the BNF, which is based in Germany, will require further risk assessment for next year's printing of the BNF once the outcome of the Brexit negotiations are known. A new contract with the current BNF mailing database provider, Wilmington Healthcare, has been agreed. The new contract will commence on 1 January 2019. Fifteen expressions of interest were received for the new contract for the BNF storage and distribution provider.

7. In September, centre staff presented 22 abstracts at the 2018 G-I-N conference on guideline development processes and methodologies. Staff were also

involved in the international GRADE working group meeting preceding the G-I-N Conference.

8. Work is ongoing to further improve the event tracker used as the basis for exceptional surveillance reviews of guidelines (e.g. looking at improving collaboration approach with NIHR, exploring links with NCRI, working with eIS around monitoring the event tracker). Exploratory work with the Office for National Statistics is underway to look at how different machine learning techniques can be used within our surveillance process.

Notable issues and developments

9. On 21 September there was a judgement against the action of Bayer and Novartis where they challenged the lawfulness of a policy of 12 CCGs on the treatment of age-related macular degeneration (AMD) which stated that 'Avastin will be offered to certain patients with wet AMD "as the preferred treatment option". Avastin (bevacizumab) is an anti-vascular endothelial growth factor (VEGF) treatment. The NICE guideline on the treatment of AMD recommends that patients are offered anti-VEGF treatments, and that no clinically significant differences in effectiveness and safety between the different anti-VEGF treatments have been seen in the trials considered by the committee. Bevacizumab does not have a license for use in AMD. Given the guideline committee's view that there is equivalent clinical effectiveness and safety of different anti-VEGF agents including bevacizumab, comparable regimens will be more cost effective if the agent has lower costs. NICE's guidance still stands following this judgement, although this may not be the final legal position if an appeal is lodged.

10. We are carefully considering concerns raised by some stakeholders during consultation on the draft guideline on the diagnosis and management of abdominal aortic aneurysm. The draft guideline aimed to clarify when aneurysms should be repaired and what surgical method – open or minimally invasive endovascular repair - is most appropriate, cost effective and best for patient care.

11. We are recruiting the committee to update our guideline on the diagnosis and management of myalgic encephalomyelitis/chronic fatigue syndrome (ME/CFS). This is a chronic and disabling illness, the severity of which varies widely and unpredictably. The description and diagnostic criteria used in clinical practice and research have been contested, and many people do not meet the existing criteria but still need care. Concerns have been raised about the interventions recommended in the 2007 guideline that this update will replace, including challenges to the evidence and reports that people with ME/CFS have been pressured to participate in exercise programmes, leading to a worsening of

symptoms. The committee needs to be able to take these factors into account and objectively review the evidence for these and other interventions.

12. At the request of the Department of Health and Social Care, a guideline on cannabis-based products for medicinal use is being developed, and the committee chair has been appointed. Cannabis-based products for medicinal use were moved from schedule 1 to schedule 2 of the Misuse of Drugs Regulations in October, meaning that some might in future be prescribed by specialists where there is unmet clinical need.

November 2018

National Institute for Health and Care Excellence

Centre for Health Technology Evaluation progress report

1. This report sets out the performance of the Centre for Health Technology Evaluation (CHTE) against our business plan objectives during September and October. It also highlights key issues and developments in the Centre during that period.

2. CHTE is responsible for delivering the following programmes of work:

    - Diagnostic Assessment Programme (DAP)
    - Cancer Drugs Fund (CDF)
    - Commissioning Support Programme (CSP)
    - HealthTech Connect (HTC)
    - Highly Specialised Technologies (HST)
    - Interventional Procedures (IP)
    - Medical Technologies Evaluation Programme (MTEP)
    - Observational Data Unit (ODU)
    - Patient Access Schemes Liaison Unit (PASLU)
    - Technology Appraisals (TA)
    - Topic Selection (TS)

Performance

3. All programmes within the Centre are performing more or less according to plan for the September to October period, with minor variations reported for some individual programmes. Detailed performance and exception reporting for a number of the abovementioned programmes can be found in the Chief Executive's report. In this section we report on the performance of the remaining programmes of work, and provide highlights for all activities in CHTE.

4. Over the reporting period, we further provided advice to NHS England for 10 patient access schemes, against a planned number of 6, and NHS England's

clinical panel considered the clinical evidence reviews and draft policy propositions for 3 CSP topics; in line with the target for this period.

5. The CDF team has 9 ongoing or completed managed access agreements in the work programme for the 2018/19 business year and is likely to meet the target of up to 14 managed access agreements. Briefing documents to support commercial discussions between NHS England and companies have been developed for the majority of these CDF topics and for a number of HST topics.

6. For each piece of TA guidance, a suggested time for its review is given. This is the length of time after publication when NICE will consult with relevant organisations on a proposal about whether or not the guidance needs to be updated, and if so, how to update the guidance. So far, the technology appraisal reviews team have completed 17 review proposal projects. This remains on course to deliver against a target of 33 for the 2018/19 business year.

Notable issues and developments

Centre Coordination Team

7. During September and October CHTE advertised 10 vacancies, including 3 coordinator roles, 3 associate director roles, 2 project manager roles, an administrator and a technical analyst post. These vacancies were created by secondment opportunities elsewhere in NICE, maternity cover, and - in the case of 2 of the associate director roles - promotion to programme directors within the Centre. While most recruitment campaigns are at the interview stage, offers have been made for all interviews that have already taken place.

8. In September and October 7 recruitment campaigns for Committee members have taken place. We have appointed 14 new members: 5 lay members and 9 professional members.

Commercial and Managed Access Programme

9. The PASLU and CDF teams have become part of the broader programme of work that we refer to as the 'commercial and managed access programme' (CMAP). This programme also provides leadership oversight for the Accelerated Access Collaborative secretariat and the Office for Market Access; highlights of activities for these programmes of work are included in the Chief Executive's report.

10. The appraisals of all licensed treatments initially made available via the old model of the CDF are virtually complete, with publication of the last piece of guidance expected in December 2018. Of the 33 topics, 30 resulted in

recommendations for routine commissioning, 1 appraisal was terminated and 2 had negative recommendations (with 1 being a draft final recommendation).

11. In October PASLU had engagement with companies and NHS England on 2 complex PAS that have not been approved and one complex PAS that has been needed as an alternative to an MAA. There have been additional discussions about changes to 2 existing PAS to accommodate uncertainties highlighted at the technology appraisal committee meeting. PASLU has also been involved in continued engagement around the complicated supply agreements that have been emerging for the CAR-T products.

Commissioning Support Programme

12. The programme continues to meet targets for submitting to NHS England's clinical panel. However, of the current live topics, none have received the panel's authorisation to proceed to the next step in the process, with some being returned to the policy working groups for reworking a number of times. As a result, the number of live topics continues to increase as work commences on new topics in order to meet pre-existing targets. NICE and NHS England are discussing the most useful role for the programme and its outputs in future years.

Diagnostic Assessment Programme

13. NHS England has introduced a national Genomic Medicines Service as part of which a National Genomic Test Directory - which currently covers rare and inherited diseases, and cancer - will specify which tests are commissioned, the technology used, and the patients who will be eligible to be tested. The diagnostics programme has evaluated and produced guidance on many genomic tests, and precision medicine remains a key area of interest and engagement. We are currently working with NHS England genomics leads to align NICE evaluations of genomic tests with the development of the directory. The DAP associate director is also active in external stakeholder engagement at key conferences and forums involving NHS England, Genomics England, Office for Strategic Coordination of Health Research, parliamentarians industry and patient groups.

HealthTech Connect

14. Following excellent progress by the Evidence Resources and HealthTech Connect teams on the technical development, stakeholder engagement, confidentiality agreements and governance structures, a first phase of launch is planned before the November 2018 Board meeting. This means companies already engaging with NICE will be able to enter their products on the

HealthTech Connect database for review by NICE and NHS England. The second phase of launch is planned in early 2019.

15. The HealthTech Connect Project Board has agreed a sustainable funding model which will be activated when NHS England's 3 year financial support for the set-up phase ends in summer 2020. The NICE Senior Management Team and the HealthTech Connect Board supported a mixed, blended funding model with contributions from the Office for Life Sciences, Devolved Administrations, Accessor organisations and Industry Bodies. Individual companies submitting details of their product will not contribute to the cost. The agreed funding model recognises the distinctive role played by NICE, which will not be making a financial contribution.

Interventional Procedures

16. The use of "mesh" in procedures for the treatment of pelvic organs prolapse and stress urinary incontinence in women continues to attract significant public, political and press attention. A detailed response to the Independent Medicines and Medical Devices Safety Review ("Cumberlege review") which includes a summary of the importance of implementation of interventional procedures guidance has been submitted.

Medical Technologies Evaluation Programme

17. The new External Assessment Centre contracts, which run until June 2021, commenced on 1 October 2018. The MTEP team has started commissioning work for programmes across the centre under the new framework arrangements using SMT-approved procedures, which were considered by NICE audit and risk committee at its September meeting.

18. Work is progressing well to develop a framework of standards for the evidence required by digital health technologies to demonstrate their value to patients and the health and care system. The project, called 'Evidence for Effectiveness (EfE)' is commissioned and funded by NHS England and is being delivered in collaboration with MedCity London and Public Health England as well as other partners (see http://www.medcityhq.com/evidence-for-effectiveness/ for more information). An interim version of the framework is planned to be published in early December 2018, to coincide with the publication of the 1st version of the Code of Conduct for Data-Driven Technologies, an initial version of which was launched by the Secretary of State for Health and Social Care, Matt Hancock, at NHS Expo in September 2018.

Observational Data Unit

19. Two Commissioning through Evaluation projects, commissioned from NICE by NHS England, are proceeding from the initial set up phase:

    - Rituximab for idiopathic for membranous nephropathy. As part of this project, the National Registry of Rare Kidney Diseases (RaDaR), with project management and other support from the KITEC External Assessment Centre (EAC), will collect and validate the patient data;

    - Post-Market Study of the Argus II Retinal Prosthesis System. This is a particularly complex project in terms of the research governance arrangements because NICE IPG519 recommends that the procedure should only be undertaken in the context of research. Since neither NICE nor NHS England are research funding organisations, the National Institute for Health Research will be subcontracted by NHS England to provide the governance support required for patient facing research activities. King's College London will sponsor the project and the CEDAR EAC will carry out research activities.

Technology Appraisals (TA) and Highly Specialised Technologies (HST)

20. The updated guide to the process of TA was published on 3 April, and the transition to the new process is ongoing. The first topic to go through the new process is ID1175; durvalumab for maintenance treatment of unresectable non-small-cell lung cancer after platinum-based chemoradiation. The first of the new technical engagement step is expected to take place in December 2018.

21. The budget impact test is used to trigger discussions about developing potential commercial agreements between NHS England and companies in order to manage the budget impact of introducing high cost treatments. Since implementation in July 2016, 97 TA and HST topics have been assessed for the budget impact test at the company submission stage of the process (59 in 2017/18, 38 so far in 2018/19). Twenty seven (28%) have been identified as potentially meeting the criterion. Two of these topics have resulted in a successful commercial arrangement between the company and NHS England, and final NICE guidance has been published. One topic resulted in a recommendation for use within the CDF therefore the budget impact test was no longer required. Another topic was found to no longer breach following the submission of further data from the company. The remaining 23 topics are still going through NICE's processes, awaiting the final outcome of value assessment.

22. The centre director and senior members of the team have continued to participate in various meetings with the Department of Health and Social Care,

NHS England and colleagues from the pharmaceutical industry to support the arrangements for a new Pharmaceutical Price Regulation Scheme.

November 2018

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 September and October 2018. The business plan objectives are listed on page 7.

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. We are continuing to develop new content for the website and exploring different formats to increase engagement with our audiences. A project is underway to create a suite of interactive charts to present our technology appraisal data in a more visual way.

5. New web pages have been created to promote our commercial services. The new Scientific Advice pages aim to improve the visitor journey, provide more engaging and interesting content and a new online enquiry form highlighting all options available and giving the opportunity to sign up to receive marketing information, adhering to GDPR.

6. A video we created to promote our Fellows and Scholars scheme has been incorporated into a new toolkit developed by Health Education England for Allied Health Professions.

7. As part of our continuous improvement programme for the website we have made improvements to the social care quick guide landing page and created a digital version of the latest guide: promoting independence through intermediate care. Work has also begun to improve the header and footer that appear on all web pages to help users move around the site more easily.

8. We are providing communications support for an HR recruitment marketing pilot for hard-to-fill roles in digital services. This pilot features real life case studies of staff at NICE, videos and messages across our corporate social media accounts.

9. The October edition of NICEtimes was published and has been well received by staff. Our most popular article has been an in-depth interview with Chief Medical Officer, Dame Sally Davies on antimicrobial resistance and the importance of NICE guidance. A quote from the article has been used for external engagement on this topic through our social media channels.

10. We are working with HR to plan events for the next Healthy Work Week in January 2019 and have successfully increased uptake of the flu vaccination through a range of internal communications activities.

Enquiries

11. Since the last reporting period, we've responded to 1738 enquiries which included 28 MP letters, 26 Freedom of Information (FOI) requests, 15 parliamentary questions and 2 requests for information from DHSC, 60 content re-use enquiries and 224 reports of technical issues.

12. The team continues to work through a backlog of enquiries with around 300 enquirers awaiting a response. In addition we are receiving a high volume of emails regarding committee appointments for the update of guidance on myalgic encephalomyelitis (or encephalopathy)/chronic fatigue syndrome, taking the total backlog to more than 1,000.

13. The Rezum device remains a popular topic for enquiries. We've also seen a high number of enquiries on nusinersen for treating spinal muscular atrophy and ocrelizumab for treating primary progressive multiple sclerosis.

Audience insights

14. We have appointed Populus to do the 2019 reputation research project. They have experience of doing similar projects for large organisations and government departments and will bring a fresh perspective to the work, while maintaining the ability to compare performance over time. The project includes a large scale online survey and interviews with 25 senior stakeholders. The fieldwork will take place in early 2019, with a report produced by the end of March.

15. The team has recently completed a report about staff and developer perspectives of the recommendation writing process. This report is a follow up to a similar project completed with committee members earlier in the year. The findings will inform the user research plan that is being developed to support the Pathways pilot project.

16. The team is starting several new evaluation projects to take place over the coming months. These include

    - an evaluation of the patient decision aid on antipsychotic medicines for treating agitation, aggression and distress in people living with dementia
    - an evaluation of how we involve people with learning disabilities in the development of quality standards.
    - an evaluation of the revised Into Practice guide.

Editorial and publishing

17. We have edited and published the updated guidelines manual. Alongside this, we have produced a short summary document to show when and how people and organisations can get involved in the process. There is a visual version (in PDF format), plus a fully accessible version in HTML (web) format.

18. We have worked with Public Health England and the NICE managing common infections team to produce and publish a summary table containing all the NICE and PHE guidance on managing common infections. This will be updated with new NICE antimicrobial prescribing guidelines as they are published. It has been published on the antimicrobial prescribing guidelines page on our website.

19. We have prepared and published over 200 documents. This includes new and updated guidance, quality standards, evidence documents, and tools and resources. We have also produced 22 pieces of information for the public.

20. We have edited and published 4 guidelines on antimicrobial prescribing for urinary tract infections, covering lower UTIs, recurrent UTIs, pyelonephritis and prostatitis. Each of these also has a visual summary.

21. Three new NICE Pathways have been produced and published, on pancreatitis, prostatitis (antimicrobial prescribing) and suicide prevention. The pathways on chronic kidney disease and urinary tract infections received major updates.

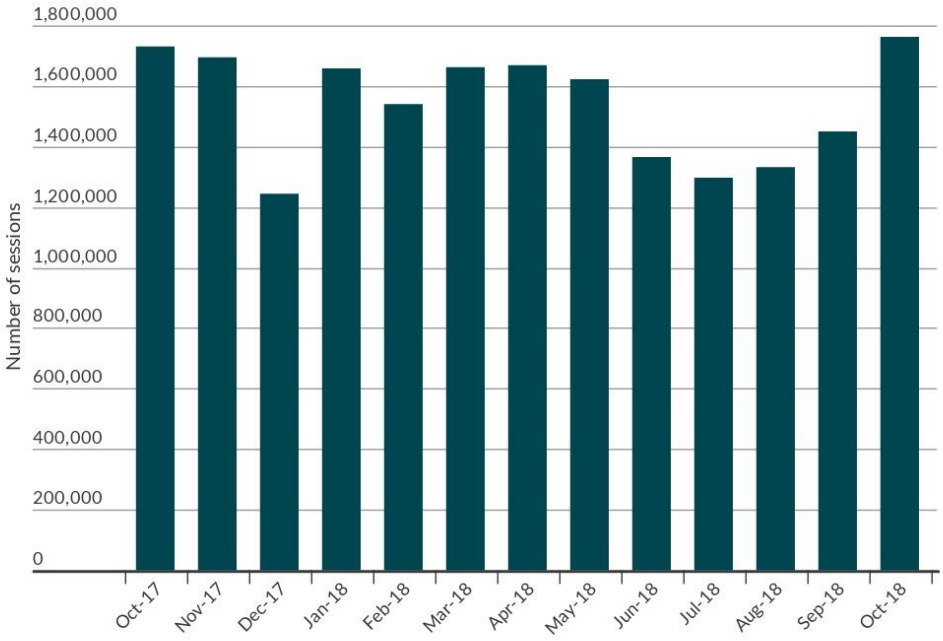
22. There are now 260 live pathways available, which consist of 1,843 guidance, advice and CKS products.

23. We are responding to new regulations for public sector bodies to make our website as accessible as possible to the widest audience, regardless of disability or the technology they use. We are writing a ‘how to guide’ that explains how to make NICE documents accessible and will be offering training to teams over the next few weeks so that, from January 2019, we will only publish documents that meet accessibility requirements.

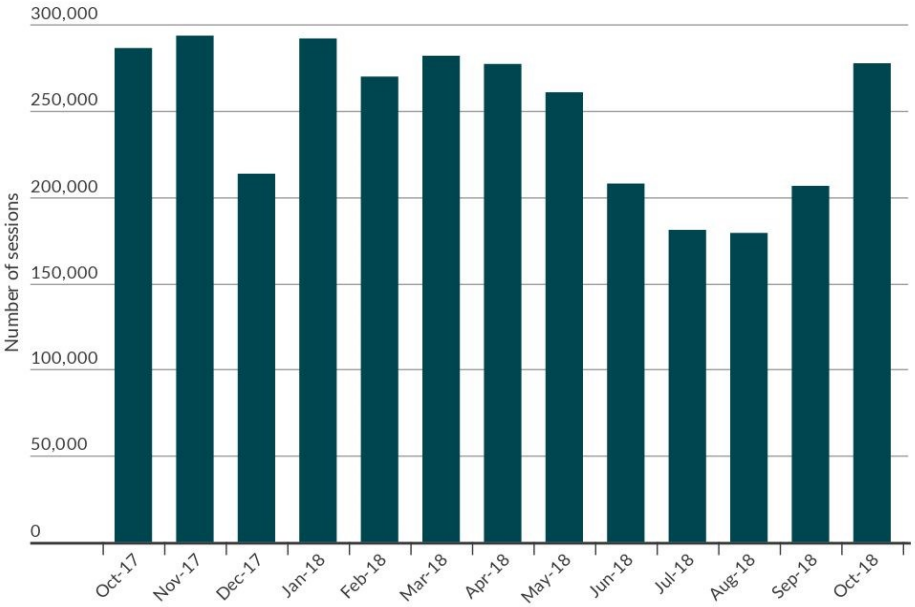
24. The new associate director for editorial and publishing, Philip Hemmings, started in September.

Website performance

Number of sessions on nice.org October 2017 to October 2018



Number of sessions on Pathways October 2017 to October 2018



Events

25. The G-I-N 2018 Conference, jointly hosted by NICE and our Scottish Counterparts at SIGN, was delivered on 11-14 September in Manchester. The event was a success, attracting 449 delegates from guideline-developing organisations and academia in 39 countries. The theme of the event was: "Why we do what we do: the purpose and impact of guidelines", and NICE's work/expertise was profiled prominently in both the plenary and parallel programme. The conference featured:

    - 4 panel sessions (2 from NICE)
    - 7 workshops (2 from NICE)
    - 57 oral presentations (11 from NICE)
    - 208 posters on display (37 from NICE)

26. On 5 October, we submitted NICE's corporate bid to host HTAi's annual meeting in 2021 in Manchester. We worked closely with colleagues in CHTE to develop a strong bid which proposes jointly hosting the large annual conference with Health Improvement Scotland (HIS) and the All Wales Therapeutics and Toxicology Centre (AWTTC), at the Manchester Central Convention Complex.

27. The theme we have proposed for the event is: "Innovation through HTA". The HTAi Board are due to consider all bids in January, and a final decision is due on 8 February 2019.

28. The NICE Annual Conference 2019 is confirmed for Thursday, 9 May, and will take place at the Deansgate Hilton again. The Shared Learning Awards will be held on the evening of Wednesday 8 May at a networking reception. We will use the venue differently this year to allow more people to attend the conference (following last year's tickets selling out).

29. The Conference programme will be launched in mid-November.

30. Our staff were involved in 5 speaking engagements in September and October, including a quality forum organised by Staffordshire County Council; the Care Show conference at the NEC and a patient information forum at the Royal College of Anaesthetists. Speakers included the field team, social care team and a guideline committee member. NICE also had the opportunity to engage in an international congress via Skype: Stephen Barnes, Technical Advisor in the Centre for Guidelines Team, spoke on 'developing NICE guidelines' to the 3rd Congress of Hungarian Paediatric Emergency Medicine through a live stream.

31. NICE exhibited at a total of 11 conferences including NHS Expo where we held 2 workshops titled: 'frailty' and 'improved outcomes in care homes' in partnership with external speakers from Local Authorities, social care providers and NHS England colleagues. We had a large stand in the exhibition hall, where we promoted our social care quick guides and the chance to meet the field team. Of these 11 events, three were social care focused.

Media

32. There was a great deal of national coverage related to the CAR-T approval for children with leukaemia. Although this was sparked by an NHSE announcement, the sentiment was largely positive for both NICE and NHSE. We also generated positive trade coverage for the approval of new melanoma treatment, debrafanib. Cannabis was also a popular story over September and October, and was covered heavily on broadcast media. The general excitement that NICE will be reviewing medicinal cannabis for use on the NHS contributed to much of this positive coverage.

33. The coverage regarding vaginal mesh, in reaction to the update of our guideline, was fairly neutral. Most stories followed the 'mesh as a last resort' angle and did not have a negative stance.

34. There was some negative coverage related to the rejection of MS drug, Ocrelizumab. Stories about antidepressant withdrawal symptoms, which mentioned the Roehampton study and NICE guidelines also contributed to this negative coverage.

35. Sentiment percentages for media coverage:

    - Positive – 76%
    - Neutral – 6%
    - Negative – 19%

Social media and podcasts

36. Our monthly podcast, NICE Talks was launched in January 2018. We are now approaching 11,000 plays in total and from September to October we received more than 3,000 plays. This includes listeners through SoundCloud directly and third party RSS applications, like Apple podcasts.

37. Our most popular podcast episode, 'Diabetes and weight loss, how do we get it right?' working with Diabetes UK, was released in September with a total of 1,342 plays. We launched an episode to coordinate with PHE's Stoptober campaign, 'How do we help people quit smoking?' featuring Martin Dockrell from Public Health England.

38. In October we also coordinated a Facebook live video on smoking cessation, broadcasting live from a smoking cessation clinic. Martin Dockrell also featured in this session. He was joined by a stop smoking intervention advisor and relevant case studies. The video received a total of 2.2K views. It reached over 4.5K people and had 91 interactions (comments, likes and shares).

Communication directorate objectives 2018-2019:

39. Ensure guidance and related products from NICE are of the highest quality.

40. To be relevant and authoritative - engaging the media, digital audiences, key partners and stakeholders in NICE's work.

41. To encourage and enable our key audiences to discover and implement NICE's work.

42. To offer a creative and productive work environment by prioritising team engagement and personal development.

43. Inform and engage everyone at NICE including Board members in order to embed a shared understanding of NICE's work.

44. Shape and manage our resources in order to support NICE and its strategic objectives effectively and efficiently.

Notable issues and developments

45. Capacity within the enquiry handling team is significantly reduced as result of vacancies and long term sickness absence. The high volume of emails regarding committee appointments for the update of guidance on myalgic encephalomyelitis (or encephalopathy)/chronic fatigue syndrome is also adding to pressures on the team.

46. Despite our best efforts, it is possible we will start to fall below our balanced scorecard target of responding to 90% enquiries within 18 days whilst we recruit to vacant posts.

47. In this reporting period we have received notice of several resignations at a senior level in the directorate. Recruitment will begin soon and we will work to maintain continuity in our support for the business.

November 2018

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 September and October 2018. It also highlights the usage performance of the NICE Evidence suite of on-line services. Other notable developments during the last 2 months are covered in the last section.

2. The Evidence Resources Directorate comprises three teams which provide a range of functions to NICE:

    - The Information Resources team provides access to high quality evidence and information to support guidance development. It also commissions key items of content made available to the NHS via the NICE Evidence Services.
    - The Intellectual Property (IP) and Content Business Management team manages the range of activities involved in granting permissions to use NICE's IP and content.
    - The Digital Services team delivers NICE's digital transformation activities and maintains all the live digital services of NICE.

Performance

3. Performance against the Evidence Resources objectives for 2018/19 is summarised for each team of the directorate. We also provide an update on our work pertaining to the assessment of Digital Health Tools. Finally, we provide some usage statistics about NICE Evidence Services.

Information Resources update

4. A key objective of the Information Resources team in 2018/19 is to support the re-procurement of the National Core Content (NCC) on behalf of Health Education England. In the last 2 months, key stages of this procurement have been completed; resources for the new NCC have been selected and we have started work on implementing the resources into HDAS. Suppliers and users have been notified of the outcome of the procurement and we are moving to award the contracts to successful bidders.

5. Another objective is to maintain and monitor the performance of NICE Evidence Services (the Clinical Knowledge Summary service (CKS), the HDAS federated search, the BNF microsites, the Evidence Search), with investment in new

features on a strictly needed basis. As reported in paragraph 28 of this report, a dip in the performance of Evidence Search has been observed over the summer. This is being investigated and remedial actions are being taken.

6. The guidance Information Services team, which supports NICE centres with the retrieval of evidence material, supported workshops, developed posters and presentations at the recent GIN and Cochrane conferences. The team is also piloting a process to identify real world data sources at the scoping stage of guidance development, and will work on this further with the new health analytics team.

Intellectual Property (IP) and Content Business Management update

7. The objective set out for the team in 2018/19 was to actively pursue revenue generation opportunities associated with international interest in the expertise of NICE and the re-use of NICE content.

8. Over the last two months, the team has continued to respond to requests to re-use NICE content. 18 quotes to re-use NICE content were issued and 8 licences were signed. A contract to syndicate NICE content was renewed for 5 years. The total income invoiced for the year-to-date for content re-use services amounts to approximately £150,000.

9. During September 2018, the work to deliver Knowledge Transfer Services (KTS), which typically consists of short training events and delegation arrangements, has been transferred to the NICE Scientific Advice (NSA) team, as part of a commitment to assemble all fee-for-services of NICE under one management structure. In future, notable progress with the KTS work will be reported by NSA.

Digital Services update

10. There are 4 principal objectives underpinning the work of the Digital Services team in 2018/19. Notable updates against these objectives are addressed in turn.

Delivery of strategic digital services projects:

11. The Evidence management platform (delivering web tools for systematic review needs and building an evidence surveillance capability) continues to be developed in a new cloud infrastructure. Users now have sifting, deduplication (of studies and reviews) and data extraction functionality. Work is further progressing towards delivering evidence synthesis functionality. Work also continues to support the successful rollout of relevant aspects of the evidence management platform to NICE's Guideline collaboration centres.

12. The Comment Collection project (work to bring efficiencies to the external consultation process) is progressing towards an expected Government Digital Service (GDS) Service Assessment in early 2019. An ACD (appraisal consultation document) using the new tool was released in October but returned minimal comments so we are working with the Centre for Health Technology Evaluation to identify other consultations to assess user experience. This is happening in parallel to the ongoing development of features to support the administration of the consultation process within NICE.

13. The procurement of an identity management solution and support for implementation has been approved by GDS and the Department of Health and Social Care (DHSC), and is progressing with an expectation that the new identity management solution can be rolled out to NICE digital services from Quarter 1 2019 onwards.

14. The procurement of consultancy expertise to advise on approaches and supporting technology to enable authoring and management of complex content is also under way. It will include a review of mature systems. This will also include an understanding of links to ontology management solutions for managing health and domain vocabularies. The ability to produce and store guidance in a more structured format will be integral to realising the NICE pathways vision.

Live services maintenance and improvements:

15. NICE Digital Services operated within the service levels (98%) agreed with DHSC for availability (uptime): 100% in September and 99.4% in October.

16. In September and October, 118 defects were closed. In the same period, 7 Change Control Requests were completed. During the first half of 2018/19, we have seen a marked reduction in the % of digital services resources invested in live services maintenance, from over 60% in 2017/18 to just 35% in the first half of this year. This has been managed proactively and has enabled more of our resource to be prioritised for strategic project work.

17. The maintenance of the planning and contact tools (supporting stakeholder management and planning activities for all guidance producing teams) was transitioned to the Digital Services team at the end of September. Risks associated with the transition of this important suite of software are being actively managed. Longer term plans to develop NICE's wider stakeholder management capabilities are in the early stages of consideration.

18. A strategic review of live services, designed to support prioritisation of capacity and resource to maintain live services, is progressing well. The first stage of the review, the technical assessment, has been completed for all 30 live digital

services. The next steps of the strategic review will investigate service cost/benefit against evolving business needs.

19. The first outcome of the review was the Senior Management Team's approval to retire the NICE Guidance App. Closure of the Guidance App is scheduled for the end of 2018. A news story has been published by the communications team with tweets and the newsletter to follow, all informing users of the closure of the app and where to access guidance. This will be repeated in November. A message will also appear when users launch the app on their device. Content updates will continued to be released until the app's final closure.

Team productivity improvement:

20. Recruitment update: Six vacant roles have recently been advertised via NHS Jobs. We have also sourced an agency to help increase the coverage these roles receive and our likelihood to successfully recruit. The interviews and any offers will be concluded in December with the outcome impacting our ongoing capacity into 2019.

21. Talent management update: One of the key areas arising from the staff survey for the team was the lack of potential career progression and this places challenge on our ability to retain and motivate talented ambitious individuals with digital expertise. The Digital Services management team are discussing how to support development opportunities in this area.

Promoting external collaborations:

22. On the fringes of the GIN conference, the Digital Services team hosted a workshop in September to bring together NHS Digital and guideline standards developers to discuss how to improve collaborative working. There was strong agreement from the first meeting that these meetings would be valuable to continue we are therefore planning to run another meeting in the first half of 2019. There was also agreement that further clarity and shared agreement is needed regarding the level of structure with which guidelines are developed and shared. A 4-tier model was discussed and this will be further refined by the group.

23. We are continuing to develop our relationship with Kings College London with a focus on research and development of provenance models for guidelines. A joint proposal for EPSRC funding for a 12 month collaboration has just been submitted. These provenance models are seen as important for both maintenance of guidelines and interoperability with systems used across the NHS.

'Evidence for Effectiveness' standards for digital health technologies update

24. An important objective of the directorate is to work with NHS England, Public Health England, MedCity and Digital Health London to develop standards for assessing the effectiveness and economic impact of Digital Health Technologies (DHTs). The standards will set out the levels of evidence that manufacturers should be aiming to develop (and commissioners should be looking for) in order to demonstrate effectiveness and economic impact on the health system for different types of digital health technology. The work commenced in June and excellent progress was achieved during September and October. A draft of the standards was prepared and shared with SMT. This included feedback received from PHE, MHRA, NHS England, NHS Digital and York Health Economics Consortium, as well as insight gained from eight stakeholder workshops with manufacturers and commissioners. Further stakeholder workshops were held with organisations in the innovation landscape who are expected to promote and use the standards framework such as Allied Health Science Networks, NHS Accelerator Programmes and NHS England's Tariff Teams.

25. The work was referenced in the 'Initial Code of Conduct' published by the Department for Health and Social Care in September. Our work underpins Principle 9 of the Code of Conduct. The next iteration of the Code of Conduct document will be published on 6 December 2018. NICE is aiming to publish an interim version of the standards on the NICE website at the same time, to align with this timeline. A further version of the standards will be published in January 2019 which will include educational and signposting resources, including case studies.

Notable issues and developments

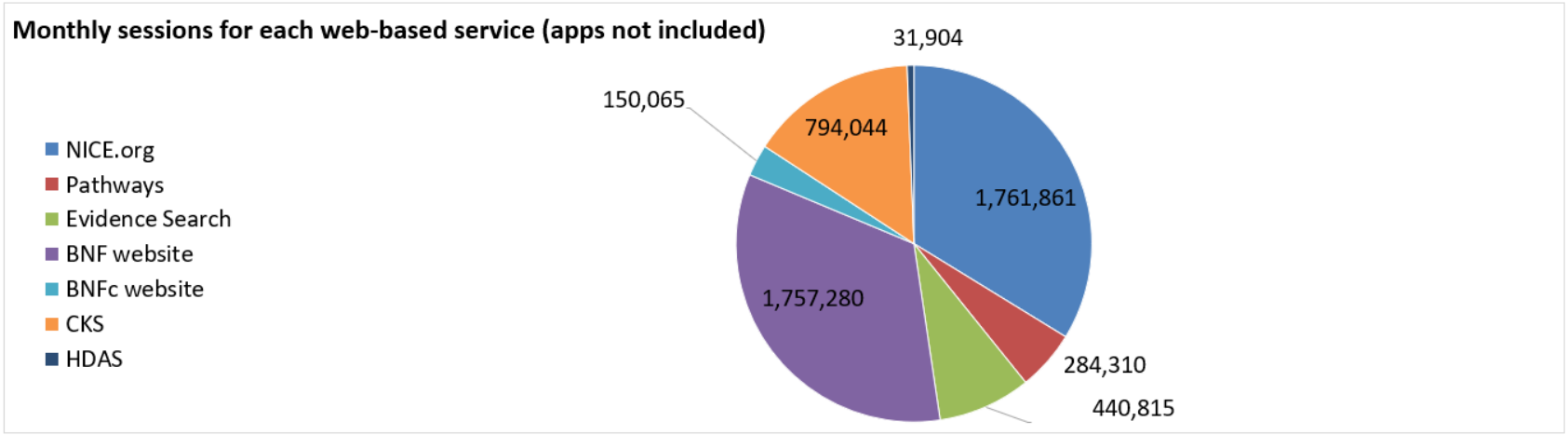
26. A significant dip in the performance of Evidence Search was observed over the summer. In September, usage of the search portal was down 40% relative to the same month in 2017. The decrease in visits was directly caused by a decrease in referrals from Google Search. There are a number of potential factors contributing to this, so we adopted a broad range of immediate optimisations, including updated XML sitemaps, improved handling of duplicate URLs, improved handling of redirects and changes to titles and meta-descriptions. A number of further actions have been identified pending a review of these initial fixes. So far, the remedial action appears to have been effective. At the beginning of October usage compared with 2017 was minus 40%. Towards the end of October, it stood at minus 15%. We will to continue to closely monitor performance.

Performance statistics for NICE Evidence Services

Figure 1: Overview of NICE's digital services performance as of October 2018

Overview of Digital Services performance in October 2018

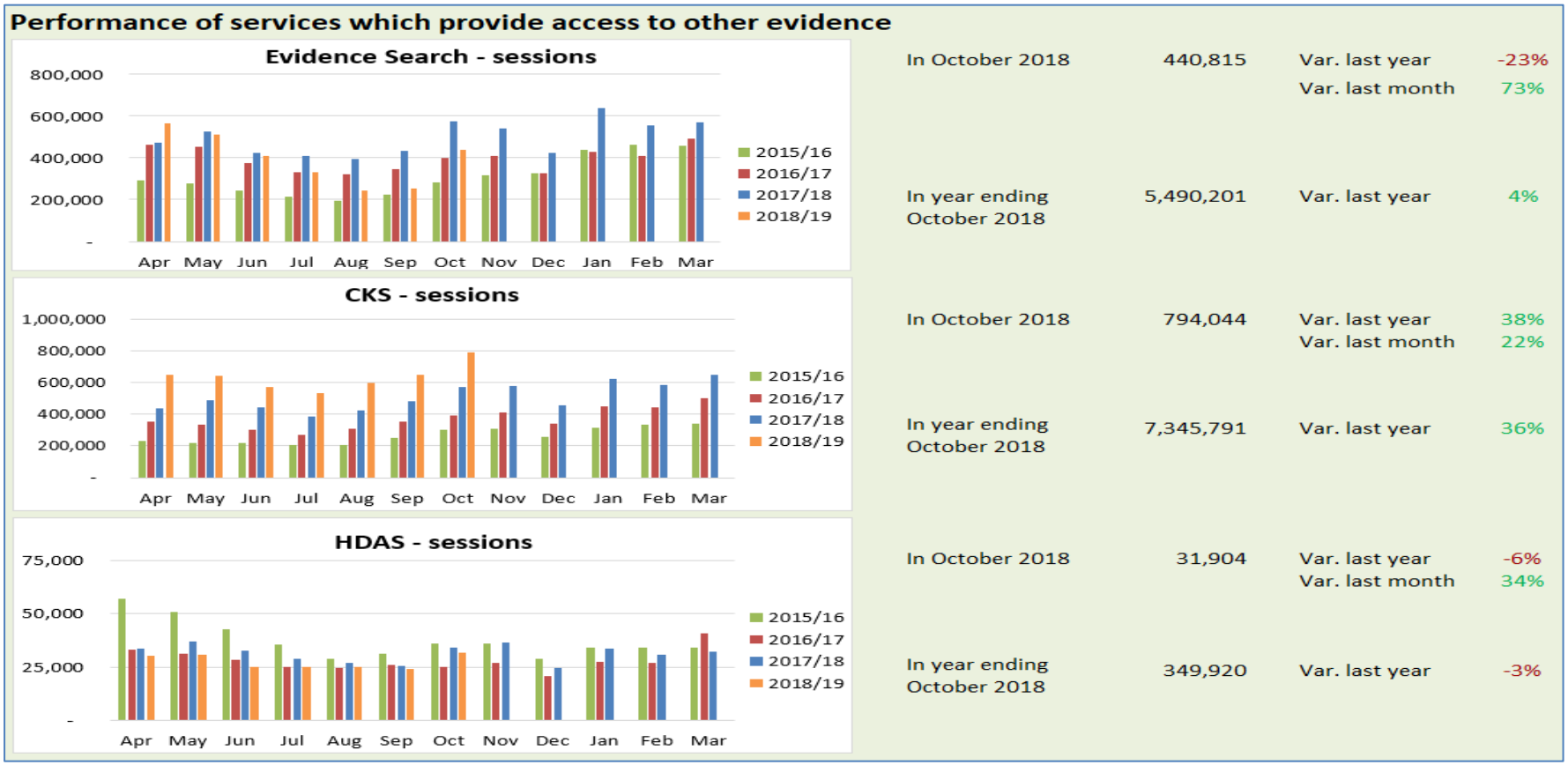
Total sessions* in October 2018 across NICE websites and apps:	5,274,834	% variance on same month last year % variance on last month	30.07% 29.26%
Total sessions for the full year ending in October 2018:	50,653,880	% change compared to same period last year:	11.62%



*Session is a group of interactions one user takes within a given time frame on your website

27. Figure 1, above summarises the position of all NICE's digital services at the end of October 2018, exposing the relative size of the different externally facing services of NICE, measured in number of 'sessions' (the number of visits to a website within a date range). There were over 50.5 million sessions across all digital services of NICE in the last twelve months which translates to a 12% increase in comparison with the same period in 2017/18.

Figure 2: Performance of services providing access to 'other evidence' as of October 2018



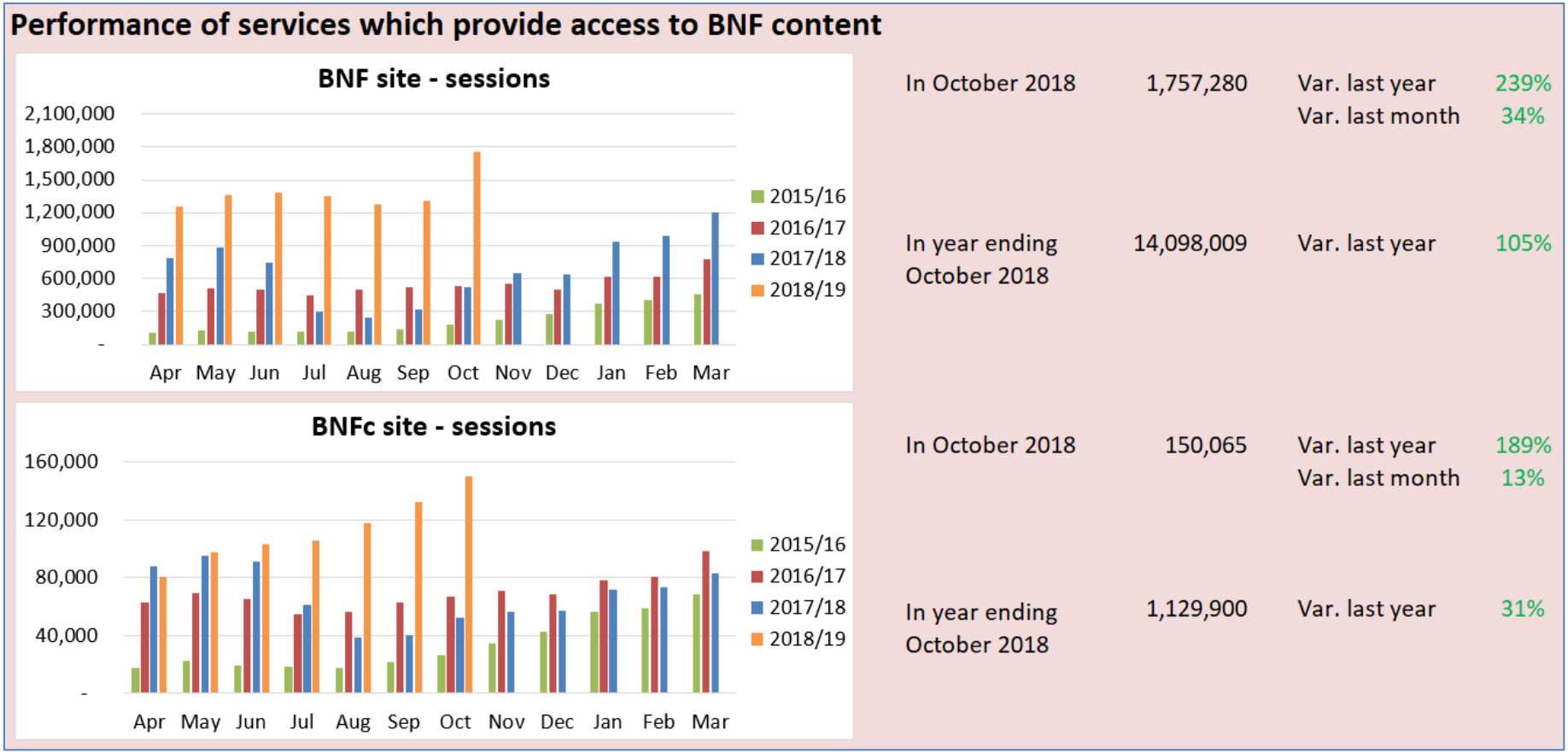
28. Figure 2, details the performance of the 3 services which provide access to evidence beyond that produced by NICE: Evidence Search, Clinical Knowledge Summaries (CKS) and HDAS. Trends for these three services were:

- Traffic to CKS remained significantly ahead of last year's trend and this service received on average 37% greater sessions than in September and October 2017.

- Evidence Search again received fewer sessions than last year. However, the difference in sessions with last year's seems to have shortened in October (from -41% variation in September to -23% in October).

- Finally, although HDAS saw the usual seasonal increase in sessions in October, the volume of traffic to this service continued behind last year's (on average -6% sessions in the last two months).

Figure 3: Performance of services providing access to BNF content as of October 2018



29. Figure 3 summarises the performance of our BNF microsites. Both microsites, the BNF and BNFc, continue to perform very strongly and in October BNF reached the same volume of monthly sessions than the NICE website (just under 1.8 million monthly sessions).