

Putting NICE guidance into practice

Resource impact report: Low back pain and sciatica in over 16s: assessment and management (NG59)

Published: September 2020

Summary

This report focuses on the recommendations from NICE's guideline on low back pain and sciatica in over 16s that we think will have the greatest resource impact nationally (for England), and will need the most additional resources to implement or potentially generate the biggest savings. They are:

- do not offer gabapentinoids, other antiepileptics, oral corticosteroids or benzodiazepines for managing sciatica (**recommendation 1.2.16**)
- do not offer opioids for managing chronic sciatica (**recommendation 1.2.17**).

Financial impact

The estimated net financial impact of implementing this guideline for the population of England in the next 5 years is a saving of around £220,000 in 2021/22 rising to a saving of around £1.1 million per year from 2025/26 as shown in table 1 and figure 1. This is equivalent to a saving of around £2,000 per 100,000 population.

The resource impact for primary care is as a result of changes to the pharmacological treatments for people with severe sciatica that is acute or chronic and is an estimated cash saving of £4.5m. The resource impact for secondary care is as result of an expected increase in the number of patients receiving an epidural, with an estimated non-cash impact for providers of £3.4m (based on national tariffs). However, the impact for secondary care may result in a cash impact for commissioners. There may also be a small cash impact for secondary care providers due to any additional non pay costs being incurred arising from the increase in patients receiving an epidural.

The estimated financial impact of implementing this guideline for primary care for an average GP practice (10,000 people) is a saving of around £800, and for an average STP population (500,000 people) is a saving of around £40,000.

Implementation of 100% represents achieving the maximum uptake expected, it does not represent 100% achievement of the recommendations.

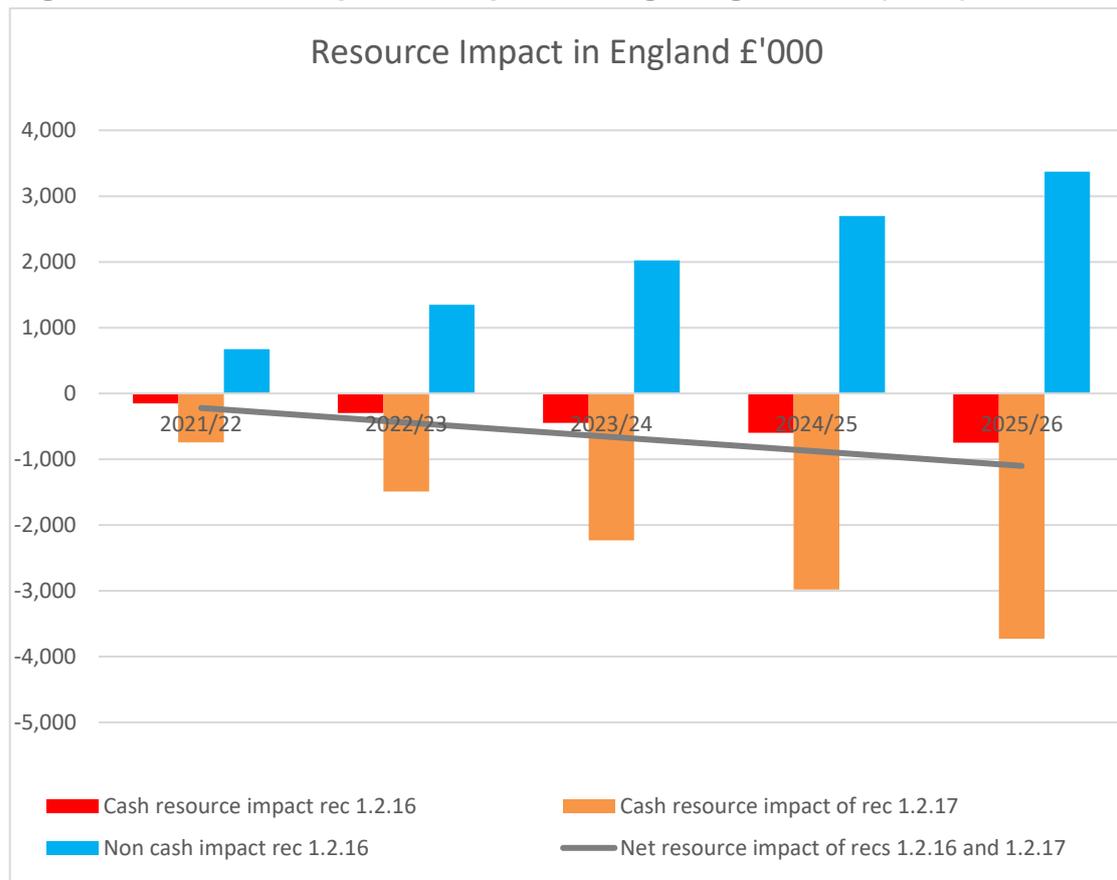
Table 1 Estimated annual saving of implementing the guideline in England

	Yr 1	Yr 2	Yr 3	Yr 4	Yr 5
Implementation rate of guideline	20%	40%	60%	80%	100%
Estimated savings for recommendation 1.2.16 (£000s) (cash cost – primary care/commissioners)	-149	-299	-448	-598	-747
Estimated cost for recommendation 1.2.16 (£'000s) (non-cash/cash cost – secondary care/commissioners)	674	1,349	2,023	2,697	3,372
Estimated savings for recommendation 1.2.17 (£000s) (cash saving – primary care/commissioners)	-745	-1,490	-2,236	-2,981	-3,726
Total resource impact for the population of England (£000s) (total saving)	-220	-441	-661	-881	-1,102

Table 2 Estimated annual saving of implementing the guideline per 100,000 population

	Yr 1	Yr 2	Yr 3	Yr 4	Yr 5
Implementation rate of guideline	20%	40%	60%	80%	100%
Estimated savings for recommendation 1.2.16 (£s) (cash saving primary care/commissioners)	-267	-534	-801	-1,068	-1,335
Estimated cost for recommendation 1.2.16 (£'000s) (non-cash/cash cost – secondary care/commissioners)	1,205	2,410	3,615	4,819	6,024
Estimated savings for recommendation 1.2.17 (£s) (cash saving primary care/commissioners)	--1,332	-2,663	-3,995	-5,326	-6,657
Total resource impact per 100,000 population (£s) (total saving)	-394	-787	-1,181	-1,575	-1,968

Figure 1 Resource impact of implementing the guideline (£000)



1 Introduction

- 1.1 The guideline offers best practice advice on low back pain and sciatica.
- 1.2 This report discusses the resource impact of implementing our guideline on [low back pain and sciatica in over 16s: assessment and management](#) in England. It aims to help organisations plan for the financial implications of implementing this NICE guideline.
- 1.3 A resource impact template accompanies this report to help with assessing the resource impact at a local level in England, Wales or Northern Ireland.
- 1.4 We have considered direct costs and savings to the NHS (and local authorities if applicable) and not those for the individual, the private sector or the not-for-profit sector. Any costs arising from a change in practice have been offset against the savings from implementing the change.
- 1.5 Low back pain and sciatica services are commissioned by clinical commissioning groups; in some areas this will be through Integrated Care Systems. Providers are primary care, community and secondary care services.

2 Background

- 2.1 Sciatica is a relatively common condition with a lifetime incidence ranging from 13 to 40%. The corresponding annual incidence of an episode of sciatica ranges from 1 to 5% ([Stafford et al, 2007](#)).
- 2.2 Currently most people with severe sciatica are treated with gabapentinoids, opioids or both, despite neither being a first-line treatment (expert clinical opinion). Other treatment options include amitriptyline, naproxen or people choosing not to use NHS resources (alternatives such as over the counter medications or

privately funded treatments). A small proportion of people will also receive an epidural.

3 Significant resource impact recommendations

3.1 Do not offer gabapentinoids, other antiepileptics, oral corticosteroids or benzodiazepines for managing sciatica (recommendation 1.2.16).

Do not offer opioids for managing chronic sciatica (recommendation 1.2.17).

Background

- 3.1.1 In the guideline acute is defined as less than three months duration and chronic is defined as three months duration or longer. Recommendation 1.2.16 relates to both the acute and chronic sciatica population. Recommendation 1.2.17 relates to the chronic population only. There is a separate research recommendation for opioids in the acute sciatica population.
- 3.1.2 Some prescription medicines can be associated with dependence and can cause potential harm from sudden withdrawal from these medicines.
- 3.1.3 The committee agreed that the evidence showed that gabapentinoids, other antiepileptics, oral corticosteroids and benzodiazepines did not improve severe sciatica symptoms and they increased the risk of adverse events in the long term.
- 3.1.4 The committee also agreed that there was a lack of evidence on the use of opioids for chronic sciatica. Given the lack of evidence, and the committee's knowledge of potential harms when used long term, the committee agreed to recommend against the use of opioids for chronic sciatica.

Assumptions made

- 3.1.5 According to [Stafford et al, 2007](#) the annual incidence of sciatica ranges between 1 and 5%. We have used a midpoint of 3% in the template.
- 3.1.6 It is assumed that 35% of people with sciatica have severe sciatica ([Stafford et al, 2007](#)).
- 3.1.7 It is also assumed that 32% of people with severe sciatica will have chronic severe sciatica, based on expert clinical opinion and the figures in [Stafford et al, 2007](#) (20-40% of people with severe sciatica will have chronic sciatica).
- 3.1.8 It is assumed that the population being considered are primarily being treated for severe acute sciatica and severe chronic sciatica.
- 3.1.9 It is assumed that there will be no change in the uptake of surgery, between current and future practice, for people with severe sciatica. Therefore, we have not included surgery within the resource impact model. This is based on clinical expert opinion.
- 3.1.10 It is assumed, based on clinical expert opinion, that people with acute severe sciatica would, on average, receive pharmacological treatments for six months. This is because of the severity of the person's sciatica.
- 3.1.11 It is assumed, based on clinical expert opinion, the people with chronic severe sciatica would receive pharmacological treatments for the entire year.
- 3.1.12 The potential resource impact of treatment for people with chronic severe sciatica, for the withdrawal from their current pharmacological treatment has not been included in this analysis. There is a line in the template for your local input. A piece of NICE guidance currently under development, [Safe prescribing and withdrawal management of prescribed drugs associated with](#)

[dependence and withdrawal](#), will look at the potential resource impact of withdrawal.

- 3.1.13 It is assumed, based on clinical expert opinion, that additional referrals to physiotherapy, resulting from a reduction in the number of people receiving drug treatments, may lead to an increase in waiting times and service may need to be reconfigured. There has been no potential impact resulting from this included in the assessment.
- 3.1.14 It is assumed that increased referrals into pain management services will not be significant and therefore these have not been included in the assessment.
- 3.1.15 For gabapentinoids and opioids the average cost of treatment is based upon average uptake of the treatments in tables 3 and 4. This is for both current and future practice.

Table 3 Proportions of gabapentinoids used for treating severe sciatica

Treatment	Average uptake
Pregabalin 2 x 75mg capsules twice daily	51%
Gabapentin 1 x 300mg capsules three times daily	49%

Table 4 Proportions of opioids used for treating severe sciatica

Treatment	Average uptake
Co-codamol 2 x 30mg / 500mg tablets 4 times a day	39%
Tramadol 2x 50mg capsules 4 times a day	16%
Morphine sulfate 5-10mg for injection every 4 hours	13%
Codeine phosphate 30-60 mg every 4 hours up to 240mg per day (1-2 tablets 4 times a day)	13%
Buprenorphine 200-400 micrograms 4 times a day	6%
Oxycodone hydrochloride 10mg 4 times a day	5%
Co-dydramol (Dihydrocodeine/paracetamol) 2x 10mg/500mg 4 times a day	4%
Dihydrocodeine tartrate 2x 30mg tablets 4 times a day	4%

- 3.1.16 Alternative treatments for severe sciatica that are not gabapentinoids or opioids include amitriptyline 50 mg once daily

and naproxen 500 mg two times a day. Treatment with naproxen requires gastric protection with omeprazole 20 mg once daily.

- 3.1.17 In current practice in the acute severe sciatica population it is assumed that around 11% of people will have gabapentinoids only, 28% of people will have gabapentinoids and opioids, 28% of people will have opioids only, and 15% will have amitriptyline, based on expert clinical opinion.
- 3.1.18 According to expert clinical opinion, currently around 1% of people with acute severe sciatica will have an epidural.
- 3.1.19 In current practice for the acute severe sciatica population it is assumed around 17% of people will not use NHS resources. It is expected that they would seek either over-the-counter or privately funded treatments. This group of people is not expected to change in future practice. This is based on clinical expert opinion.
- 3.1.20 It is assumed that 90% of people having an epidural will need a magnetic resonance imaging scan of one area prior to the epidural to aid positioning. This is based on clinical expert opinion.
- 3.1.21 In future practice it is estimated that in the acute severe sciatica population 6% of people will have gabapentinoids only, 17% of people will have gabapentinoids and opioids and 31% of people will have opioids only. This is based on clinical expert opinion.
- 3.1.22 The use of amitriptyline is expected to increase for people with acute severe sciatica in future practice. It is assumed that 16% of people will be treated with amitriptyline alone, 8% will be treated with amitriptyline and opioids and 3% will be treated with naproxen and amitriptyline. This is based on clinical expert opinion.
- 3.1.23 Clinical expert opinion is that in future practice the number of people having an epidural will increase by 1%. Therefore, it is

assumed that around 2% of the population with acute severe sciatica will have an epidural.

- 3.1.24 In current practice around 11% of people with chronic severe sciatica are treated with gabapentinoids, around 28% are treated with both gabapentinoids and opioids, around 28% are treated with opioids and around 15% of people will have amitriptyline. This is based on clinical expert opinion.
- 3.1.25 In current practice for the chronic sciatica population it is assumed around 18% of people will not use NHS resources. It is expected that they would seek either over-the-counter or privately funded treatments. This group of people is not expected to change in future practice. This is based on clinical expert opinion.
- 3.1.26 In future practice it is assumed that around 7% of people with chronic severe sciatica will be treated with gabapentinoids, 17% will be treated with both gabapentinoids and opioids, around 17% will be treated with opioids, a further around 38% will be treated with amitriptyline and 3% will be treated with naproxen. This is based on clinical expert opinion.
- 3.1.27 Current and future practice for severe acute sciatica is summarised in table 5.

Table 5 Current and future practice for people who have severe acute sciatica

Population	Current practice		Future practice	
	%	Number of people	%	Number of people
Acute severe sciatica				
People with acute sciatica who are treated with gabapentinoids	11	52,239	6	28,494
People with acute sciatica who are treated with opioids	28	132,972	31	147,219
People with acute sciatica who are treated with gabapentinoids and opioids	28	132,972	17	80,733
People with acute sciatica who are treated with amitriptyline	15	71,235	16	75,984
People with acute sciatica who are treated with amitriptyline and opioids	0	0	8	37,992
People with acute sciatica who are treated with naproxen and amitriptyline	0	0	3	14,247
People with acute sciatica who are treated with an epidural	1	4,749	2	9,498
People with acute sciatica who do not use NHS resources	17	80,733	17	80,733
Total people treated for acute severe sciatica	100	474,902	100	474,902

3.1.28 Current and future practice for severe chronic sciatica is summarised in table 6.

Table 6 Current and future practice for people who have severe chronic sciatica

Population	Current practice		Future practice	
	%	Number of people	%	Number of people
Chronic severe sciatica				
People with chronic sciatica who are treated with gabapentinoids	11	16,717	7	10,638
People with chronic sciatica who are treated with opioids	28	42,551	17	25,835
People with chronic sciatica who are treated with gabapentinoids and opioids	28	42,551	17	25,835
People with chronic sciatica who are treated with amitriptyline	15	22,795	38	57,748
People with chronic sciatica who are treated with naproxen	0	0	3	4,559
People with chronic sciatica who do not use NHS resources	18	27,354	18	27,354
Total people treated for chronic severe sciatica	100	151,968	100	151,968

Costs

3.1.29 Table 7 summarises the costs of treatment options for people with acute severe sciatica.

Table 7 Cost of treatment options for people with acute severe sciatica

Treatment	Duration	Reference	Cost (£)
People receiving gabapentinoids	6 months	eMIT (July 2020)	20.32
People receiving opioids	6 months	eMIT (July 2020)	55.14
People receiving gabapentinoids and opioids	6 months	eMIT (July 2020)	75.46
People receiving amitriptyline	6 months	eMIT (July 2020)	11.28
People receiving amitriptyline and opioids	6 months	eMIT (July 2020)	66.41
People receiving naproxen and amitriptyline	6 months	eMIT (July 2020)	22.10
People receiving an epidural	One off	NHS National tariff	710

3.1.30 Table 8 summarises the costs of the treatment options.

Table 8 Cost of treatment options for people with chronic severe sciatica

Treatment	Duration	Reference	Cost (£)
People receiving gabapentinoids	12 months	eMIT (July 2020)	40.64
People receiving opioids	12 months	eMIT (July 2020)	110.27
People receiving gabapentinoids and opioids	12 months	eMIT (July 2020)	150.91
People receiving amitriptyline	12 months	eMIT (July 2020)	22.55
People receiving naproxen	12 months	eMIT (July 2020)	21.64

Resource impact

3.1.31 The resource impact of implementing recommendations 1.2.16 and 1.2.17 is summarised in tables 9 - 12.

Table 9 Estimated change in number of people with acute severe sciatica affected by recommendation 1.2.16

Activity	Current practice	Yr 1 change	Yr 2 change	Yr 3 change	Yr 4 change	Yr 5 change
Implementation rate		20%	40%	60%	80%	100%
People with acute sciatica who are treated with gabapentinoids	52,239	-4,749	-9,498	-14,247	-18,996	-23,745
People with acute sciatica who are treated with opioids	132,972	2,849	5,699	8,548	11,398	14,247
People with acute sciatica who are treated with gabapentinoids and opioids	132,972	-10,448	-20,896	-31,344	-41,791	-52,239
People with acute sciatica who are treated with amitriptyline	71,235	950	1,900	2,849	3,799	4,749
People with acute sciatica who are treated with amitriptyline and opioids	0	7,598	15,197	22,795	30,394	37,992
People with acute sciatica who are treated with naproxen and amitriptyline	0	2,849	5,699	8,548	11,398	14,247
Primary care impact		-950	-1,900	-2,849	-3,799	-4,749
People with acute sciatica who are treated with an epidural	4,749	950	1,900	2,849	3,799	4,749
People with acute sciatica who do not use NHS resources	80,733	0	0	0	0	0
Secondary care impact		950	1,900	2,849	3,799	4,749
Total number of people for with acute sciatica (rec 1.2.16)	474,902	474,902	474,902	474,902	474,902	474,902

Table 10 Estimated resource impact for people with acute severe sciatica affected by recommendation 1.2.16

Cost	Current practice (£000s)	Yr 1 change (£000s)	Yr 2 change (£000s)	Yr 3 change (£000s)	Yr 4 change (£000s)	Yr 5 change (£000s)
Implementation rate		20%	40%	60%	80%	100%
People with acute sciatica who are treated with gabapentinoids	1,062	-97	-193	-290	-386	-483
People with acute sciatica who are treated with opioids	7,331	157	314	471	628	786
People with acute sciatica who are treated with gabapentinoids and opioids	10,033	-788	-1,577	-2,365	-3,153	-3,942
People with acute sciatica who are treated with amitriptyline	803	11	21	32	43	54
People with acute sciatica who are treated with amitriptyline and opioids	0	505	1,009	1,514	2,018	2,523
People with acute sciatica who are treated with naproxen and amitriptyline	0	63	126	189	252	315
Impact due to changes in drug use - cash impact		-149	-299	-448	-598	-747
Total cost from drug use - cash impact	19,230	19,080	18,931	18,781	18,632	18,482
People with acute sciatica who are treated with an epidural	3,372	674	1,349	2,023	2,697	3,372
People with acute sciatica who do not use NHS resources	0	0	0	0	0	0
Non-drug impact – non-cash/cash impact		674	1,349	2,023	2,697	3,372
Total non-cash/cash cost	3,372	4,046	4,721	5,395	6,069	6,744
Total resource impact of acute severe sciatica (rec 1.2.16)		525	1,050	1,575	2,100	2,625
Total cost of acute sciatica (rec 1.2.16)	22,601	23,126	23,651	24,176	24,701	25,226

Table 11 Estimated change in number of people with chronic severe sciatica affected by recommendations 1.2.16 and 1.2.17

Activity	Current practice	Yr 1 change	Yr 2 change	Yr 3 change	Yr 4 change	Yr 5 change
Implementation rate		20%	40%	60%	80%	100%
People with chronic sciatica who are treated with gabapentinoids	16,717	-1,216	-2,431	-3,647	-4,863	-6,079
People with chronic sciatica who are treated with opioids	42,551	-3,343	-6,687	-10,030	-13,373	-16,717
People with chronic sciatica who are treated with gabapentinoids and opioids	42,551	-3,343	-6,687	-10,030	-13,373	-16,717
People with chronic sciatica who are treated with amitriptyline	22,795	6,991	13,981	20,972	27,962	34,953
People with chronic sciatica who are treated with naproxen	0	912	1,824	2,735	3,647	4,559
People with chronic sciatica who do not use NHS resources	27,354	0	0	0	0	0
Total number of people with chronic sciatica (rec1.2.17)	151,968	151,968	151,968	151,968	151,968	151,968

Table 12 Estimated resource impact for people with chronic severe sciatica affected by recommendations 1.2.16 and 1.2.17

Cost	Current practice (£000s)	Yr1 change (£000s)	Yr2 change (£000s)	Yr3 change (£000s)	Yr4 change (£000s)	Yr5 change (£000s)
Implementation rate		20%	40%	60%	80%	100%
People with chronic sciatica who are treated with gabapentinoids	679	-49	-99	-148	-198	-247
People with chronic sciatica who are treated with opioids	4,692	-369	-737	-1,106	-1,475	-1,843
People with chronic sciatica who are treated with gabapentinoids and opioids	6,421	-505	-1,009	-1,514	-2,018	-2,523
People with chronic sciatica who are treated with amitriptyline	514	158	315	473	631	788
People with chronic sciatica who are treated with naproxen	0	20	39	59	79	99
People with chronic sciatica who do not use NHS resources	0	0	0	0	0	0
People with chronic sciatica who are treated for withdrawal	0	0	0	0	0	0
Cash resource impact of chronic severe sciatica (rec 1.2.17)		-745	-1,490	-2,236	-2,981	-3,726
Total cost of chronic sciatica (rec 1.2.17)	12,307	11,562	10,817	10,071	9,326	8,581

3.1.32 There will be savings from the reduction in use of gabapentinoids and opioids for people with severe sciatica.

Benefits and savings

3.1.33 Long term use of gabapentinoids and opioids can lead to dependency. This will be reduced with fewer people using these treatments. [Public Health England](#) reviewed the use of these treatments and the difficulties of dependency and withdrawal in 2019.

Other considerations

3.1.34 Clinical experts expect an increase in referrals to physiotherapy services as a result in the reduction of people having drug

treatments for severe sciatica. This is expected to increase waiting times and may need adjustments to the prioritisation of services.

- 3.1.35 There may be an increase in referrals to pain management services. This is not anticipated to be significant and has not been included in the resource impact assessment.
- 3.1.36 Clinical experts expect that there may be additional time needed for healthcare professionals to support people withdrawing from opioids and gabapentinoids. It is expected that there will need to be more appointments with GPs and that they may be of a longer duration. This has not been included in the resource impact assessment.

4 Resource impact over time

- 4.1 The estimated annual saving of implementing this guideline for the population of England based on the uptake in the resource impact assumptions is shown in table 13. The saving from year 5 once steady state is reached is equivalent to around £2,000 per 100,000 population (see table 14).

Table 13 Resource impact of implementing the guideline using NICE assumptions

	Yr 1	Yr 2	Yr 3	Yr 4	Yr 5
Implementation rate of guideline	20%	40%	60%	80%	100%
Estimated savings for recommendation 1.2.16 (£000s) (cash savings – primary care/commissioners)	-149	-299	-448	-598	-747
Estimated cost for recommendation 1.2.16 (£'000s) (non-cash/cash cost – providers/commissioners)	674	1,349	2,023	2,697	3,372
Estimated savings for recommendation 1.2.17 (£000s) (cash saving – primary care/commissioners)	-745	-1,490	-2,236	-2,981	-3,726
Total resource impact for the population of England (£000s) (total saving)	-220	-440	-661	-882	-1,101

Table 14 Resource impact of implementing the guideline per 100,000 population

	Yr 1	Yr 2	Yr 3	Yr 4	Yr 5
Implementation rate of guideline	20%	40%	60%	80%	100%
Estimated savings for recommendation 1.2.16 (£000s) (cash cost primary care/commissioners)	-267	-534	-801	-1,068	-1,335
Estimated cost for recommendation 1.2.16 (£'000s) (non cash/cash cost – providers/commissioners)	1,205	2,410	3,615	4,819	6,024
Estimated savings for recommendation 1.2.17 (£000s) (cash saving)	--1,332	-2,663	-3,995	-5,326	-6,657
Total resource impact per 100,000 population (£s) (total saving)	-394	-787	-1,181	-1,575	-1,968

5 Implications for commissioners

- 5.1 Sciatica falls under programme budgeting category 07A Chronic pain.
- 5.2 There is likely to be a saving from the reduction in use of gabapentinoids and opioids for people with severe sciatica. This may require additional time for healthcare professionals in primary care to support people withdrawing from opioids and gabapentinoids.
- 5.3 There may be additional pressures on services providing epidurals and community based physiotherapy services.

6 Assumptions made

- 6.1 The resource impact template makes the following assumptions:
- There are around 1.4 million people in England who are diagnosed with sciatica each year.
- 6.2 If a national tariff price or indicative price exists for an activity, this has been used as the unit cost. The resource impact template can be used to amend unit costs to account for any local market forces factor.
- 6.3 Using these prices ensures that the costs in the report are the cost to the clinical commissioning groups of commissioning predicted changes in activity at the tariff price but may not represent the actual cost to individual trusts of delivering the activity.

7 Sensitivity analysis

- 7.1 There are some assumptions in the model for which no empirical evidence exists, so we cannot be as certain about them. Appropriate minimum and maximum values of variables were used in the sensitivity analysis to assess which variables have the

biggest impact on the net cost or saving. This enables users to identify the significant cost drivers.

Appendix A is a table listing all variables modified. The key conclusions are discussed below. The baseline resource impact is around £4 million for England.

- 7.2 Varying the incidence of people with severe acute sciatica from 1% to 5% leads to an estimated saving of between £367,000 and £1.8 million for the population of England.
- 7.3 Varying the incidence of people with severe chronic sciatica between 20% and 40% leads to an estimated resource impact of between a cost of £296,000 and a saving of £2.0 million for the population of England.
- 7.4 Varying the number of people with the acute sciatica who receive epidurals in future practice from 1% to 5% leads to an estimated resource impact between a saving of £4.5 million and a cost of £9.0 million for the population of England. Based on clinical expert opinion it is not anticipated that the increase to 5% will occur. The estimated cost for people who receive epidurals is based on national tariffs, it is not anticipated that any change in activity will have a significant cash impact.

Appendix A. Results of sensitivity analysis

<u>Individual variable sensitivity</u>				Recurrent resource impact			Change (£000s)	Sensitivity ratio
	Baseline value	Minimum value	Maximum value	Baseline resource impact (£000s)	Minimum resource impact (£000s)	Maximum resource impact (£000s)		
Incidence of people with sciatica	3%	1%	5%	-1,102	-367	-1,836	-1,469	0.16
Incidence of people with chronic sciatica	32%	20%	40%	-1,102	296	-2,033	-2,329	0.55
People having epidurals for acute sciatica in future practice	2%	1%	5%	-1,102	-4,473	9,014	13,487	1.00

About this resource impact report

This resource impact report accompanies the [NICE guideline Low back pain and sciatica in over 16s: assessment and management](#) and should be read in conjunction with it. See [terms and conditions](#) on the NICE website.

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