



*National Institute for  
Health and Clinical Excellence*



Volume 1

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ANNUAL REPORT **2008/09**



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# **National Institute for Health and Clinical Excellence (Special Health Authority)**

## **Annual Report and Accounts 2008/09**

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of the National Health Service Act 2006*

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### **Volume 1**

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# CHAIRMAN'S AND CHIEF EXECUTIVE'S FOREWORD

NICE came into existence in April 1999. This year therefore provides us with an opportunity to look backwards as well as forwards.

Over the past 10 years we have published 583 individual pieces of NICE guidance; we have earned a national and international reputation for the quality of our work; and we have made a real difference to the lives of millions of people.

In this past year we have published 19 clinical guidelines, 30 technology appraisals, advice on the use of 39 interventional procedures and 7 pieces of public health guidance. The latter included recommendations about promoting physical activity, and finding ways to decrease mortality in disadvantaged areas.

But publishing NICE guidance is not enough. We also need to help professionals put our guidance into practice. Our field team of implementation consultants engages with people working in the NHS, local government and the wider community. And we have published 25 commissioning guides to help the NHS in England commission effective, evidence-based care.

The year also held some challenges. Our processes and recommendations were closely scrutinised in the High Court when our clinical guideline on chronic fatigue syndrome/myalgic encephalomyelitis (CFS/ME) and our technology appraisal of drugs for osteoporosis were both subject to judicial review. In each case our guidance was upheld. The judgement on the CFS/ME guideline fully endorsed the rigorous way we develop our clinical guidelines. For the appraisal, in response to the Court's request, we reached agreement on partial release of previously confidential information held by a third party.

Our processes are robust because we've spent 10 years developing them. This year alone, we've sought the opinions of our stakeholders and the public on updated process and methods guides to all of our guidance programmes.

As well as periodic reviews of our processes and methods, we also listen and respond to the needs of people who use and support the NHS. In January, for example, we changed the way we appraise medicines

that extend the lives of people with certain less common conditions who are near the end of life. We know that people value any extra time at the end of their life, so we have asked our independent advisory bodies to take this into account when making decisions about these life-extending treatments.

Health service funding is limited, and it is our job to assess the clinical and cost-effectiveness of diagnostic, therapeutic and preventive interventions to make sure that NHS money is well spent. In these difficult economic times, the need to ensure value for money is even more important. For example, our clinical guideline on respiratory tract infections is estimated to save the NHS over £3.5 million a year. Antibiotics have been widely over-prescribed for many years, leading to resistance and wasted NHS resources. This guideline helps healthcare professionals decide when antibiotics are appropriate.

As a result of Lord Darzi's NHS Next Stage Review, our remit is growing. We are taking on new responsibilities for setting clinical and public health quality standards to help health and social care professionals achieve the best outcomes for patients for the best value for money. And NICE will break new ground with NHS Evidence, a web portal that delivers evidence to decision-makers and the wider healthcare community.

Such a strong endorsement by Lord Darzi reflects the confidence and trust we have worked hard to build. As we grow and develop, we continue to be grateful for the commitment and hard work of our staff, as well as the experts working on our advisory bodies, and the consultees and stakeholders who support them. It is thanks to all of them that we have achieved so much in this and previous years. But we are only as good as our last piece of NICE guidance. We need the continuing help and support of all our friends and colleagues; and we are fully confident that they will respond in the future as they have in the past.

**Professor Sir Michael Rawlins** Chairman  
**Andrew Dillon CBE** Chief Executive

# OVERVIEW

## National Institute for Health and Clinical Excellence

NICE is the national organisation responsible for providing guidance on promoting good health and preventing and treating ill health. Professor Sir Michael Rawlins is Chairman and Andrew Dillon CBE is Chief Executive.

### THE ROLES AND RESPONSIBILITIES OF NICE

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NICE produces guidance in three areas: public health, health technologies and clinical practice.

**PUBLIC HEALTH** – promoting good health and preventing ill health for those working in the NHS, local authorities and the wider public and voluntary sector. The Centre for Public Health Excellence develops NICE public health guidance. In 2008/09 the Centre produced guidance on seven new topics.

**CLINICAL PRACTICE** – the appropriate treatment and care of people with specific diseases and conditions within the NHS. The Centre for Clinical Practice at NICE develops clinical guidelines that recommend the evidence-based treatment and care of people with specific diseases and conditions within the NHS. In 2008/09 the Centre produced 19 new clinical guidelines.

**HEALTH TECHNOLOGIES** – the use of new and existing medicines, treatments and procedures within the NHS. The Centre for Health Technology Evaluation develops NICE technology appraisal and interventional procedure guidance. In 2008/09 the Centre produced 30 new technology appraisals and 39 new pieces of interventional procedure guidance.

NICE supports the implementation of its guidance by engaging stakeholders, patients and the public in the selection of topics and in the guidance development process. In addition, NICE provides a range of resources – such as slide sets and tools to estimate the local cost of implementing guidance – to help practitioners put guidance into practice.

### WHERE NICE GUIDANCE APPLIES

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#### SCOTLAND

- Technology appraisal guidance\*
- Interventional procedures guidance

*\*With advice from NHS Quality Improvement Scotland*

#### NORTHERN IRELAND

- Clinical guidelines\*
- Technology appraisal guidance\*
- Interventional procedures guidance

*\*With advice from the Department of Health, Social Services and Public Safety*

#### ENGLAND

- Clinical guidelines
- Technology appraisal guidance
- Interventional procedures guidance
- Public health guidance

#### WALES

- Clinical guidelines
- Technology appraisal guidance
- Interventional procedures guidance

## NHS NEXT STAGE REVIEW OUTLINES KEY ROLE FOR NICE

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In summer 2008, Health Minister Lord Ara Darzi delivered his final report on the NHS Next Stage Review. 'High quality care for all' calls for a health service that empowers staff and offers patients choice. It says that healthcare should be personalised and fair, include the most effective treatments within a safe system and help people to stay healthy.

Lord Darzi envisaged a key role for NICE, recommending that:

- patients are guaranteed access to NICE-approved drugs and treatments
- NICE technology appraisals are published earlier
- NICE sets up and manages a new NHS Evidence service to enable NHS staff to access clinical and non-clinical evidence and best practice
- NICE works with the Department of Health and professional and patient groups to create an independent, transparent process for developing and reviewing the indicators in the Quality and Outcomes Framework
- NICE becomes responsible for independent quality standards and setting clinical priorities within the NHS
- more of NICE's capacity should be diverted to evaluating medical devices and diagnostics.

Lord Darzi's report represents a strong endorsement of NICE and acknowledges the confidence and trust we have worked hard to build in the NHS. The additional work we have been given fits well with our current remit and is in line with our vision for the future. After the report was published we worked closely with the Department of Health and our other partners to determine how we will implement these recommendations and, by doing so, help to bring about a truly evidence-based, quality driven NHS.

## HIGH COURT UPHOLDS NICE GUIDANCE

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NICE faced two judicial reviews in 2008/09, with challenges to our 2007 clinical guideline on chronic fatigue syndrome/myalgic encephalomyelitis (CFS/ME) and our 2008 technology appraisal guidance on drugs for osteoporosis. In each case the High Court broadly endorsed our rigorous methods and the guidance was upheld.

In the ruling on the technology appraisal guidance on osteoporosis, the High Court agreed that NICE was correct not to release confidential information from a third party that was used in the economic model. The judgement asked us to do all we could to encourage the owner of the information to allow us to release it. In March 2009 the Court ruled that we had worked constructively on this.

In May 2008, the Court of Appeal ruled on appeals against the judicial review of the NICE technology appraisal guidance on drugs for Alzheimer's disease. As a result, we were asked to release 'fully executable' versions of the economic model to stakeholders for comment. The Court of Appeal did not ask for the guidance to be withdrawn or amended. NICE made the fully executable model available to stakeholders in November 2008. Comments on the reliability of the model were reviewed by NICE's Decision Support Unit, which prepared a report that was considered by the Technology Appraisal Committee in April 2009.

The High Court ruled in favour of NICE on all grounds brought against the Institute in the judicial review of its clinical guideline on CFS/ME. The judgement, which was made in March 2009, acknowledged the dedication of the guideline development group members in working together to produce the best guideline possible. The result means that the NICE guideline continues to be the gold standard for best practice in managing CFS/ME.

# NICE GUIDANCE

NICE guidance sets the standard for good healthcare so that everyone has access to the same high quality care. All NHS organisations in England and Wales are expected to meet our standards. We also provide guidance to help local authorities and other public organisations ensure that their services improve the health and wellbeing of their communities.



**IN 2008/09 NICE PUBLISHED:**

- 19 new clinical guidelines

and guidance on:

- 7 public health topics
- 39 interventional procedures
- 30 technology appraisals.

All of our guidance is supported by a suite of implementation tools. There is more about our implementation programme on pages 17–19.

**NICE GUIDANCE IS:**

- designed to promote good health and prevent ill health
- produced by the people affected by our work, including health and social care professionals, patients and the public
- based on the best evidence
- transparent in its development, consistent, reliable and based on a rigorous development process
- good value for money, weighing up the cost and benefits of treatments
- internationally recognised for its excellence.

## Public health

NICE public health guidance is about promoting good health and preventing ill health. The Centre for Public Health Excellence develops NICE public health guidance for those working in the NHS, local authorities and the wider public and voluntary sector. In 2008/09 the Centre produced guidance on seven new topics.

### LETTING CHILDREN PLAY

There is widespread concern that many children are not active enough and that this has long-term health implications. Current government guidelines say that children should do at least an hour of moderate-intensity exercise every day and that at least twice a week this should include activities such as running and jumping to improve bone health, muscle strength and flexibility. Yet fewer than half of 15-year-old girls and only 66% of 15-year-old boys manage this.

In January 2008, NICE published public health guidance to provide practical recommendations for everyone with a role in promoting physical activity for children and young people. Its recommendations range from a call for a long-term national campaign to advice for local practitioners and planners on making activities relevant and suitable for all young people.

Parents may fear the risks of increasing their children's levels of physical activity, whether it is through sport or everyday activities such as playing outdoors or walking rather than being taken by car. Organisations that work with young people may fear they will be sued if a child is injured. These fears of risk may not necessarily correspond to the reality. The group that developed the guidance thought that the risks of increased physical activity need to be weighed up against the benefits. And an inactive lifestyle can put children at greater risk in the long term, because they are more likely to develop conditions such as obesity, heart disease and cancer.

Professor Mike Kelly, Director of the NICE Centre for Public Health Excellence, explained: "Obesity rates in this country are rocketing and with the number of children not taking part in physical activity increasing, this problem can only get worse. Dealing with the long-term consequences of obesity costs an estimated £2.5 billion each year, placing a huge strain on the health service. It's important that we let children play, and don't let society's aversion to risk stop young people from being physically active.

This guidance makes strategic and practical recommendations to promote physical activity to children and young people in a variety of settings and so will help to ensure that this frightening trend is halted.”

The guidance supports the Department of Health-led Change4Life campaign that aims to get young people eating better and moving more.

*Public health guidance 17: Promoting physical activity for children and young people. See [www.nice.org.uk/PH17](http://www.nice.org.uk/PH17)*

## PREVENTING THE FIRST CIGARETTE

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Most adult smokers started smoking before they were 18 years old. In July 2008 NICE published guidance on ways to prevent children and young people picking up that first cigarette.

Professor Catherine Law, who chairs NICE’s Public Health Interventions Advisory Committee, explained: “Children who smoke become addicted to nicotine very quickly and research shows the earlier you start smoking the harder it is to give up in later life. If starting is delayed or prevented there is the potential to reduce the number of early deaths attributed to smoking and improve health throughout life.”

Mass media campaigns are effective, she said. Evidence-based messages can be used to put young people off smoking and empower them to refuse offers of cigarettes.

The guidance looks at how those with an interest in children’s health can jointly develop mass media campaigns, whether national, local or regional. It also spells out what national and local organisations should be doing to help enforce the existing law prohibiting under-age tobacco sales.

We have already published three sets of public health guidance on smoking cessation, but our remit in this case was to look at how to approach children and young people specifically. These recommendations were developed to complement existing activities, with the aim of supporting a comprehensive tobacco control strategy.

*Public health guidance 14: Preventing the uptake of smoking by children and young people. See [www.nice.org.uk/PH14](http://www.nice.org.uk/PH14)*

## WORKING FOR HEALTH

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In 2008/09 NICE brought a new focus to health in the workplace with two separate pieces of public health guidance. They aim to help employers – and others with an interest in workplace health – to address some issues that are costly to them, their workers and society in general.



The first piece of guidance is on physical activity in the workplace. It looks at ways in which employers can support employees in being active, for example by encouraging them to walk or cycle to work. Physical inactivity is estimated to cost £8.2 billion a year in England. This includes not only the direct costs of treating diseases linked to lack of exercise but also the indirect costs of sickness absence from work.

Dr Matt Kearney, a GP who is a member of NICE's Public Health Interventions Advisory Committee, which developed the guidance, said: "Physically active employees are less likely to suffer from major health problems, less likely to take sickness leave and less likely to have an accident at work. These recommendations aim to help employers make it easier for staff to be active, and so contribute towards a healthier workplace."

The second piece of guidance looked at ways employers can develop organisation-wide strategies to help and support their employees affected by long-term sickness absence. The annual cost associated with sickness absence and people being out of formal employment is estimated at over £100 billion a year in Britain.

Dr Richard Preece, a freelance occupational medicine consultant and member of the group that developed the guidance, said: "Being out of work can have a serious impact on your health and the longer you are off sick, the harder it is to return to work. This guidance is about ensuring people who are away from work get access to the right kind of support at an early stage, enabling them to return to work sooner."

*Public health guidance 13: Promoting physical activity in the workplace. See [www.nice.org.uk/PH13](http://www.nice.org.uk/PH13)*

*Public health guidance 19: Managing long-term sickness and incapacity for work. See [www.nice.org.uk/PH19](http://www.nice.org.uk/PH19)*

## REDUCING THE RISK

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Needle and syringe programmes (NSPs) have been helping drug users obtain safe injecting equipment and advice for more than 20 years. With an estimated 150,000–200,000 injecting drug users within the UK, these programmes have an important role in tackling the spread of viruses, including hepatitis C and HIV, and helping drug users to access further treatment. The evidence shows that not only are NSPs an effective way of tackling blood-borne viruses among injecting drug users, they also save the NHS and the public sector money.

In February 2009, NICE produced guidance that explains how NSPs can operate most effectively, for example by looking at whether they are open at the best times for drug users to access them, whether they are in the right places and whether they provide the right services.

Colin Bradbury, Treatment Delivery Manager at the National Treatment Agency (NTA) for Substance Misuse, said: "The NTA welcomes this guidance as needle and syringe programmes are an essential element of the balanced drug treatment system advocated by NICE. Needle and syringe programmes, particularly when used in conjunction with substitute prescribing, are an effective means of reducing the risk of HIV and changing injecting behaviour.

"This publication complements the full suite of NICE guidance on drug treatment, which says local services should have a range of interventions available to tackle drug misuse, including harm reduction services, substitute prescribing and abstinence-orientated drug treatment."

*Public health guidance 18: Needle and syringe programmes. See [www.nice.org.uk/PH18](http://www.nice.org.uk/PH18)*

## ACTIVE BODY, ACTIVE MIND

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Declining mental wellbeing is not an inevitable part of ageing and can often be fended off by staying active. But it is not always easy for older people to maintain physical activity: poor physical health, financial insecurity, attitudes in society, geographical location, access to support and services and the responsibility of caring for others can all get in the way.

With 9.7 million people aged over 65 in the UK, and the number set to rise to one in five of the population by 2020, this is a big issue for older people and the NHS. So in October 2008 NICE issued new public health guidance on occupational health and physical activity interventions to promote the mental wellbeing of older people in primary and residential care. Recommendations include physiotherapists providing tailored exercise programmes such as dancing, swimming or walking. In addition, the guidance says that occupational therapists should work with groups or individuals to find ways of building activities that promote wellbeing into the daily routines of older people.

Professor Catherine Law, Chair of the Public Health Interventions Advisory Committee at NICE, said: “Despite longer lives and an increase in wealth over the last 50 years, there is evidence that many older people live with low levels of life satisfaction and wellbeing. Forty per cent of older people attending GP surgeries, and 60% of those living in residential institutions, are reported to have ‘poor’ mental health. All people coming into contact with older people, including health and social care professionals, have the potential to promote and maintain physical activity, health and independence, factors frequently mentioned by older people as important to their mental wellbeing.”

*Public health guidance 16: Mental wellbeing and older people. See [www.nice.org.uk/PH16](http://www.nice.org.uk/PH16)*

See page 32 for all of the guidance on public health topics that NICE issued in 2008/09.

# Clinical practice

The Centre for Clinical Practice at NICE develops clinical guidelines that recommend the evidence-based treatment and care of people with specific diseases and conditions within the NHS. In 2008/09 the Centre produced 19 new clinical guidelines.

## TALKING ABOUT MEDICATION

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Up to half of medicines for treating long-term conditions are not taken as prescribed. Sometimes patients don’t want to take the medicines because of worries about side effects. In other cases, practical problems – such as not being able to open the packaging – could be to blame. Or, as Alison Bowser, service user representative on NICE’s guideline development group, explained: “The reason why

a patient can’t take a particular medicine may be because their hectic lifestyle may make it difficult to take medicines at the same time each day.”

In January 2009 NICE published guidance for healthcare professionals on the importance of involving patients in decisions about prescribed medicines – even if that means accepting a patient’s informed decision to refuse medication.

It takes two-way communication to help patients understand how a medicine could improve their disease or condition and voice any concerns they might have. The key is to establish the most effective way of communicating. If necessary, NICE says, consider using pictures, symbols or an interpreter where language is a barrier.

Healthcare professionals should be non-judgemental in their assessments, prepared to listen to patients' concerns and ready to offer a follow-up review to patients who choose not to take medication.

Alison Bowser highlighted the need for dialogue: "Many patients feel that if they approach their healthcare professional about failure to take their medicines, they will be told off. The good thing about this guidance is that it opens a path to renegotiate how the patient and healthcare professional communicate about medicine."

*Clinical guideline 76: Medicines adherence. See [www.nice.org.uk/CG76](http://www.nice.org.uk/CG76)*

## SPECIALIST TEAMS FOR ADHD

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Attention deficit hyperactivity disorder (ADHD) is a behavioural condition that affects not only the life of the person with the disorder, but also families and carers. The symptoms include being unable to concentrate for very long or finish a task, being fidgety and unable to sit still, and being impulsive. ADHD is common: it is estimated to affect up to 3% of school-age children and young people in the UK, and about 2% of adults worldwide.

In guidance issued in September 2008, NICE emphasised that children, young people and adults affected by ADHD need accurate diagnosis and effective treatment. It called for local NHS trusts to provide specialist teams of professionals able to provide appropriate services to people of all ages. The guidance also recommends that:

- parents and carers receive training in supporting children and young people affected by ADHD
- children with moderate levels of impairment should receive cognitive behavioural therapy

- children with the most severe symptoms should be offered drug treatment as a first-line treatment
- in all cases drug treatment should form part of a comprehensive care package.

Dr Kapil Sayal, Senior Lecturer in Child and Adolescent Psychiatry and guideline development group member, said: "This guideline will help to ensure that ADHD is accurately identified and recognised by health professionals. There needs to be improved awareness, identification and recognition of children and young people with these problems, so that they are able to access the right care at the right time."

*Clinical guideline 72: Attention deficit hyperactivity disorder. See [www.nice.org.uk/CG72](http://www.nice.org.uk/CG72)*

## ALTERNATIVE PRESCRIBING STRATEGIES FOR RESPIRATORY TRACT INFECTIONS

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Each year one in four people visits their GP because of an acute respiratory tract infection (RTI). Treatment for RTIs accounts for 60% of all antibiotic prescribing in general practice. Yet the clinical evidence is that antibiotics have limited effectiveness in many of these cases and that complications are rare among people who are not prescribed antibiotics to treat the infection.

In July 2008, NICE published a short clinical guideline recommending alternative prescription strategies for people presenting with RTI in primary care and other first-contact centres such as emergency departments and walk-in centres.

Good practice starts with a clinical assessment to diagnose and exclude complications. Some patients, such as children aged under 2 years with acute infections in both ears and older people who have other pre-existing health conditions, should receive an immediate antibiotic prescription.

But where the evidence shows that antibiotics will make little difference, patients should not be prescribed them or they should be given a prescription to keep and use only if the symptoms worsen. GPs should always explain the options and reasons behind their decision.

Anne Joshua, Associate Director of Pharmacy at NHS Direct and guideline development group member, said: "This short clinical guideline brings together everything we know on targeting antibiotics to those who really need them. It sets out very clearly the information that should be provided by healthcare professionals when they are assessing children and adults presenting with RTI symptoms in order to reassure them that they are receiving the most effective course of treatment, based on the most up-to-date evidence."

*Clinical guideline 69: Respiratory tract infections.*  
See [www.nice.org.uk/CG69](http://www.nice.org.uk/CG69)

## CHANGING PRACTICE FOR PEOPLE WITH STROKE

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Stroke is a major health issue in the UK, killing more than one in ten people. It is the third largest cause of severe disability. The NICE guideline on stroke was published in 2008 and was incorporated into a broader guideline published at the same time by the Royal College of Physicians (RCP).

The NICE guideline covers the acute stage of stroke and transient ischaemic attack – the crucial 48 hours after symptoms start when quick action can contribute to much better outcomes for patients.

The RCP guideline covers recovery and rehabilitation, secondary prevention, and long-term care, and has new sections on commissioning and resources. The guidelines were produced in close collaboration with each other, and both reference and relate to the Department of Health's 2007 National Stroke Strategy.

It is good news for patients, said Joe Korner, Director of Communications at the Stroke Association, adding: "These guidelines show exactly what treatment and care everyone should get if they have a stroke. Too often in the past, vital stroke guidelines such as these have been put on a shelf and ignored, causing unnecessary deaths, disability and loss of independence for many thousands of people. But stroke is now a top priority in the health service across the UK and the guidelines will underpin the step change in stroke services that we all want to see."

*Clinical guideline 68: Stroke.*  
See [www.nice.org.uk/CG68](http://www.nice.org.uk/CG68)

See page 32 for all of the clinical guidelines that NICE issued in 2008/09.



# Health technologies – Technology appraisals

NICE technology appraisals are recommendations on the use of new and existing medicines and treatments within the NHS in England and Wales. They cover drugs, medical devices, diagnostic techniques, surgical procedures and health promotion activities (for example, ways of helping people manage a condition).

## LEADING THE WAY

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NICE is a global leader in the evaluation of new drugs and treatments and is committed to ensuring it uses the most up-to-date methods. In June 2008, we published the new 'Guide to the methods of technology appraisal', updating the version published in 2004. The guide was published after detailed examination of the way NICE takes decisions and consultation with stakeholders and the public.

The methods guide is an overview of the principles and methods of health technology assessment and appraisal that underpin the NICE technology appraisal process. It is not only for the independent advisory committees that prepare NICE guidance on technology appraisals, but also for those organisations representing patient groups, healthcare professionals and manufacturers that submit evidence and comment on draft recommendations.

In 2008/09 NICE published 30 new technology appraisals, all of them available in full on our website. Of these, 15 were the result of a full multiple technology appraisal (MTA) and included new technologies for pain management as well as the use of insulin pumps and drugs for treating and preventing influenza. The other 15 were the result of a single technology appraisal (STA), the process NICE uses to produce rapid guidance on life-extending drugs that have already been licensed and new medicines close to when they become available. Ten new STAs covered drugs for a wide range of conditions, including psoriasis and ulcerative colitis.

NICE was unable to recommend the use of four treatments in the NHS because insufficient evidence was provided by the manufacturers. They were bevacizumab for breast cancer, carmustine implants for recurrent glioma, cetuximab for colorectal cancer and bevacizumab for lung cancer. A fifth appraisal, of rimonabant for obesity, was withdrawn after publication when its marketing authorisation was suspended because of safety concerns.

## HEART OF THE MATTER

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A coronary stent has been likened to a frame inserted into a diseased artery in the heart, keeping it open and blood flowing. Heart surgeons have used stents for years and NICE guidance on them dates back to 2003.

But technology moves on and in 2008/09 NICE carried out a partial review of its original guidance, looking at the use of 'drug-eluting stents'. These are stents that are coated in a drug that reduces the likelihood of the artery from becoming narrow again after surgery. Once implanted into the artery, the drug is slowly absorbed into the tissues surrounding the stent. The final guidance issued in July 2008 outlines when drug-eluting stents can be used in the NHS.

Drug-eluting stents are more expensive than stents without a coating of the drug ('bare-metal' stents). The independent Appraisal Committee looked carefully at the evidence of the risks and benefits of using different kinds of stents. The Committee also

looked at the economic modelling and considered the costs of the stents supplied to the NHS. The provisional guidance put out for consultation did not recommend the use of drug-eluting stents in the NHS. But after consultation, the Appraisal Committee considered new information on the costs of the stents. Broadly, the guidance recommends drug-eluting stents for patients who are at high risk of requiring further interventions if a conventional bare-metal stent is used instead, provided that the price difference between the two is no more than £300. In reaching this decision, the independent Appraisal Committee took into account the evidence of the risks and benefits of using different types of stent as well as economic modelling,

Carole Longson, Director of NICE's Centre for Health Technology Evaluation, said: "We are aware, both from industry and from the NHS, that the maximum price difference between a drug-eluting stent and a conventional bare-metal stent allowed for in our guidance is available already in some NHS hospitals and achievable for the rest of the NHS. Therefore, this decision to recommend the use of drug-eluting stents will ensure that, despite their higher cost, they will continue to be an important treatment option for patients who would be at high risk of requiring further interventions if a bare-metal stent was used instead."

*Technology appraisal guidance 152: Drug-eluting stents for the treatment of coronary artery disease. See [www.nice.org.uk/TA152](http://www.nice.org.uk/TA152)*

## REVIEW OF INSULIN PUMP THERAPY GUIDANCE

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People with type 1 diabetes need daily injections of insulin to survive. The insulin regulates their blood sugar so that they have neither too little (hypoglycaemia) nor too much (hyperglycaemia), either of which can be disabling and potentially life threatening.

But it is not always easy to get this balance right and for some people an insulin pump is the answer. This is a small device worn outside the body that continuously delivers insulin through a very thin

tube or needle inserted under the skin. The insulin can be delivered at a set rate throughout the day and increased when it is needed, for example at meal times.

In July 2008 NICE published a review of its 2003 guidance on insulin pump therapy for people with type 1 diabetes. This was in line with our policy of regularly reviewing guidance to make sure it stays up to date. In this case no change was needed.

The 2008 guidance reiterates that patients who suffer disabling hypoglycaemia with daily injections should use a pump, as should those who have consistent hyperglycaemia despite attempts at careful management. Children under 12 should use a pump only if daily injections are not practical or appropriate. An insulin pump is not suitable for people with type 2 diabetes.

The NICE guidance means that people with type 1 diabetes will continue to be able to have access to this important technology to achieve better blood glucose control, an improved quality of life and fewer situations where they need help from others.

*Technology appraisal guidance 151: Continuous subcutaneous insulin infusion for the treatment of diabetes mellitus. Review of technology appraisal guidance 57. See [www.nice.org.uk/TA151](http://www.nice.org.uk/TA151)*

See page 33 for all of the technology appraisal guidance that NICE issued in 2008/09.

## NEW THINKING ON END-OF-LIFE CARE

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In January 2009 NICE introduced changes to its technology appraisal process to make clearer the circumstances in which it may be appropriate to recommend the use of life-extending treatments licensed for terminal illnesses affecting small numbers of patients. These treatments, following appraisal, will be ones that the committees decide offer demonstrable survival benefits over current NHS practice.

This means that treatments that may have been previously ruled out as not sufficiently cost effective for routine use in the NHS might now be recommended for use. Treatments that are licensed for small patient populations and that will increase a short life expectation by at least 3 months will be considered. The change followed a public consultation during which NICE received 1100 responses.

Andrew Dillon, NICE Chief Executive, said: “The existing guidance to our Appraisal Committees recognises that there may be circumstances in which they might consider it appropriate to accept higher incremental cost-effectiveness ratios for life-extending treatments at the end of life.

“This reflects the views of NICE’s Citizens Council and previous decisions have taken a number of particular circumstances into account. NICE is also conscious of its responsibility to support the development of novel treatments for smaller patient groups that provide innovative benefits over and above existing NHS care. NICE is therefore asking its Appraisal Committees to consider the impact of giving greater weight to extensions to life when people have a short remaining life span.”

The first technology to be approved using this new criteria was sunitinib for the first-line treatment of advanced and/or metastatic renal cell carcinoma.

## Health technologies – Interventional procedures

The Centre for Health Technology Evaluation develops NICE interventional procedure guidance. In 2008/09 the Centre produced 39 new pieces of interventional procedure guidance.

### PROMOTING SAFE INNOVATION

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Dr Hannah Patrick joined the Interventional Procedures Programme at NICE in March 2008 as a consultant clinical adviser, combining 3 days a week at NICE’s London office with a clinical role in haematological oncology at Queen Mary’s Hospital, Sidcup.

Dr Patrick said: “The programme assesses the safety and efficacy of interventional procedures, with the aim of protecting patients and helping clinicians, healthcare organisations and the NHS to introduce procedures appropriately.”

No interventional procedure is entirely free from risk and the programme gauges the extent of uncertainties and makes recommendations on their

implications. The programme also helps patients to understand new procedures and their risks by producing information for them about each procedure and NICE’s recommendations.

Last year NICE published guidance on 39 interventional procedures: for some of them there was a good body of evidence; for others there was much less information available.

For example, the guidance on keyhole surgery to remove all or part of the stomach as a treatment for people with stomach cancer recognises that there is now good evidence that this procedure is safe and effective when carried out by well-trained doctors. For patients, keyhole surgery means less time in hospital, faster recovery and smaller scars.

The guidance on treating advanced age-related macular degeneration using an artificial lens system looked at a highly innovative concept. Dr Patrick explained: "In essence, it involves inserting a tiny telescope into the patient's eye and using this to deflect the image away from the damaged part of the retina to an undamaged part. There is limited evidence for its effectiveness and long-term safety. As a result we have recommended that doctors make special arrangements with their hospital trusts and ensure that patients understand the doubts about the procedure's efficacy and safety."

*Interventional procedures guidance 269: Laparoscopic gastrectomy for cancer. See [www.nice.org.uk/IPG269](http://www.nice.org.uk/IPG269)*

*Interventional procedures guidance 272: Implantation of miniature lens systems for advanced age-related macular degeneration. See [www.nice.org.uk/IPG272](http://www.nice.org.uk/IPG272)*

See page 34–35 for all of the interventional procedures guidance that NICE issued in 2008/09.



## PATIENT INVOLVEMENT IN GUIDANCE DEVELOPMENT

NICE involves patients, carers and other members of the public in many areas of its work. One of our most active contributors, Susan Bennett, discusses NICE and her work as a lay representative.

**Q:** In what capacity are you involved with NICE?

**A:** I'm a lay member of the Interventional Procedures Advisory Committee.

**Q:** What first prompted you to get involved?

**A:** I am a trustee of Incontact, the bladder and bowel organisation. Three years ago, Incontact suggested that I should apply to be a patient representative for the guideline development group (GDG) that was developing NICE's clinical guideline on faecal incontinence.

**Q:** What impact do you think your work as a lay member has had on the committees and guideline development groups you have been involved in?

**A:** I have helped raise awareness of patient and service user views as well as disability and equality issues.

**Q:** What has been your greatest challenge?

**A:** Overcoming my own disabilities, especially my hidden ones such as chronic neuropathic pain, to attend meetings.

**Q:** Have there been any unexpected benefits for you?

**A:** Being involved with NICE means I've kept my own skills up to date, such as my IT skills. Generally, it has boosted my confidence and self-esteem.

**Q:** What advice would you give to someone who has decided to join NICE as a lay member on one of its committees or guideline development groups?

**A:** Always remember, you are an equal team member. You are the member of the group who has knowledge of living with a condition 24/7 – most professionals only know about the condition.

# PUTTING GUIDANCE INTO PRACTICE

Putting NICE guidance into practice can be challenging. NICE has an implementation team that works in a variety of ways to help support people responsible for implementing our guidance – this includes people in the NHS, local authorities, the workplace and voluntary sectors.

## THE BENEFITS

Implementing NICE guidance offers benefits to patients and carers, healthcare professionals and organisations.

- It can help patients and carers receive care in line with the best available evidence of clinical and cost effectiveness.
- It can help healthcare professionals ensure the care provided is based on the best evidence available.
- It can help organisations meet nationally agreed standards for better health.

## PRACTICAL SUPPORT TOOLS

In 2008/09 NICE continued to develop a range of materials to support implementation.

**Commissioning guides** In 2008/09 NICE published 25 new or updated commissioning guides. These are topic-specific, web-based resources that provide support for the local implementation of NICE clinical guidelines through commissioning, and are underpinned by NICE clinical guidelines.

See pages 35–36 for all of the commissioning guides published in 2008/09.

**Uptake reports** We published ten implementation and uptake reports to assess the level of compliance with guidance across the NHS.

See page 36 for all uptake reports published in 2008/09.

**Guidance-specific tools** We published guidance-specific tools for all new guidance. These include costing tools, slide sets and audit tools. The costing tools help organisations to assess the financial implications of implementing NICE guidance and we provide an Excel spreadsheet that can be used to estimate local costs and savings.

**Generic implementation tools** We updated our generic implementation tools, which are designed to help organisations keep informed about developments. A forward planner alerts users to forthcoming NICE guidance, and a NICE e-alert system keeps people in touch with the latest news on guidance development.

**Informing patients and the public** We worked with the Healthcare Commission to help patients and the public in England and Wales by publishing 'Accessing treatment recommended by NICE'.

We produced two documents to help local authorities put NICE guidance into practice.

- 'How to put NICE guidance into practice and improve the health and wellbeing of communities: practical steps for local authorities' was launched at the NICE annual conference in December 2008. This guide, for chief executives, their senior officers and others within local authorities who lead on different aspects of health and wellbeing, is in three parts: getting started on implementation; principles; and practical steps.
- In February 2009 we published a guide on how NICE guidance can help local authorities to achieve a number of Local Area Agreement (LAA) and Multi-Area Agreement (MAA) priorities ('How NICE guidance can help you achieve Local Area Agreement targets'). This guide highlights 70 national indicators concerned

directly or indirectly with health and wellbeing, linking them to relevant NICE guidance, implementation advice and tools as well as useful background information.

Many patient, carer and voluntary organisations are actively promoting and supporting the implementation of NICE guidance. Their activities range from awareness-raising campaigns and promotional activities through to providing direct funding to support implementation and training and support to health professionals. We keep a collection of examples of these activities that is updated regularly and available through our website.

## VICTORIA'S STORY

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In January 2009, NICE published a new guideline on treating and managing borderline personality disorder. Victoria Green, a guideline development group member representing service users and carer interests, explains why implementing this guideline matters.

"I was diagnosed with borderline personality disorder about 10 years ago when in my early 20s, although I had displayed symptoms throughout most of my adolescence.

"I feel I have been fortunate enough to have benefited from a positive experience of mental health services which helped me to achieve what I consider to be a recovery from this disorder.

"My story is a positive one, but for many it is different. I know of people who have been denied access to services or have only been allowed minimal support, or have been given a different and inappropriate diagnosis and so on. Unfortunately, two of my friends with borderline personality disorder lost hope and gave up.

"There is considerable misunderstanding about borderline personality disorder both within and outside mental health services. People with borderline personality disorder aren't inherently bad, but are usually people who have encountered difficult early experiences and led difficult lives.

For me, the NICE guideline for borderline personality disorder represents an important step forward. If people with this condition are able to have better access to treatment that fully addresses their needs, as well as being in an environment that encourages understanding, optimism and hope, then I believe more people will be able to move on from this disorder to live fulfilling lives. I believe more people could recover."

*Clinical guideline 78: Borderline personality disorder: treatment and management. See [www.nice.org.uk/CG78](http://www.nice.org.uk/CG78)*

## SHARING LEARNING

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During 2008/09 we continued to receive submissions for our Shared Learning Database, which features examples of good practice in implementing NICE guidance from the NHS and partner organisations. By the end of the year, it contained over 140 examples.

Our Shared Learning Awards celebrate the best examples of how organisations have implemented NICE clinical or public health guidance. Shortlisted candidates presented their work at the 2008 NICE 'Excellence in action' conference.

- **North Bristol NHS Trust** won the clinical category – and the overall award of £1000 and an engraved trophy – for 'NICE training improves outcomes: making the right way the easiest way'. The Trust used the recommendations from the NICE clinical guideline on intrapartum care to develop training for a multidisciplinary team on electronic fetal monitoring, halving the number of babies born with brain damage.
- The general category prize went to **Bournemouth and Poole Teaching PCT** for its work linking the commissioning role of the PCT to the GP education and training strategy. The PCT provides GPs with summaries of NICE guidelines and identifies differences between the guidelines and existing clinical practice or commissioning plans. It also organises awareness-raising workshops for GPs on relevant NICE guidance. In addition, computer-based prompt and reminder systems make it easier for them to apply the guidance when face-to-face with the patient.

- 'Enthusiasm for life: creative stimulation and behaviour change for older people and others' won the £500 public health category for its work in helping isolated and often depressed older people in Devon. The project is run by **Upstream in the Community**, a social enterprise that started life as a voluntary organisation run by several local GPs. It is now funded by **Devon PCT** and the county council, and already more than 1000 people have benefited. Trained community mentors help get people involved in activities, through which they can learn new skills and make new friends. The idea is to improve their health generally and reduce the use of medication, unnecessary GP visits and unplanned hospital admissions.

## FIELD TEAM FOCUS ON MATERNITY UNITS

The NICE Implementation Field Team aim to make it as easy as possible for clinicians to implement NICE guidance. In 2008/09 the team's seven implementation consultants set out to visit every maternity unit in England to demonstrate how NICE implementation support can help them.

There are currently 12 clinical guidelines relevant to maternity services, including our recently completed maternity suite covering antenatal care right through to postnatal care. The team visited all except one unit and found that NICE guidance is being used to shape and monitor services.

"We take NICE guidance extremely seriously", said one clinical director. A head of midwifery added: "NICE guidance is helpful and welcome. It gives focus and provides support and back-up when introducing change. The NICE brand helps."

The field team was able to show how NICE implementation tools can help frontline clinicians. Steve Sparks, Associate Director for the team, said that the costing report and local costing template proved particularly popular. These spreadsheets can be used to calculate the cost of implementing NICE advice, using statistics based on the local population.

Heads of maternity saw the potential for using our audit tools and involving junior doctors in using them as part of their audit training. Similarly, midwives could use the tools to conduct their own audits. This, in turn, would help develop their management skills.

The slide sets in particular raised interest. These ready-made PowerPoint presentations, complete with presenter's notes, accompany guidance.

After the visit of a NICE field team consultant, the head of one maternity unit commented: "You have opened my eyes today – and now I'm going to go and open the eyes of my clinical team."



# REACHING OUT

NICE has a wide range of stakeholders and we take our message to them in a variety of ways. From the continually improving and updated website through to participation in regional, national and international events, NICE has fostered dialogue with stakeholders and partner organisations.



## 'EXCELLENCE IN ACTION'

NICE's annual conference in December 2008 at Manchester's Central Convention Complex focused firmly on the practical, with the theme 'Excellence in action'. The event featured a range of case studies on how to implement NICE guidance and what works in practice. It also featured key sessions on NICE's future roles under the new arrangements described by Lord Darzi and how they will impact on all those working in the health services.

More than 1000 delegates attended, including people from the NHS, local authorities and the private, voluntary and community sectors, as well as patients, carers, the general public and those who represent them.

Conference speakers included David Nicholson (Chief Executive of the NHS in England), Dame Carol Black (National Director, Health and Work) and Lord Adebawale (Chief Executive, Turning Point). Speakers discussed their predictions for the NHS over the next 10 years, sharing the latest news and views on the design, delivery and audit of NICE guidance.

NICE introduced more opportunities to network with colleagues during several open-space workshops that were hosted by our partner organisations. These were organised around various topics: public health; commissioning in primary care; clinical

engagement and secondary care; and clinical audit and management. Delegates also had a chance to tour the lively exhibition with more than 70 stands.

## NICE BOARD MEETINGS 2008/09

NICE held six public Board meetings in 2008/09, each time at a different location. In each case healthcare professionals were invited to take part in the morning sessions, at which they could question the NICE Board about guidance and other aspects of our work.

- May 2008, Bangor, Wales
- July 2008, Banbury
- September 2008, Plymouth
- November 2008, Stoke-on-Trent
- January 2009, Norwich
- March 2009, Manchester

## NICE WEBSITE A HIT

The website is a tool for helping practitioners and the public access all our guidance. In 2008/09 there were 6,054,994 total visits to the website.

The most visits in a single day was 30,522 on Wednesday 25 February 2009 when we launched three clinical guidelines, two pieces of interventional procedures guidance, two pieces of technology appraisal guidance and new public health guidance.

### **FIVE MOST VIEWED PIECES OF GUIDANCE IN 2008/09**

### **VISITS**

#### **Type 2 diabetes**

(NICE clinical guideline 66, published May 2008)

**177,222**

#### **Hypertension**

(NICE clinical guideline 34, published June 2006)

**133,121**

#### **Obesity**

(NICE clinical guideline 43, published December 2006)

**127,936**

#### **Chronic obstructive pulmonary disease**

(NICE clinical guideline 12, published February 2004)

**115,497**

#### **Antenatal care**

(NICE clinical guideline 62, published March 2008)

**114,496**

## GUIDANCE RECEIVING THE MOST VIEWS IN FIRST MONTH AFTER LAUNCH, 2008/09

VISITS

<b>Type 2 diabetes</b> (NICE clinical guideline 66, published May 2008)	<b>29,926</b>
<b>Stroke and transient ischaemic attack (TIA)</b> (NICE clinical guideline 68, published July 2008)	<b>28,009</b>
<b>Attention deficit hyperactivity disorder</b> (NICE clinical guideline 72, published September 2008)	<b>27,052</b>
<b>Schizophrenia (update)</b> (NICE clinical guideline 82, published March 2009)	<b>21,171</b>
<b>Lipid modification</b> (NICE clinical guideline 67, published May 2008)	<b>20,682</b>

### ANY QUESTIONS?

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NICE's enquiry handling team is based in Manchester and handles around 12,000 calls, letters and emails a year on a wide range of topics, ranging from enquiries about our recommendations and the evidence behind them through to navigating the NICE website and how to respond to a consultation.

Teresa Birch, communications manager, said: "The four team members here handle about 650 emails, 330 telephone calls and 20 letters a month. Just over half come from healthcare professionals in the NHS and the rest from the general public, charities and academics."

The team researches the guidance to answer many of the questions themselves, often redirecting people to the right section of the website. Other times they call in clinical expertise from NICE directorates or the guideline development groups.

"We have to keep an eye on the press too because that can affect the number and type of enquiries we receive," says Teresa. "The hottest topic for us in 2008/09 was renal cell carcinoma. NICE guidance on drugs for the treatment of this condition generated a lot of interest."

The best part of her job is the enormous variety, she says, and being able to change people's minds. "We sometimes get calls after people have read a press article and they have one opinion about NICE. Once we've had the opportunity to talk about the role of NICE, it's satisfying to know that they often go away with a more informed opinion and a better understanding of what we do."

### DEVELOPING NICE INTERNATIONAL

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NICE has earned a global reputation over the past decade and a wide range of countries, both developing and developed, have sought our advice as they build evidence-based practice in their own health services.

It was clear that we needed to respond in a more systematic way, both to enable NICE to make the best use of resources and to provide a high quality service. In 2009, the NICE Board agreed to set up NICE International. Its aims are to:

- enable NICE to address international health issues in a professional way and enhance our reputation
- offer NICE staff and partners the opportunity for international collaboration and learning
- assist recruitment and retention of high-calibre staff
- help NICE deliver the UK government's global health policies.

NICE International is a not-for-profit division with its own staff. All international collaboration is carried out on a cost–recovery basis through contracts and grants secured from government funders and international organisations such as the World Bank.

In 2008/09, NICE International worked with eight countries on a wide range of projects, including comparative analyses to inform health policy in the USA, and exploratory missions in Colombia and Ghana with support from the Department for International Development. In March 2009 NICE ran a 3-day workshop on using evidence to inform healthcare policy and practice for senior policy makers and clinicians in Jordan.

Such international engagements also help NICE to develop the approach set out in government policy in the 2007 white papers 'Health is global' and 'Working together for better health'. These seek to protect the health of the UK population, reduce global poverty and harness the opportunities of globalisation.

## CLINICAL GUIDELINES IN TURKEY

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The Turkish government has invested significant resources in a pay-for-performance scheme and in developing quality standards to improve health services for its population.

In 2008 Turkey asked NICE International to help develop this work further and assist in implementing the structures, processes and capacity to produce clinical guidelines for best practice. These will include measures of quality that could be used in pay-for-performance schemes that reward healthcare providers and in monitoring the quality of the services offered.

"This will be run as a hands-on pilot for us and for the Turkish government," said Kalipso Chalkidou, who leads NICE International. "Our Turkish colleagues will pick a high-burden disease area and develop a guideline adapting the NICE evidence base to the local setting. They will be doing the developing and we will be doing the assisting. The idea is to build capacity to ensure this is a sustainable process in Turkey in the long run."

Work is now well under way on this 10-month project, which is being funded through the World Bank. In March 2009 NICE International brought together a team of experts from NICE, the national collaborating centres and academics from the USA for their first mission to Ankara to meet with their Turkish counterparts.

# PATIENT AND PUBLIC INVOLVEMENT

The views of patients or service users, their carers and the public matter to NICE. By involving patients, carers, patient organisations and the public in our work, NICE aims to produce guidance that addresses their issues, reflects their views and meets their healthcare needs.



In 2008/09 patients, carers and members of the public were involved in a wide range of work with NICE, influencing how we carry out our work, contributing to the development of our guidance and helping us to disseminate and encourage uptake of our guidance. They joined advisory committees and working groups, the Citizens Council and the Partners Council, and made valuable contributions to consultations.

In 2008 NICE made its advisory group meetings open to the public for the first time.

NICE has a dedicated Patient and Public Involvement Programme (PPIP), which supports the lay people who work with us. In 2008/09 the PPIP:

- recruited 59 lay people to 22 guideline and programme development groups, where they helped develop clinical guidelines and public health guidance
- ran 8 training days, training a total of 61 lay people in guideline and public health guidance methodology
- recruited 4 new lay people to the Public Health Interventions Advisory Committee and the Technology Appraisals Committees and 3 new lay people to the new Primary Care Quality and Outcomes Framework Indicator Advisory Committee.

## EQUALITIES FORUM

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NICE has an equality scheme that sets out how we are meeting our obligations on equality and discrimination and what we still need to do. In October 2008 NICE held an inaugural equalities forum to consider ways of involving disabled people and other groups at a strategic level in the scheme and its implementation. It was attended by 18 people from a wide range of groups affected by the equality scheme, as well as NICE staff and Board members. Participants felt the forum was a useful mechanism for reviewing equality and diversity issues within NICE.

Key issues raised by the forum included:

- The apparent tension between the quality-adjusted life year (QALY) measure and NICE's commitment to promote equality, particularly in the case of disabled people and older people.
- The balance of issues that NICE considers, given the range of types of equality issues.
- NICE's response to profound health inequalities among particular groups, for example, in relation to sickle cell disease, mental health, and the physical health of people with learning disabilities and mental health problems.
- NICE's role in influencing local implementation to promote equality.
- The potential of NICE's annual conference to raise issues of equality, draw in a wider range of stakeholders, and involve clinicians from black and minority ethnic groups.

## THE CITIZENS COUNCIL

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The Citizens Council brings the views of the public to NICE decision-making. It is a group of 30 people drawn from all walks of life who provide NICE with insights into the public's views on challenging issues that often involve values such as fairness and need. It meets twice a year and reports directly to NICE's Board. Its recommendations inform a wide programme of work.

In 2008/09 the Citizens Council delivered a report on whether NICE should take into account the severity of a disease alongside cost and clinical effectiveness of treatment and if so, whether economic analyses need to include consideration of severity.

The quality-adjusted life year (QALY) lies at the heart of the economic analysis that NICE uses to inform decisions. Although QALYs offer the best way of comparing the benefits of different types of healthcare technologies, their use in helping to decide how NHS funds are used and what treatments to provide can be controversial.

The council discussed the evidence – including the calculations and NICE’s preferred quality-of-life questionnaire, the EQ-5D – that lies behind the QALY calculation. Its members then voted 24 to 2 that the severity of disease is an important additional consideration. Those who agreed were unanimous that severity should be taken into consideration alongside the cost and clinical effectiveness evidence. The Council called for “a thoughtful and penetrating review” of both QALY and the EQ-5D.

Professor Peter Littlejohns, Clinical and Public Health Director at NICE, said: “This report gave NICE valuable insight from a fresh perspective. In 2008, the Medical Research Council agreed to fund a scoping study on NICE’s methodological research needs and this will help us to respond to the public concerns that the council has identified.”

## WHY I AM INVOLVED...

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Bren McInerney is health involvement lead at Barton and Tredworth Community Trust in Gloucestershire. He was a lay member of the programme development group (PDG) that produced guidance in January 2008 on how to encourage people to be physically active.

**Q:** What prompted you to get involved?

**A:** I work in one of the most deprived areas of the country – with significant health inequalities. I feel it’s important that policies to reduce health inequalities are embedded in grassroots knowledge.

**Q:** What impact do you think you had on the PDG?

**A:** I would have been uncomfortable going back to the communities I work with unless inequalities were recognised. I gave a paper to the group on the impact that health inequalities can have on people’s lives. I’m very proud to say that, as a result, the group recognised the need to ensure the recommendations were ‘equality and diversity-proofed’.

**Q:** Have there been any unexpected benefits?

**A:** I’ve developed my own skills, knowledge and expertise and learnt more about the topic.

**Q:** How have you helped disseminate and implement the guidance?

**A:** I helped set up Gloucestershire Physical Activity and Environment Action Board. It includes people from planning, public health, housing, academia, national governing bodies, children and young people’s services and members of the local voluntary and community sectors.

One day after the launch of the guidance in London, I organised a local launch of the guidance in Gloucestershire. Since then, we’ve carried out a mapping exercise of activities to see what changes are needed.



# ABOUT NICE

## THE BOARD

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The NICE Board is made up of executive and non-executive directors. The Board's membership in 2008/09 was as follows:

**Professor Sir Michael Rawlins**

Chairman

**Mark Taylor**

Vice-chairman

**Professor Shah Ebrahim**

Non-executive Director (until December 2008)

**Reverend Frederick George**

Non-executive Director

**Jenny Griffiths OBE**

Non-executive Director

**Dr Margaret Helliwell**

Non-executive Director

**Mercy Jeyasingham**

Non-executive Director

**Professor Rona McCandish**

Non-executive Director

**Professor Patrick Morrison**

Non-executive Director

**Professor Helen Roberts**

Non-executive Director

**Jonathan Tross CB**

Non-executive Director

**Andrew Dillon CBE**

Chief Executive

**Dr Gillian Leng**

Chief Operating Officer for NHS Evidence and Deputy Chief Executive

**Professor Peter Littlejohns**

Clinical and Public Health Director

**Ben Bennett**

Business Planning and Resources Director

## BOARD COMMITTEES

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### AUDIT COMMITTEE

The Audit Committee provides an independent and objective review of arrangements for internal control within NICE, including risk management. The members of the Audit Committee in 2008/09 were:

**Jonathan Tross CB\***

Non-executive Director

**Reverend Frederick George**

Non-executive Director

**Jenny Griffiths OBE**

Non-executive Director

**Mark Taylor**

Non-executive Director

\*Chair of the Committee

### HUMAN RESOURCES COMMITTEE

The Human Resources Committee agrees, monitors and reviews NICE human resources strategies and policies. The members of the Human Resources Committee in 2008/09 were:

**Mercy Jeyasingham\***

Non-executive Director

**Jenny Griffiths OBE**

Non-executive Director

**Professor Helen Roberts**

Non-executive Director

\*Chair of the Committee

## THE REMUNERATION AND TERMS OF SERVICE COMMITTEE

The Remuneration and Terms of Service Committee sets remuneration levels and terms of service for senior staff at NICE, in line with NHS practice. The members of the Remuneration and Terms of Service Committee in 2008/09 were:

**Professor Sir Michael Rawlins**  
Chairman\*

**Reverend Frederick George**  
Non-executive Director

**Mark Taylor**  
Vice-chairman

**Jonathan Tross CB**  
Non-executive Director

\*Chair of the Committee

## SENIOR MANAGEMENT TEAM

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The members of the NICE Senior Management Team in 2008/09 were:

**Andrew Dillon CBE**, Chief Executive

**Dr Gillian Leng**, Chief Operating Officer for NHS Evidence and Deputy Chief Executive (Implementation Director to August 2008)

**Ben Bennett**, Business Planning and Resources Director

**Professor Peter Littlejohns**, Clinical and Public Health Director

**Dr Carole Longson**, Director of the Centre for Health Technology Evaluation Centre

**Professor Mike Kelly**, Director of the Centre for Public Health Excellence

**Dr Fergus Macbeth**, Director of the Centre for Clinical Practice (from September 2008)

**Carol Bewick**, Interim Communications Director (April–September 2008)

**Jane Gizbert**, Communications Director (from September 2008)

**Val Moore**, Interim Implementation Director (from September 2008)

## INDEPENDENT ADVISORY COMMITTEES

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Membership of these committees includes healthcare professionals working in the NHS and people who are familiar with issues affecting patients and carers. Although they may seek the views of organisations that represent healthcare professionals, patients and carers, manufacturers and government, their advice is independent of any vested interest. They are:

- **Interventional Procedures Advisory Committee** chaired by Professor Bruce Campbell
- **Public Health Interventions Advisory Committee** chaired by Professor Catherine Law OBE
- **Research and Development Advisory Committee** chaired by Professor Tony Culyer
- **Technology Appraisal Committees** chaired by Professor David Barnett and Professor Andrew Stevens

## INDEPENDENT ACADEMIC CENTRES

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NICE commissions an independent academic centre to review the published evidence on the relevant technology when developing technology appraisal guidance. NICE currently works with the following organisations:

- Health Economics Research Unit and Health Services Research Unit, University of Aberdeen
- Liverpool Reviews and Implementation Group, University of Liverpool
- NHS Centre for Reviews and Dissemination, University of York
- Peninsula Technology Assessment Group (PenTAG), Peninsula Medical School, Universities of Exeter and Plymouth
- School of Health and Related Research (ScHaRR), University of Sheffield
- Southampton Health Technology Assessment Centre (SHTAC), University of Southampton
- West Midlands HTA Collaboration (WMTHAC), Department of Public Health and Epidemiology, University of Birmingham

NICE also commissions an independent academic centre to review published evidence on the relevant topics when developing public health guidance. The Centre for Public Health Excellence at NICE in 2008/09 worked with the following organisations:

- Centre for Public Health, Liverpool John Moores University
- The British Heart Foundation Health Promotion Research Group (University of Oxford) and the British Heart Foundation National Centre for Physical Activity and Health (University of Loughborough)
- Institute for Employment Studies, Institute of Work Psychology and School of Health and Related Research (ScHaRR), at the University of Sheffield
- London School of Hygiene and Tropical Medicine at the University of London

## REVIEW BODY FOR INTERVENTIONAL PROCEDURES

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NICE commissions an independent review body to carry out a systematic review if more information is needed before guidance can be developed on an interventional procedure. The review body is a joint venture between the School of Health and Related Research (ScHaRR) at the University of Sheffield and the Health Services Research Unit at the University of Aberdeen.

## NATIONAL COLLABORATING CENTRES

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The national collaborating centres (NCCs) develop clinical guidelines for NICE. The NCCs bring together a multidisciplinary guideline development group for each guideline. These groups include patients, healthcare professionals such as nurses and GPs, and technical experts who work together to interpret evidence and draft recommendations. The draft guidelines are made available on our website for 8 weeks so that stakeholders can comment. After careful consideration of all the comments made, the guideline is finalised for the NHS. In 2008/09 the NCCs were:

- NCC for Acute Care based at the Royal College of Surgeons
- NCC for Cancer based at the Velindre NHS Trust
- NCC for Chronic Conditions based at the Royal College of Physicians
- NCC for Mental Health run jointly by the Royal College of Psychiatrists and the British Psychological Society
- NCC for Nursing and Supportive Care based at the Royal College of Nursing

- NCC for Primary Care based at the Royal College of General Practitioners
- NCC for Women’s and Children’s Health based at the Royal College of Obstetricians and Gynaecologists and the Royal College of Paediatrics and Child Health

## PUBLIC HEALTH COLLABORATING CENTRES

The public health collaborating centres (PHCCs) undertake reviews of the evidence and economic analyses for consideration by the Public Health Interventions Advisory Group (PHIAC) or a programme development group (PDG). In 2008/09, the PHCCs were:

- The School of Health and Related Research (SchARR), University of Sheffield
- The West Midlands Health Technology Assessment Collaboration (WMHTAC), Department of Public Health & Epidemiology, University of Birmingham; and Peninsula Technology Assessment Group (PenTAG), Institute for Health Services Research, Peninsula Medical School, Universities of Exeter and Plymouth

## TOPIC SELECTION CONSIDERATION PANELS

The topic selection consideration panels consider possible topics for NICE guidance that have been suggested by a variety of sources. The panels prioritise and recommend topics they think are most important and fit best with NICE’s work programme. There are seven topic selection consideration panels, each focusing on a topic: cancer; children,

adolescents and maternity; vascular conditions (including renal conditions and diabetes); long-term conditions; mental health; public health; general and acute conditions.

## CITIZENS COUNCIL COMMITTEE

The Citizens Council Committee, in consultation with the rest of NICE, decides the questions to be put to the Citizens Council. The members of the Citizens Council Committee in 2008/09 were:

### **Professor Sir Michael Rawlins**

NICE Chairman\*

### **Mercy Jeyasingham**

Non-executive Director

### **Professor Peter Littlejohns**

Clinical and Public Health Director

### **Professor Helen Roberts**

Non-executive Director

\*Chair of the Committee

## APPEALS COMMITTEE

The Appeals Committee has the role of hearing appeals against Technology Appraisal Final Appraisal Determinations (FAD) that fall within one or more of the three strictly limited grounds upon which interested parties appeal. Membership includes non-executive directors of NICE, NHS representatives, members with experience of the relevant industry or clinical field, and members with experience of carer organisations.

## PARTNERS COUNCIL

The Partners Council provides a forum for exchanging ideas and future plans between NICE and its stakeholders.

Members are drawn from organisations with special interests in NICE’s work. They include patient groups, healthcare professionals, NHS management, quality organisations, industry and trade unions. Members are appointed by the Secretary of State for Health and the Welsh Assembly Government. Members of the NICE Partners Council in 2008/09 were:

<b>ORGANISATION</b>	<b>NAME</b>
Academy of Medical Royal Colleges	Professor Tim Coates
Arthritis & Musculoskeletal Alliance	Ros Meek
Association of Ambulance Services	To be appointed

Association of British Healthcare Industries	Colin S Morgan
Association of British Insurers	Dr Natalie-Jane Macdonald
Association of Directors of Social Services	Mr Ted Unsworth
Association of the British Pharmaceutical Industry	Mr David J Fisher
Association of Welsh Community Health Councils	To be appointed
Black Health Agency	Mr Nick Barstow
British Dental Association	Susie Sanderson
British Dietetic Association	Caroline Lee Hooper
British Medical Association	Dr David Geoffrey Lewis
British Psychological Society	Stephen Pilling
BUPA	Dr Andrew Vallance-Owen
Carers UK	To be appointed
Chartered Institute of Environmental Health	Mr Graham Jukes
Chartered Society of Physiotherapy	To be appointed
College of Occupational Therapists	Dr Elizabeth White
Community Practitioners and Health Visitors Association	Ms Lesley Young-Murphy
Equalities National Council BME Disabled People/Carers	Ms Julie-Jaye Charles
Faculty of Dental Surgery	Professor Fraser McDonald
Faculty of Pharmaceutical Medicine	To be appointed
Faculty of Public Health Medicine	Dr Alan Maryon Davis
Independent Healthcare Advisory Services	Dr JJ De Gorter
Institute for Quality Assurance	To be appointed
Local Government Association	Cllr David Rogers OBE
National Consumer Council	Saranjit Sihota
National Federation of Women's Institutes	Margeret Simons
NHS Confederation	To be appointed
Princess Royal Carers for Trust	Mr Nicholas Shan
Royal College of Anaesthetists	To be appointed
Royal College of General Practitioners	To be appointed
Royal College of Midwives	To be appointed
Royal College of Nursing	Maura Buchanan
Royal College of Obstetricians and Gynaecologists	Professor Arulkumaran
Royal College of Ophthalmologists	Heidi Booth-Adams
Royal College of Paediatrics and Child Health	Dr Edward Wozniak
Royal College of Pathologists	Dr Lance N Sandle
Royal College of Physicians	Professor Ian Gilmore
Royal College of Psychiatrists	Dr Paul Lelliott
Royal College of Radiologists	Professor Andy Adam
Royal College of Speech and Language Therapists	Diane Payne
Royal College of Surgeons	Dr Mark Emberton
Royal Institute of Public Health	To be appointed
Royal Pharmaceutical Society of Great Britain	Mr John Patrick Farrell
UNISON	Bob Abberley
United Kingdom Public Health Association	Professor David Hunter
Wales Council for Voluntary Action	David Smith
Former member of Citizens Council	Sylvia Brown
Former member of Citizens Council	To be appointed

# PUBLISHED GUIDANCE 2008/09

## PUBLIC HEALTH GUIDANCE PUBLISHED IN 2008/09

TITLE	PUBLICATION DATE
Promoting physical activity in the workplace (PH 13)	May 2008
Preventing the uptake of smoking by children and young people (PH 14)	July 2008
Identifying and supporting people most at risk of dying prematurely (PH 15)	September 2008
Mental wellbeing and older people (PH 16)	October 2008
Promoting physical activity for children and young people (PH 17)	January 2009
Needle and syringe programmes (PH 18)	February 2009
Management of long-term sickness and incapacity for work (PH 19)	March 2009

For information about public health guidance in development see [www.nice.org.uk/guidance/PHG/InDevelopment](http://www.nice.org.uk/guidance/PHG/InDevelopment)

## CLINICAL GUIDELINES PUBLISHED IN 2008/09

TITLE	PUBLICATION DATE
Inadvertent perioperative hypothermia (CG 65)	April 2008
Type 2 diabetes (update) (CG 66)	May 2008
Lipid modification (CG 67)	May 2008
Stroke (CG 68)	July 2008
Respiratory tract infections – antibiotic prescribing (CG 69)	July 2008
Induction of labour (CG 70)	July 2008
Identification and management of familial hypercholesterolaemia (CG 71)	August 2008
Attention deficit hyperactivity disorder (CG 72)	September 2008
Chronic kidney disease (CG 73)	September 2008
Surgical site infection (CG 74)	October 2008
Metastatic spinal cord compression (CG 75)	November 2008
Medicines adherence (CG 76)	January 2009
Antisocial personality disorder (CG 77)	January 2009
Borderline personality disorder (CG 78)	January 2009
Rheumatoid arthritis (CG 79)	February 2009
Early and locally advanced breast cancer (CG 80)	February 2009
Advanced breast cancer (CG 81)	February 2009
Schizophrenia (update) (CG 82)	March 2009
Rehabilitation after critical illness (CG 83)	March 2009

For information about clinical guidelines in development see [www.nice.org.uk/Guidance/CG/InDevelopment](http://www.nice.org.uk/Guidance/CG/InDevelopment)

## TECHNOLOGY APPRAISAL GUIDANCE PUBLISHED IN 2008/09

TITLE	PUBLICATION DATE
Ulcerative colitis (subacute manifestations) – infliximab (TA 140)	April 2008
Rheumatoid arthritis (refractory) – abatacept (TA 141)	April 2008
Anaemia (cancer-treatment induced) – erythropoietin (alpha and beta) and darbepoetin (TA 142)	May 2008
Ankylosing spondylitis – adalimumab, etanercept and infliximab (TA 143)	May 2008
Obesity – rimonabant (withdrawn) (TA 144)	June 2008
Head and neck cancer – cetuximab (TA 145)	June 2008
Psoriasis – adalimumab (TA 146)	June 2008
Breast cancer (advanced & metastatic) – bevacizumab (terminated appraisal) (TA 147)	June 2008
Lung cancer (non-small-cell) – bevacizumab (terminated appraisal) (TA 148)	June 2008
Glioma (recurrent) – carmustine implants (terminated appraisal) (TA 149)	June 2008
Colorectal cancer (metastatic) – cetuximab (terminated appraisal) (TA 150)	June 2008
Diabetes – insulin pump therapy (TA 151)	July 2008
Coronary artery disease – drug-eluting stents (TA 152)	July 2008
Hepatitis B – entecavir (TA 153)	August 2008
Hepatitis B – telbivudine (TA 154)	August 2008
Macular degeneration (age-related) – ranibizumab and pegaptanib (TA 155)	August 2008
Pregnancy (rhesus negative women) – routine anti-D (review) (TA 156)	August 2008
Venous thromboembolism – dabigatran (TA 157)	September 2008
Influenza (prophylaxis) – amantadine, oseltamivir and zanamivir (TA 158)	September 2008
Pain (chronic neuropathic or ischaemic) – spinal cord stimulation (TA 159)	October 2008
Osteoporosis – primary prevention (TA 160)	October 2008
Osteoporosis – secondary prevention including strontium ranelate (TA 161)	October 2008
Lung cancer (non-small-cell) – erlotinib (TA 162)	November 2008
Ulcerative colitis (acute exacerbations) – infliximab (TA 163)	December 2008
Hyperuricaemia – febuxostat (TA 164)	December 2008
Organ preservation (renal) – machine perfusion and static storage (TA 165)	January 2009
Hearing impairment – cochlear implants (TA 166)	January 2009
Abdominal aortic aneurysm – endovascular stent-grafts (TA 167)	February 2009
Influenza – zanamivir, amantadine and oseltamivir (review) (TA 168)	February 2009
Sunitinib for the first-line treatment of advanced and/or metastatic renal cell carcinoma (TA 169)	March 2009

For information about technology appraisal guidance in development see [www.nice.org.uk/Guidance/TA/InDevelopment](http://www.nice.org.uk/Guidance/TA/InDevelopment)

## INTERVENTIONAL PROCEDURES GUIDANCE PUBLISHED IN 2008/09

TITLE	PUBLICATION DATE
Allogeneic pancreatic islet cell transplantation for type 1 diabetes mellitus (IPG 257)	April 2008
Intraoperative red blood cell salvage during radical prostatectomy or radical cystectomy (IPG 258)	April 2008
Interstitial photodynamic therapy for malignant parotid tumours (IPG 259)	April 2008
Canaloplasty for primary open-angle glaucoma (IPG 260)	May 2008
Endoaortic balloon occlusion for cardiac surgery (IPG 261)	May 2008
Single-incision sub-urethral short tape insertion for stress urinary incontinence in women (IPG 262)	May 2008
Lumbar infusion test for the investigation of normal pressure hydrocephalus (IPG 263)	June 2008
Implantation of multifocal (non-accommodative) intraocular lenses during cataract surgery (IPG 264)	June 2008
Stent insertion for bleeding oesophageal varices (IPG 265)	June 2008
Transcatheter aortic valve implantation for aortic stenosis (IPG 266)	June 2008
Surgical repair of vaginal wall prolapse using mesh (IPG 267)	June 2008
Brachytherapy as the sole method of adjuvant radiotherapy for breast cancer after local excision (IPG 268)	July 2008
Laparoscopic gastrectomy for cancer (IPG 269)	July 2008
Direct skeletal fixation of limb or digit prostheses using intraosseous transcutaneous implants (IPG 270)	July 2008
Total wrist replacement (IPG 271)	August 2008
Implantation of miniature lens systems for advanced age-related macular degeneration (IPG 272)	August 2008
Balloon catheter dilation of paranasal sinus ostia for chronic sinusitis (IPG 273)	September 2008
Autologous pancreatic islet cell transplantation for improved glycaemic control after pancreatectomy (IPG 274)	September 2008
Laparoscopic prostatectomy for benign prostatic obstruction (IPG 275)	November 2008
Transabdominal artificial bowel sphincter implantation for faecal incontinence (IPG 276)	November 2008
Electrically-stimulated intravesical chemotherapy for superficial bladder cancer (IPG 277)	November 2008
Functional electrical stimulation for drop foot of central neurological origin (IPG 278)	January 2009
Autologous blood injection for tendinopathy (IPG 279)	January 2009
Infracoccygeal sacropexy using mesh for uterine prolapse repair (IPG 280)	January 2009
Infracoccygeal sacropexy using mesh for vaginal vault prolapse repair (IPG 281)	January 2009
Insertion of mesh uterine suspension sling (including sacrohysteropexy) for uterine prolapse repair (IPG 282)	January 2009
Sacrocolpopexy using mesh for vaginal vault prolapse repair (IPG 283)	January 2009
Sacrocolpopexy with hysterectomy using mesh for uterine prolapse repair (IPG 284)	January 2009
Ultrasound-guided regional nerve block (IPG 285)	January 2009
Thoracoscopic epicardial radiofrequency ablation for atrial fibrillation (IPG 286)	January 2009

Laparoscopic cystectomy (IPG 287)	February 2009
Extracorporeal photopheresis for Crohn's disease (IPG 288)	February 2009
Intraocular lens insertion for correction of refractive error, with preservation (IPG 289)	February 2009
Photodynamic therapy for brain tumours (IPG 290)	March 2009
Deep dermal injection of non-absorbable gel polymer for HIV-related facial lipoatrophy (IPG 291)	March 2009
Endoscopic radiofrequency ablation for gastro-oesophageal reflux disease (IPG 292)	March 2009
Implantation of an opaque intraocular lens for intractable double vision (IPG 293)	March 2009
Percutaneous (non-thoracoscopic) epicardial catheter radiofrequency ablation for atrial fibrillation (IPG 294)	March 2009
Percutaneous (non-thoracoscopic) epicardial catheter radiofrequency ablation for ventricular tachycardia (IPG 295)	March 2009

For information about interventional procedures guidance in development see [www.nice.org.uk/Guidance/IP/InDevelopment](http://www.nice.org.uk/Guidance/IP/InDevelopment)

## COMMISSIONING GUIDES PUBLISHED AND UPDATED IN 2008/09

### CARDIOVASCULAR

Anticoagulation therapy service	updated October 2008
Cardiac rehabilitation service	updated October 2008
Diagnosis and initial management of acute stroke	published December 2008
Heart failure service	updated October 2008
Transient ischaemic attack service	published December 2008

### CENTRAL NERVOUS SYSTEM

Cognitive behavioural therapy service	published April 2008; updated October 2008
Memory assessment service	updated October 2008
Service for the accurate diagnosis of the epilepsies in adults	published August 2008

### DIGESTIVE SYSTEM

Faecal continence service	published April 2008; updated October 2008
Upper gastrointestinal endoscopy services	updated October 2008

### EAR AND NOSE

Service for the surgical management of otitis media with effusion in children	published December 2008
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## **ENDOCRINE, NUTRITIONAL AND METABOLIC**

Bariatric surgical service	updated October 2008
Foot care service for people with diabetes	updated October 2008
Patient education programme for people with type 2 diabetes	published December 2008
Insulin pump therapy service	published February 2009

## **GYNAECOLOGY, PREGNANCY AND BIRTH**

Breastfeeding peer support programme	published September 2008
Endometrial ablation service	updated October 2008
Hysterectomy service	updated October 2008
Service for the provision of intrauterine devices and the intrauterine system	published January 2008 updated October 2008

## **MENTAL HEALTH AND BEHAVIOURAL CONDITIONS**

Antenatal and postnatal mental health services	published August 2008
Service for the diagnosis and management of ADHD in adults	published February 2009

## **RESPIRATORY**

Assisted discharge service for patients with COPD	updated October 2008
Pulmonary rehabilitation service for people with COPD	updated October 2008

## **SMOKING CESSATION**

Smoking cessation service for people having elective surgery	published March 2009
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## **UROGENITAL**

Urinary continence service	updated October 2008
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## **IMPLEMENTATION UPTAKE REPORTS PUBLISHED IN 2008/09**

The NICE Implementation Directorate produces in-house implementation uptake reports to assess the level of compliance with NICE guidance across the NHS.

<b>TITLE</b>	<b>PUBLICATION DATE</b>
Nicotine replacement therapy (NRT), bupropion and varenicline for smoking cessation	July 2008
Capecitabine and oxaliplatin for colon cancer	July 2008
Statins for the prevention of cardiovascular events	November 2008
Newer hypnotic drugs for insomnia	November 2008
Pharmacological interventions for obesity	November 2008
Diabetes – glitazones (rosiglitazone and pioglitazone)	January 2009
Diabetes (types 1 and 2) – insulin glargine	January 2009
Myocardial Infarction (MI) – secondary prevention	March 2009
Obesity – surgical interventions	March 2009
Epilepsy – the diagnosis and management of the epilepsies in adults and children in primary and secondary care	March 2009

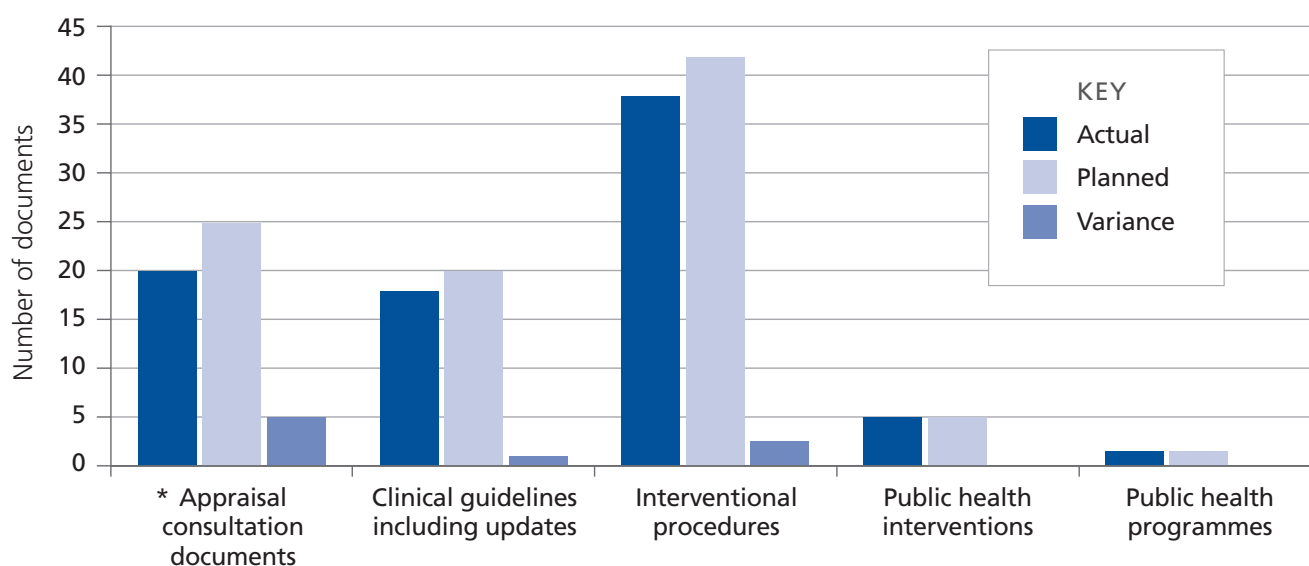
# FINANCIAL OVERVIEW

This section provides an overview of NICE's financial accounts. The full statutory accounts have been published as a supplement and accompany this document. The full annual accounts are available on our website ([www.nice.org.uk](http://www.nice.org.uk)); by writing to Natalie Sargent, Associate Director of Finance – Technical Accounting, NICE, MidCity Place, 71 High Holborn, London WC1V 6NA; or by contacting NICE on 0845 003 7780.

## OVERALL POSITION

During the year NICE continued its guidance development programme, as well as planning for and implementing some significant new programmes. The prime measure of its performance is the achievement of targets related to each guidance programme. These are summarised in figure 1:

**FIGURE 1**  
PROGRAMME ACTIVITY FOR 12 MONTHS TO END MARCH 2009



\* The figures shown for Appraisal consultation documents do not represent actual guidance documents issued. For a full list of guidance published, please see page 33.

## NEW DEVELOPMENTS

The Darzi report, 'High quality care for all', was published in June 2008. NICE will take forward a number of initiatives resulting from this report over the next year and beyond. These include:

- further development of the NHS Evidence service
- responsibility for developing the Quality and Outcomes Framework indicators for the NHS
- setting national quality standards for the NHS
- development of a NICE fellowship programme
- expansion and development of existing programmes including the development of guidance on devices and diagnostics.

As a result, NICE's annual budget will rise to about £60 million in 2009/10.

During 2008/09 NICE set up NHS Evidence, a web-based service that will help people find, access and use high-quality clinical and non-clinical evidence and best practice. The functions of the National Library for Health were transferred from the NHS Institute for Innovation and Improvement into NICE on 1 April 2009. NHS Evidence was successfully launched, on target, on 29 April 2009. The development and set-up costs incurred during 2008/09 were within the budget of £1.5 million.

The other new activities outlined above will start during 2009/10. As result, the total number of staff will increase to about 450 whole-time equivalents during 2009/10. During 2008/09, further floor space was acquired and fitted-out at the Manchester office to accommodate this increase in staffing. A good value lease was negotiated and the capital works were completed to time and within budget.

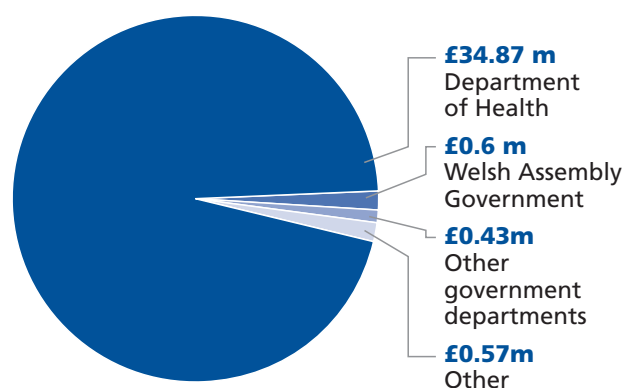
Overall in 2008/09, NICE had an underspend of £58,000 against the budget. This position was net of some variances on the original plan. There was programme slippage in a number of areas, particularly within the public health programme, for which topic referrals had been delayed. The national collaborating centres – close partners of NICE – underwent significant restructuring and mergers. This resulted in some additional, one-off costs.

Significant costs were incurred as a result of legal action taken against NICE. These were partially covered by provision made within 2007/08 resources.

## HOW IS NICE FUNDED?

Most of NICE's funding comes from the Department of Health. This year it received £34.87 million (including £0.8 million for capital) as shown in figure 2. It also received £0.6 million from the Welsh Assembly Government, £0.43 million from other government departments and £0.57 million from other sources.

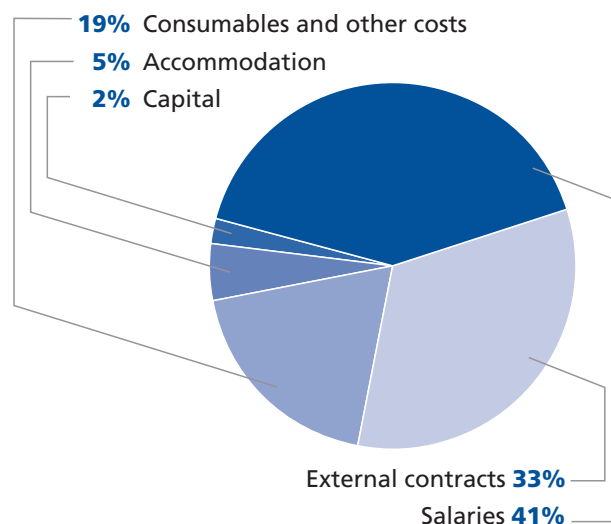
FIGURE 2



## HOW WAS THE FUNDING USED?

Figure 3 shows what the money was spent on in 2008/09. The main areas of expenditure were external contracts and salaries. External contracts include the national collaborating centres that help us to produce clinical and public health guidance.

FIGURE 3

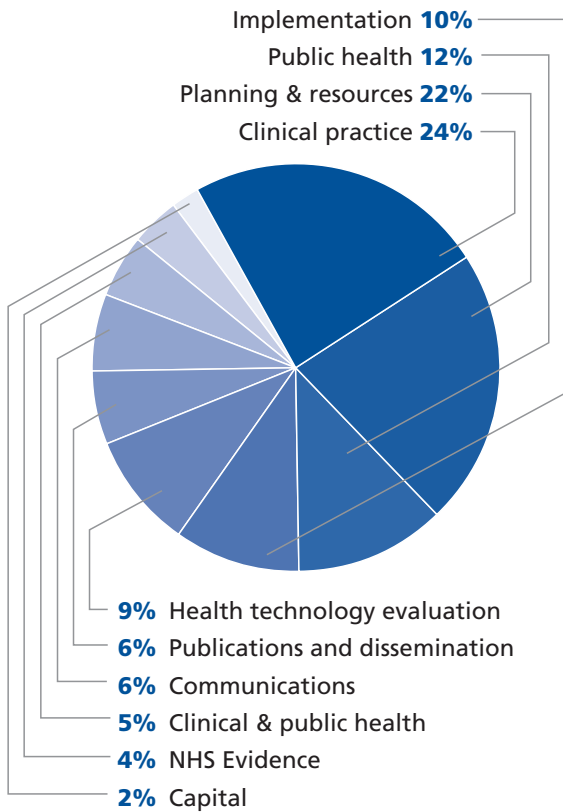


## PROGRAMME COSTS

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Figure 4 shows how the spending was split between NICE's work programmes and the support functions.

**FIGURE 4**



## AUDITORS

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The accounts have been audited by the Comptroller and Auditor General in accordance with the National Health Service Act 2006. The Audit Certificate can be found on pages 12 to 13 of the Annual Report and Accounts 2008/09 (Volume 2).

Amyas C E Morse  
Comptroller and Auditor General  
National Audit Office  
151 Buckingham Palace Road  
Victoria  
London SW1W 9SS

## CONTACTING NICE

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The contact details for NICE are:

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Website: **[www.nice.org.uk](http://www.nice.org.uk)**

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