



**National Institute for
Clinical Excellence**

***National Institute for
Clinical Excellence***

90 Long Acre
Covent Garden
London
WC2E 9RZ

Web: www.nice.org.uk

00000 0p 00K July 00 (??)



***National Institute for
Clinical Excellence***

Corporate Plan

2000 – 2003

Corporate Plan 2000 – 2003

June 2000

**Corporate Plan
2000 – 2003**

National Institute for Clinical Excellence

Corporate Plan 2000 - 2003

National Institute for Clinical Excellence
90 Long Acre
Covent Garden
London
WC2E 9RZ

June 2000
ISBN: 1-84257-021-8

Tel: 020 7849 3444
Fax: 020 7849 3127
Email: nice@nice.nhs.uk
Web: www.nice.org.uk

Corporate Plan 2000 - 2003

Contents

1	Purpose.....	1
2	Partnerships.....	9
3	Objectives	16
4	Programmes	23
5	Resources and Organisation.....	27
6	Future Direction.....	29

Corporate Plan 2000 - 2003

1 Purpose

The National Institute for Clinical Excellence has been established to assist health professionals in providing NHS patients with the highest attainable quality of clinical care. In pursuing this goal the Institute has two guiding principles:-

- Its advice must be based on a rigorous analysis and assessment of the totality of the available evidence.
- Its advice must encompass both clinical *and* cost effectiveness.

The Institute's guidance must not only be robust and authoritative but also be directly relevant to contemporary clinical practice.

The Institute's purpose can therefore be defined as producing:

'Authoritative guidance on best clinical practice for patients and health professionals.'

1.1 The Changing NHS

1.1.1 Since its formation, in 1947, the National Health Service (NHS) has sought to provide universal health care to all citizens of the United Kingdom that is free at the time of need. During its early years the service was largely pre-occupied with financial and organisational issues. The responsibility for maintaining standards of clinical practice (the quality of care) was almost exclusively left to health professionals themselves, and to their representative organisations such as the Royal Medical Colleges and other professional bodies concerned with setting clinical standards.

1.1.2 There has been a gradual acceptance, over the past few years, that the delivery of the highest attainable standards of care in a modern health service requires close co-operation and co-ordination between the NHS, the health professionals working within it, and their representative organisations. One manifestation of this is the requirement, now placed on boards of NHS trusts and health authorities, to give as close attention to clinical governance¹ as they have traditionally placed on corporate governance. The enthusiasm with which health professionals themselves have embraced these new arrangements is remarkable. Perhaps, even more so, has been the response of health professionals' traditional standard-setting organisations which have entered into these new arrangements with enthusiasm. The Institute has a major, though by no means exclusive, role to play in pursuit of this new drive for quality; and it has been greatly encouraged by the support offered by health professionals and the organisations that represent them.

1.1.3 The desire to secure the highest attainable standards of care in the NHS is, quite properly and understandably, shared by patients, by their families and friends, and by the public at large. Consumers, generally, not only have a right to expect a high quality service but also have much to contribute to its acquisition. Consumers and consumer-advocates are therefore intimately involved with the Institute's activities at all levels.

1.2 The Need for National Guidance

1.2.1 It is widely accepted, by all health professionals, that there is an information overload. Advances in clinical knowledge and understanding are now occurring so rapidly that no health professional has time to read, let alone assimilate, the relevant literature. These difficulties have given rise to unacceptable variations in the standards of care, too slow adoption of significant new advances, and continuing reliance on ineffective or outmoded treatments.

¹ Clinical governance is the responsibility placed on NHS institutions to seek continuous improvements to the quality of care they provide for their patients. See *A First Class Service – Quality in the New NHS. Department of Health 1998*

1.2.2 Health professionals have also been confused by the need to balance clinical with cost effectiveness. Most (albeit, in some instances, reluctantly) accept that all health care systems have finite resources; and they seek to provide services which offer the best value for money for the population as a whole. Few independent evaluations of individual health technologies, and even fewer clinical guidelines, have been constructed to take account of these inter-related issues. The Institute's guidance will, invariably, be based on evidence of both clinical and cost effectiveness.

1.3 The Institute's Contributions

The Institute's contributions to the NHS are in the form of guidance to health professionals on best clinical practice that takes account of both clinical and cost effectiveness and which is constructed using robust and transparent methods. Its guidance, whilst not mandatory, is expected to be taken fully into account by health professionals when exercising their clinical judgement in managing individual patients and by health service managers when allocating resources. The Institute's guidance covers, broadly, three areas:-

1.3.1 Use of Individual Health Technologies²

By "appraising" the available evidence on the clinical and cost effectiveness of new and established technologies, the Institute prepares guidance for health professionals on use within the NHS. NICE expects the implementation of this guidance to result in:-

- the more appropriate use of new and existing technologies;
- equity of access to technologies within the service;
- the more rapid uptake of significant new advances;
- the abandonment of outmoded, inappropriate and ineffective technologies.

² Health technologies subject to appraisal comprise pharmaceuticals, devices, diagnostic agents, clinical procedures and health promotion.

1.3.1 Management of Individual Conditions

The Institute's guidance on the use of individual technologies is currently its most visible, and highly publicised, contribution to the NHS. The Institute believes, however, that its advice on the management of individual conditions, primarily in the form of "clinical guidelines"³ will in the long term be its most important contribution to promoting and maintaining the health of those living in England and Wales. The primary approach will be the development, dissemination and implementation of robust and reliable clinical guidelines drawn up in partnership with the relevant professional organisations. As with all the Institute's guidance, these will be based on the closest scrutiny of the evidence for both clinical *and* cost effectiveness. This is a particular challenge for the Institute because although there is substantial national and international experience in guideline construction based on clinical effectiveness, there is only limited experience in guideline construction which also encompasses cost effectiveness. The Institute is fortunate that there exists, in the UK, a small number of guideline specialists with expertise in this field and who are enthusiastic to assist in developing this programme.

The Institute's clinical guidelines programme will underpin other forms of guidance which the Institute will be providing for NHS health professionals. These include referral advice (the circumstances under which it is appropriate to seek specialist advice on the management of individual patients), and the authoring of the guidance contained within PRODIGY (a decision-support system for primary care).

³ Clinical guidelines are "systematically designed statements to assist practitioner and patient decisions about appropriate health care for specific clinical circumstances".

1.3.2 Clinical Audit

The Institute has responsibility for promoting clinical audit. Having consulted with the national professional bodies with which it will pursue this objective, three related strands of work will be undertaken:

Information – NHS staff need access to an integrated set of national resources to support local clinical audit. This is a function that the Institute inherited from the former National Centre for Clinical Audit (NCCA).

Education – The Institute will support the proper positioning of clinical audit within the education and development programmes of NHS staff (without undermining the responsibilities of those charged with directly supporting and delivering education and development). (This is also a role that the Institute inherits from the NCCA.)

Practice – The Institute will support, directly, the implementation of national audits or audit tools either in areas where it has previously offered guidance to the NHS, or on topics of particular importance to the service.

In addition to this work, as part its guidance on the use of individual technologies, and in the management of individual conditions, the Institute will be providing health professionals with simple clinical audit methods. These will enable individual health professionals, practices and specialist services, as well as trusts and primary care organisations, to monitor their own adherence to the Institute's advice. Moreover, the Institute anticipates that the audit tools accompanying its clinical guidelines will incorporate 'benchmarks' to give health professionals practical help with their own contributions to clinical governance. The Institute fully accepts, however, that initially it will often be impossible to estimate precise 'benchmarks'; and that it will need to work with the professions in order to improve their precision. The Institute also has responsibilities for promoting national 'Sentinel' Audits, and 'Confidential Enquiries', in partnership with the Royal Medical Colleges and relevant professional associations.

1.4 International Context

- 1.4.1** The problems faced by health care professionals in England and Wales, and described in paragraph 1.2, are shared by their colleagues in all developed and developing countries. No health care professional, anywhere in the world, has successfully resolved the issue of information overload; or the tensions between clinical and cost effectiveness. Every health care system (if the relevant research has been done) displays unacceptable variations in the quality of care, slow uptake of important new treatments, and continued use of outmoded ones.
- 1.4.2** Many countries are in the process of developing measures that might resolve these global difficulties. These range, at one extreme, from clinical care plans that are imposed on health professionals to (at the other end of the spectrum) exhortation to adopt 'evidence-based' clinical practice. Whilst many thousands of clinical guidelines have been published, many (if not most) are of uncertain provenance, and very few encompass cost effectiveness alongside clinical effectiveness. In so far as we are aware, no other country has established an organisation, such as the Institute, that integrates the appraisal of health technologies, the development and dissemination of clinical guidelines, and relevant methodologies for clinical audit. The experience and impact of the Institute is therefore being watched closely across the world.

The Institute is establishing a dialogue with organisations in Europe, North America and the Far East with interests and expertise in health technology assessment (HTA), defining the quality of care (e.g. by guideline construction), and in evaluating clinical service provision. Once it has, itself, gained sufficient experience it will also seek to develop an international consensus on methodologies for assessing cost effectiveness. This is of particular importance for pharmaceuticals: given the global nature of the research-based industry, it would be both impractical and unreasonable for them to be expected to develop individual (and possibly idiosyncratic) approaches to the economic evaluation of their products for

individual markets. The Institute intends to explore the possibility of collaboration with other national or regional government health technology assessment or guidelines authoring agencies, in the preparation of the evidence base underpinning technology appraisals.

1.5 Education

1.5.1 It is obvious that the drive to secure the highest attainable quality of care for patients must be embraced by health service professionals during their initial vocational training. The Institute therefore plans to enter a dialogue with those institutions responsible for validating vocational training courses, as well as with those responsible for curricular planning and development, to ensure that young health professionals and managers gain an understanding of:-

- the principles, and limitations, that underlie the assessment of cost effectiveness as well as clinical effectiveness;
- the strengths and weaknesses of clinical guidelines, and approaches to their construction;
- the relevance, and methodology, of clinical audit.

1.5.2 Equally obviously, there is also a need to secure a commitment to the quality of clinical care amongst young health professionals during their postgraduate training. This needs to be done in close co-operation with organisations responsible for specialist accreditation (e.g. Royal Medical Colleges) and the Institute will continue its current discussions with such bodies. In particular, the adoption of clinical audit by health professionals, as a routine component of their clinical practice, needs to be included in the training programmes of all postgraduate trainees. The Institute is encouraged by the support given to this by many organisations involved in postgraduate training. It seeks to assist these organisations, and those that have yet to introduce clinical audit as integral components of their postgraduate training programmes, to capitalise on the Institute's audit framework.

1.6 Training

1.6.1 The adoption of new health technologies, and the implementation of new or revised clinical guidelines, will often carry with it specific training needs. The Institute will, in such circumstances, include training requirements in its formal guidance to the NHS. The responsibility for such training will vary with the technology or guideline and the Institute will try to ensure that the most appropriate provider(s) is/(are) identified at the time its guidance is issued. In the case of new pharmaceuticals, the manufacturer will often be the most appropriate source of training to ensure safe use within the NHS.

1.7 Research

1.7.1 The Institute has no responsibility itself for undertaking, either directly or indirectly, primary research. Nevertheless, the Institute is heavily dependent on the work of the research community, and organisations responsible for the promotion of research (especially NHS Research & Development Directorate, the Medical Research Council, the Association of Medical Research Charities and the health care industries) in order to fulfil its responsibilities.

1.7.2 First, the Institute's appraisals of new and established health technologies, as well as its development of clinical guidelines will inevitably be based on the findings of the research community. The Institute will therefore continue to foster the closest relationships with those conducting such research, and those responsible for its commissioning, to ensure that its information needs are satisfied.

1.7.3 Second, the Institute's evaluation of the existing research database will, on occasion, inevitably suggest areas where further research is needed if the use of a particular technology, or the management of a specific condition, is to be optimised. In such instances the Institute will attempt to describe the area of research need, and indicate by whom it should be conducted.

1.7.4 Third, the Institute relies (and will continue to rely) on collaboration with the research community in the evaluation of much of the evidence underpinning its guidance. The contributions of the NHS R&D Health Technology Assessment Programme, in particular, have been of critical value during the first year of the Institute's operation and we have no doubt as to the importance of its continuing support.

1.7.5 Finally, the Institute will wish to ensure that its own research requirements are met. These include the need for methodological research (particularly in the field of economic evaluation of health interventions) and a robust assessment of the impact of its guidance on clinical care within the NHS.

2 Partnerships

2.1 Stakeholder Analysis

2.1.1 The Institute's stakeholders are set out below:

- the patients who rely on the NHS for their care, represented through the nationally based patient advocate organisations
- NHS professions, represented as appropriate by their professional bodies
- NHS management
- other national NHS agencies
- the Department of Health and the National Assembly for Wales and their action teams and agencies
- the pharmaceutical, device, diagnostic and associated industries
- The Institute's Partners Council

2.1.2 Patients

The Institute exists for patients. The purpose of the guidance which we produce is to help NHS professionals provide the best care for those which rely on the NHS. They will expect (and we have committed ourselves to ensuring) that the voice of patients appropriately influences our work. All our stakeholders will reflect, in their different ways, what patients expect from us. But we will look to the nationally based professional organisations to help focus and represent the views of patients in formulating our guidance. Patient groups generally have expressed a desire to work with the Institute. Indeed, they expect much from us on behalf of those they represent. They want to be closely involved in the processes involved in our technology appraisal and guidelines authoring programmes and they want this involvement to be meaningful. Some of these organisations have expressed the view that the Institute must prove itself genuine in its desire to work with patient groups. We understand the reasons for this. NICE is a new organisation and much of what we are doing and the way we are doing it has not been attempted before. We and they will need to explore together first how to define the unique contribution of patient advocates, in our work and then how best to receive it.

2.1.3 NHS Professions

We recognise that without effective implementation, our guidance will stand little chance of influencing the standard of care offered by the NHS. A positive relationship with NHS professions and those organisations which represent them is therefore essential, both in the formulation of our guidance and in its application. We have a number of different relationships with these organisations. As with all our stakeholders, their support for the concept of NICE is vital. They can and do act as important advocates for us. In addition, they provide, from amongst their membership individuals which give generously of their time to join the advisory groups which form the core of our guidance authoring processes. They comment on emerging guidelines

and they help disseminate what we produce. The Institute provides funding for many of these professional organisations to provide an infrastructure to author clinical guidelines and to produce national audits. In this respect particularly but in all their dealings with us, they expect us to act in an efficient and businesslike manner, recognising the importance to them and their members of our investments in their work.

2.1.4 NHS Management

As with NHS professionals, we rely on NHS management to help develop and implement our guidance. Its representatives bring a particular perspective, informed by their responsibility to organise the delivery of services in what is recognised to be the most complex of environments. They are looking to us to produce clear, well presented, implementable guidance. They will want to know that there are systems in place for involving the health authorities, Primary Care Groups – England (PCGs) and Local Health Groups – Wales (LHG), and trusts, in the development of the Institute's agenda.

2.1.5 Other National NHS Agencies

There are a number of new and existing NHS agencies which, together, work to support health professionals and managers in providing modern, effective care. We intend to work with them in order:

- to help achieve our own objectives and in particular, to secure the effective dissemination and implementation of our guidance;
- to create and operate formal links with other national NHS agencies;
- to support the activities of other national NHS organisations;

- to help maximise the total contribution of those NHS agencies involved in improving the quality of care offered to patients using the NHS in England and Wales. In other words, to achieve more than just the sum of the parts. The national organisations and agencies with which the Institute intends to work closely are listed below:
 - Commission for Health Improvement
 - NHS Research and Development Programme
 - NHS Executive Clinical Governance Support Team
 - NHS Information Authority
 - NHS Litigation Authority
 - National Electronic Library for Health
 - Health Development Agency
 - Audit Commission
 - Clinical Effectiveness Support Unit, Wales

In each case, we intend to map the relationship between the Institute and its colleague organisation. We will then develop an action plan to take forward the programme of joint working.

2.1.6 The Department of Health and the National Assembly for Wales

The Institute is accountable jointly to the Secretary of State for Health and the National Assembly for Wales. The Department of Health and the Assembly monitor the Institute's performance against the objectives set out in the annual business plan, including our work programme. In this respect, they act on behalf of all our stakeholders. They expect high standards of business conduct from us and they require the Institute to operate efficiently and responsively.

2.1.7 The Industries

Our relationship with the industries whose products are appraised in or otherwise effected by our guidance has been the subject of considerable scrutiny and speculation. NICE is described, variously, as

a challenge, a threat and an opportunity to manufacturers. We rely on industry associations to help develop our systems, to ensure transparency and fairness and we use the submissions provided by individual companies to inform our technology appraisals and clinical guidelines. They, like our other stakeholders, will expect us to operate efficiently and responsively. They will expect us to recognise the substantial investment they put into developing their products and to be sensitive to the impact which our work has on their business.

2.1.8 The Partners Council

The Institute's Partners Council has been established since April 1999. It is a rich source of advice on every aspect of our work, both from individual members and collectively. It has responsibility for reviewing the Annual Report but its meetings, which are typically held in a workshop format, allow Institute staff to expose important and sometimes sensitive issues to an informed and critical audience.

2.2 Communication

2.2.1 The Institute recognises that to be successful it must ensure that:

- corporate communications activity is timely and effective - ensuring that key stakeholders understand the Institute's purpose, tasks and methods, can engage appropriately with the Institute and that their expectations are appropriately managed and;
- the products⁴ of the Institute's work are made available to those who need them, when they need to use them

2.2.2 The communications function is focused on ensuring the optimal balance between corporate communications and the effective dissemination of the Institute's products.

⁴ 'Products' can be categorized as 1) Corporate information / publications 2) Technology Appraisal Guidance, 3) Clinical Guidelines, 4) Referral Advice 5) Promotion of National Audit.

2.2.3 As the Institute and its work programme continue to develop so does the integrated communications strategy. This strategy aims to reflect the Institute's commitment to be open and transparent in its work by ensuring that:

- in its communications, the Institute complies with relevant guidance from the Department of Health and the National Assembly for Wales, and works within appropriate legal frameworks;
- the corporate objectives of the Institute and our position within the NHS family are disseminated in such a way that our stakeholders find them accessible and can understand them;
- the products of the Institute's work are available to those who need them, when they need them, to inform the decision making process;
- the Institute engages with key stakeholders at all stages of its work.
- the Institute makes best use of appropriate communications media with particular reference to effective use of existing and emerging technology for communication and dissemination;
- the Institute understands the role of other organisations in communicating with stakeholder groups and works with them to provide a cohesive package of information for stakeholders;
- the Institute has effective methods for evaluating its communications activities and undertaking follow-up action as required;
- the strategy reflects the diversity of expectations, the levels of understanding about our work, awareness and access to technology and communications media, of all stakeholders.

- 2.2.5** The Institute recognises the importance of electronic communications media in the future plans of the NHS. NICE inherited a web site, designed to launch the Institute. Whilst this has proved a useful communications tool it was insufficiently robust to carry the work of the Institute into this electronic future. In its first year the Institute has invested in a development programme for its web site allowing enhanced facilities such as integrated searching and e-mail updates to those who indicate they would like to take advantage of the facility.
- 2.2.6** Work has commenced on the Institute's first work programme (Technology Appraisals and production of Clinical Guidelines and Referral Advice). The ongoing work programmes have required the development of communication processes and procedures as a part of the process. The Rapid Assessment of zanamivir (Relenza) completed last year, provided an important learning experience for the Institute and played a part in shaping its approach to working with the media.
- 2.2.7** The Institute has also issued the first in its series of Technology Appraisal Guidance. These provide a sample of procedure, device and pharmaceutical appraisals and have tested the communication and dissemination procedures and processes developed during the Institute's early months. A review of these dissemination processes for these technologies will provide learning and development.
- 2.2.8** An analysis of the communication issues facing the Institute over the next 36 months has been completed. These have been characterised as challenges or opportunities. Addressing these key issues has, and will continue to require the development and implementation of a number of projects, policies and procedures, addressing key stakeholder requirements.

These projects, policies and procedures have been grouped under the following areas:

- Corporate Communications
- Press & Media
- 'Product' Development
- Dissemination Programmes
- Internal Communications Press & Media
- Communications Evaluation
- Umbrella Publications
- NICE Web site

3 Objectives

We have identified a set of characteristics, structured under a series of headings and statements, which describe our objectives for the Institute and our relationships with those with whom we work, as we would like them to be in 2003. They are described below in terms of outputs.

3.2 Key stakeholders

These are the organisations, described in section 2.1, which will influence our contribution to the NHS and with which we will need to construct positive working relationships. We will aim to ensure that:

- 3.2.1** arrangements are in place to enable stakeholders to influence the Institute's work programme;
- 3.2.2** stakeholders have confidence in the processes for producing guidance and in the quality and consistency of the guidance;
- 3.2.3** stakeholders consider that the Institute's guidance is being effectively presented and disseminated;
- 3.2.4** arrangements are in place to periodically assess the views of stakeholders on the Institute's performance;
- 3.2.5** there is a clear understanding of the Institute's role and contribution;
- 3.2.6** effective integrated working with the other quality-related organisations in the NHS.

3.3 Research and development

The Institute will want to contribute to methodological research in the three principal areas of our work: clinical guidelines, technology appraisals and effective clinical practice. Although we will not be a source of funding for such work in general we will commission, selectively, studies which will have a direct impact on our activities which we will want to publish. In addition to methodological research, we will commission research on the impact of our guidance in the NHS. In all of this, we will work closely with the NHS Research and Development Programme. We will aim to ensure that:

- 3.3.1** the Institute has a clearly defined set of research interests, centred on the methodologies underpinning the development of guidance, its effective dissemination and assessments of its impact;
- 3.3.2** research consists of both projects undertaken by staff in the Institute and projects commissioned from other organisations;
- 3.3.3** the results of this research are given practical effect through changes to the Institute's programmes and processes;
- 3.3.4** the Institute is collaborating with international partners.

3.4 Education

We will take the opportunity to promote the value of evidence-based practice – as well as our individual guidance topics – at the appropriate stages in the training of health professionals. We also consider that it is appropriate for the Institute to contribute to the public's understanding of the place of guidelines and associated material in modern clinical practice. We will aim to ensure that:

- 3.4.1** the Institute engages with curriculum designers to influence undergraduate and basic training programmes in the use of evidence in clinical practice, the value of clinical audit and the use and construction of clinical guidelines;
- 3.4.2** the Institute is engaging with accreditation bodies to weave guidance into the CPA evidence base;

- 3.4.3** we use the media intelligently to disseminate guidance and information about effective practice;
- 3.4.4** we exploit the potential of the web site to the full;
- 3.4.5** our publications are seen as the gold standard in patient literature;
- 3.4.6** we establish the regular publication of a journal for health professionals.

3.5 Promotion of Clinical Audit and Effective Clinical Practice

The NHS invests in the promotion of clinical audit at both a national and a local level. The Institute has a role in both. Nationally, we will work with professional organisations to educate and inform, which will produce information to support effective clinical practice on a multidisciplinary basis. Locally, we will provide tools for clinicians and managers in using audit information as part of their clinical governance arrangements. We will aim to ensure that:

- 3.5.1** our funding for national professional organisations is based on themed programmes, linked to NHS priorities and the National Service Frameworks;
- 3.5.2** this funding recognises the need for strategic partnerships;
- 3.5.3** the programmes stimulate joint working between professional groups and between professional and academic groups;
- 3.5.4** the Institute supports a network of collaborating centres;
- 3.5.5** our programmes are open to influence by professional bodies;
- 3.5.6** funding has clear outputs coupled with effective dissemination and impact assessment plans.

3.6 Technology Appraisals

Technology appraisals will continue to form a major part of the Institute's work. By 2003, the first sets of guidance issued in 2000 will have been updated. It is essential to us, in maintaining the trust and confidence of health professionals and the public, that our guidance is seen to be current at all times. By 2003, we will be producing around 50 sets of new guidance each year and reviewing up to 50 previously issued sets. We will aim to ensure that:

- 3.6.1** we play a major role in consulting on and formulating our programme of appraisals, recommending lists of technologies to the Department of Health and the National Assembly for Wales;
- 3.6.2** we produce of the order of 50 appraisals per year;
- 3.6.3** we maintain an up to date catalogue of guidance;
- 3.6.4** reviews of guidance are managed in partnership with academic organisations;
- 3.6.5** our programme shows evidence of collaboration with international partners;
- 3.6.6** the appraisal agenda is integrated with other work programmes and with the National Service Frameworks;
- 3.6.7** there is effective collaboration with the work of the Health Technology Board for Scotland.

3.7 Clinical Guidelines

We intend that our clinical guidelines and their associated information packages will become the references of first choice for health professionals and patients. Initially, we will be commissioning around 18 guidelines per year. There are, and will remain, an enormous number of clinical guidelines available, many of a very high quality. We want to be seen as a source of information which can be relied on to offer practical, high quality, guidance in an accessible format. We will aim to ensure that:

- 3.7.1** our guidelines are regarded as the gold standard for the NHS and used as a first reference by health professionals and patients;
- 3.7.2** there is a single stream of guidelines, regardless of the source material;
- 3.7.3** the process for producing the guidelines has the confidence of health professionals, patient advocates and the industries;
- 3.7.4** our guidelines are seen to be current and are reviewed formally at specified intervals;
- 3.7.5** we have intelligent dissemination strategies, including the use of electronic media and links with medical publishers, which result in widespread knowledge of and use of the guidelines;
- 3.7.6** our guidelines agenda is integrated with other work programmes and the National Service Frameworks;
- 3.7.7** we collaborate with international partners in developing authoring and quality controlling methodologies in guidelines construction.

3.8 Dissemination

- 3.8.1** The Institute recognises that to be successful the products of its work must be available to those who need them, when they need them, to inform the decision making process. The Institute terms this 'dissemination' and this is a key part of the Institute's communications function.
- 3.8.2** Within limited resources, the Institute aims to develop and deliver tailored dissemination plans for each of its individual products. This recognises that there will be a core stakeholder group who receive information on every product the Institute produce and a 'product specific' group of stakeholders who have a personal or professional interest in the specific technology or guideline.
- 3.8.3** We will work closely with the NHS, our partner organisations, key stakeholders, general and specialist media and where appropriate, the pharmaceutical and device industries to get our guidance to its intended audiences. We also aim to understand the role of existing communication routes and the responsibilities of other organisations in communicating with stakeholder groups and are working with them to provide a cohesive package of information for all stakeholders.
- 3.8.4** We recognise the growing importance of web technology in communications and are developing our capability to ensure that this route is core to our dissemination strategy. However we also recognise that not all stakeholder groups have access to this technology at present and we therefore review inherited commitments and budgets to ensure that we deliver appropriately to this group. We have committed to several projects to facilitate this work, including patient focused text, and the production of a compilation of our work that will be circulated to health professionals, in England & Wales twice a year.

3.8.5 All of this will ensure that:

- the Institute has secured sufficient resources to communicate / disseminate its purpose and its products effectively;
- there is a well developed partnership with the media, stakeholder groups, and other organisations to secure appropriate dissemination of guidance;
- sound working relationships have been developed with the industries, the professions and patient / carer groups giving good two-way communication and guidance dissemination routes;
- in its dissemination activities, the Institute complies with relevant guidance from the Department of Health and the National Assembly for Wales; and works within appropriate legal frameworks;
- the use of the web site is regarded as core to communications, both inside and outside the NHS.

3.9 Organisation

The structure and size of the Institute's organisation needs to keep pace with both the nature and the volume of its work and the way in which we develop our guidance. Our initial approach to our work has been to keep our overheads low, commissioning as much work as possible from organisations inside and outside the NHS, which have the experience and capacity to undertake it. We will aim to ensure that:

- 3.9.1** partnership working allows the organisation to remain focused on agenda setting, commissioning, technical support, quality control and dissemination;
- 3.9.2** we maintain the capacity to produce up to 50 technology appraisals each year, with subsequent reviews and up to 18 clinical guidelines each year, with routine reviews;
- 3.9.3** the organisation's culture enables and encourages team working and continuous learning;

- 3.9.4** the Institute operates a transparent and consultative style of working which encourages constructive criticism of its methods;
- 3.9.5** we have the capacity to handle an increasing volume of enquiries from health professionals and the public;
- 3.9.6** opportunities exist for fellowships and other fixed term involvement by stakeholders in the Institute.

3.10 International Links

The Institute is one of a growing number of national and regional organisations undertaking health technology assessments (HTA) and developing clinical guidelines. We believe that we have a contribution to make to the development of the methodologies, which underpin this work, and we are aware that we can learn from the experience of these other bodies. We will aim to ensure that:

- 3.10.1** the Institute works with colleague organisations to help standardise HTA and guidelines methodologies;
- 3.10.2** opportunities to provide support in developing countries have been explored;
- 3.10.3** the Institute's annual conference is regarded as an event of international standing;
- 3.10.4** the results of systematic reviews are shared internationally, enabling more effective use of resources;
- 3.10.5** we display an understanding of our international impact.

4 Programmes

4.1 The priorities which have been set for the NHS are as follows:

- Smoking
- Drugs
- Teenage pregnancy
- Cancer
- Coronary heart disease
- Waiting lists and times
- Modern primary care
- Mental health
- Older people's services
- Children's services
- Quality
- Staff
- Information technology

4.2 Our programmes for the next three years – the subjects referred to us on which guidance is requested and the way in which we will focus the audit and effectiveness funding we have been given – will track the clinical elements of these priorities and any which add to or succeed them.

4.3 The Department of Health's National Service Framework (NSF) programme includes Mental Health (published 1 September 1999) Coronary Heart Disease (published in March 2000) Older People due in Autumn 2000 and Diabetes due in 2001. There will usually only be one new NSF a year. These NSFs will be accompanied by information strategies. The Institute will support the implementation of these frameworks by populating them with technology appraisals, clinical guidelines and audit advice.

4.4 In presenting our programme of work, we will describe what we do in terms that will be familiar to patients and to health professionals. These clinical themes will enable us to organise our work into coherent packages, which will relate directly to the priorities which have been set for the NHS. The clinical themes we will be using are as follows:

- Cancer
- Heart and circulation
- Mental health
- Primary care
- Care of the elderly
- Illnesses of childhood
- Childbirth and gynaecology
- Respiratory tract
- Diagnosing illness and disease
- Skin, muscles and bone structure
- Digestive and associated systems
- Sensory systems
- Substance Abuse

The key elements in our plans for the next three years, together with *key outcome measures*, are set out below:

4.4.1 March 2000 to April 2001

- Technology appraisal guidelines process fully established
 - *appraisals capacity expanded*
 - *26 appraisals completed*
 - *revised process and methodologies guidance issued*
 - *Institute initiates topic selection process*
- Clinical guidelines process fully established
 - *all inherited guidelines reviewed and action plans established*
 - *4 guidelines completed*
 - *10 new guidelines commissioned*
 - *Guidelines Advisory Committee established*
 - *Implementation model developed*
 - *guidelines process consulted on and published*
 - *collaboration with SIGN established (Scottish guidelines group)*

- Clinical audit strategy published
 - *clear dissemination plan for the strategy*
 - *8 inherited national audits reviewed*
 - *5 national audits completed*
 - *mid year reviews of contracts with professional bodies*
 - *revised (2001/2002) contracts agreed with professional bodies*

- Impact research commissioned
 - *research questions refined*
 - *project tendered and commenced*

- Key reviews completed
 - *Confidential Enquiries (in June)*
 - *PRODIGY guidelines authoring (in June)*
 - *follow up action plans published*

- Risk analysis completed and actioned
 - *controls assurance arrangements in place*

- Efficiency gain demonstrated
 - *2000/2001 inflation costs absorbed*

4.4.2 March 2001 to April 2002

- Technology appraisal process at capacity
 - *45 appraisals completed*
 - *first reviews undertaken (up to 10 estimated)*
 - *process, methodologies and capacity reviewed*

- Clinical guidelines programme accelerates
 - *9 guidelines completed*
 - *18 new guidelines commissioned*
 - *implementation model enhanced*

- Collaborating Centres fully established
 - *Centres operating*
 - *Outputs fully integrated into NHS priorities and Institute agenda*
- Output delivered in clinical theme packages
 - *single Institute work programme framed around clinical themes*
- Confidential Enquiries review report actioned
 - *any proposed changes implemented*
- Efficiency gain demonstrated
 - *inflation costs absorbed*

4.4.3 March 2002 to April 2003

- Technology appraisal process reaches maturity
 - *45 new appraisals completed*
 - *around 25 reviews undertaken*
- Clinical guidelines process reaches capacity
 - *15 guidelines produced*
 - *18 new guidelines commissioned*
- Institute guidance used as first reference by clinicians and public
 - *survey reports used to assess impact*
- The Institute is a world leader in HTA and guidelines authoring
 - *presence at international meetings*
 - *references to Institute guidance internationally*
- Collaborating Centres fully mature
 - *networks incorporate academic centres*

- Dissemination and implementation arrangements reviewed
→ *Web access used as principal NHS dissemination route*
- Institute co-ordinates outcomes indicators work
→ *indicators work embedded in Institute work programme*
- Efficiency gain demonstrated
→ *2002/2003 inflation absorbed*
- Impact research reports
→ *research published*
→ *action plan developed and implemented*

5 Resources and Organisation

- 5.1** The Institute's initial (1999/2000) allocation was constructed from a series of existing allocations for clinical guidelines and effective practice contracts and two new allocations, for national appraisal of new technologies and a sum for corporate overheads. The total allocation amounted to £10,112,000.
- 5.2** Our assumptions for funding for the three years covered by this corporate plan have, of necessity, to be cautious. The Business Plan for 2000/2001, is based on an allocation of £10,650,000. Work programmes have been planned on this basis, with the additional benefit of a non recurring sum of £1,345,000 brought forward from 1999/2000, which resulted from the organisation's phased start up in 1999.
- 5.3** A bid for additional funding, amounting to £2 million has been made to the Department of Health and the National Assembly for Wales, for 2001/2002. This consists of three components:
- i) £1,300,000 for dissemination costs
 - ii) £200,000 for additional technology appraisal costs
 - iii) £500,000 for additional guidelines costs

The recurring costs associated with additional technology appraisals (three additional technical and one additional administrative support post) have been committed, at risk, in 2000/2001, using the non-recurring funding referred to in 5.2 above.

- 5.4 Until the outcome of the funding bid for 2001/2002 is known, it is difficult for the Institute to make any robust assumptions about its allocation for 2002/2003. The assumptions about workload made elsewhere in this plan are based on a steady state position (from the 2000/2001 baseline) with the Institute absorbing inflation costs as an efficiency gain.
- 5.5 The basis which the Institute will use to form and manage its organisation was rehearsed in its first Business Plan. There are no existing models on which the design of the Institute's organisation can be based. We have a unique purpose and the organisation needs to be designed specifically to deliver it. Our approach to creating the organisation will be based on the following principals:
- 5.5.1 **out-sourcing** corporate services and activities associated with our work programme, where this can be demonstrated as being the most efficient method of operating;
 - 5.5.2 **multi-tasking** as a means of making the most out of what will be a highly motivated and well qualified work force;
 - 5.5.3 **team working** to promote innovation and efficient working and as an aid to internal communication and joint learning;
 - 5.5.4 **managed informality**: as a small organisation, the Institute will need to develop a hierarchy to maintain its focus and to deliver its work programmes. Its size will also allow it to operate with a degree of managed informality, as a way of providing an attractive and supportive working environment;
 - 5.5.5 **commitment to purpose** will be expected from all employees, which will manifest itself in a desire to get the job done to the highest possible standard.

- 5.6 The Institute's establishment in 2000/2001 will be 28 full time equivalents. This includes the additional four members of the appraisal team referred to above
- 5.7 Organic growth of the Institute's work is likely to result in the establishment growing by three posts each year, in 2001/2002 and 2002/2003, to an estimated size of 34 by the end of the planning period.

6 Future Direction

The Institute's short and medium-term goals, as well as the broad strategy it has derived to meet them, are contained within this corporate plan. There are, however, a number of areas in which the Institute might at some future date make important contributions.

6.1 Extending the Appraisal Programme

6.1.1 The Institute's current appraisal agenda excludes immunisation and screening. The Joint Committee on Vaccination & Immunisation (JCVI) currently provides the Department of Health with advice on immunisation policy and practice. The Committee has had a major role, over many years, in developing a national immunisation policy; and any changes to the existing arrangements would need to complement, rather than substitute, its current role. Nevertheless, there are two reasons why the present arrangements are worthy of review. First, the approach taken by the JCVI in appraising new and existing vaccines bears many analogies with that of the Institute's own Appraisal Committee. The expertise in balancing clinical and cost effectiveness in a public health context that is available, within the Institute, might therefore complement the existing arrangements. Second, and more importantly, there is an increasing need to ensure coherence between the prevention of infectious diseases and their treatment: considerations of either, in isolation, could lead to serious difficulties. A coherent approach to the control of influenza, covering immunisation and the use of neuramidase inhibitors, is an important example. Any re-alignment of the present arrangements, however, would need to ensure that they met the needs and responsibilities of the Chief Medical Officers of England & Wales.

6.1.2 Advice on screening is currently provided, for the UK, by the National Screening Committee (NSC). In its review of new and established screening programmes, the NSC inevitably takes into account the validity, sensitivity and specificity of the particular technique; its potential (or predicted) impact on the disease in question; and its cost-effectiveness. These are, of course, matters with which the Institute, in its appraisal of diagnostic technologies generally, is also concerned, particularly in its appraisal of diagnostic technologies. Greater coherence might therefore be achieved by subsuming the functions of the NSC within the Institute. Again, however, the interests and responsibilities of the Chief Medical Officers would need to be ensured. Moreover, since the NSC advises on policy in all four territories of the United Kingdom, any new arrangement would need to satisfy the requirements of both the Scottish Parliament and the Northern Ireland Executive. The Institute does not believe that such collaboration and co-operation would pose insuperable difficulties and it would welcome the opportunity of working with the Health Technology Board for Scotland in this respect.

6.2 Extending the Clinical Guidelines Programme

6.2.1 The Institute's role in developing and disseminating clinical guidelines, together with its responsibilities for the authorship of PRODIGY guidance, needs to be consistent with other clinical advice provided by the NHS. In particular, there is an obvious need for the Institute's clinical guidelines to be fully compatible with that provided by NHS Direct and NHS Direct Online. The Institute has already established informal contacts with some of those responsible for NHS Direct. Whilst the Institute does not wish to be involved with managing the service, it seeks close interaction with those responsible for authoring the content of NHS Direct's advice. In due course there may be merit for us to take responsibility for this work.

6.2.2 Our responsibilities in the field of guideline development and dissemination are strictly confined to the NHS. There may, at some future date, be merit in extending our responsibilities to other areas where public funds are used to promote or maintain health. These include the specific (as opposed to the more general) needs of:-

- The Defence Medical Service
- The Prison Medical Service
- Occupational Health Services

All these have close interaction with the NHS but each has special problems which require individual consideration. The Institute would welcome the opportunity to be able to contribute to these areas.

6.2.3 The Institute is aware that the private health sector is interested in adopting, where appropriate, its guidance. Although our advice is intended for health professionals working within the NHS, it welcomes any use that may be made of its guidance by the private sector.

6.3 Extending the Boundaries

6.3.1 The Institute's responsibilities are confined to advising health professionals and managers on securing the highest attainable standards of clinical care for their patients. The Institute does not, however, have responsibility for advising either the NHS as a whole, or trusts and health authorities, on organisational issues (i.e. arrangements for service delivery). These fall, properly, within the remit of the NHS Executive, and their Regional Offices and the National Service Frameworks.

6.3.2 Nevertheless the Institute is conscious that there will often be a synergy between professional clinical practice and necessary arrangements for their delivery within the service. The Institute has no 'blue print' as to how this interface might be most effectively overcome, and for the foreseeable future intends to adopt a case-by-case approach. The Institute accepts that it has a key role in alerting the NHS Executive, and other key stakeholders, of potential interface issues; and a responsibility for ensuring that appropriate (and necessary) arrangements have been made at the time its guidance is disseminated to health professionals.

6.4 Clinical Indicators and Outcomes

6.4.1 The Institute is charged with developing and promoting clinical audit methods that support its guidance on the use of individual technologies and the management of specific conditions. These methods will, in the main, be concerned with 'process' rather than 'outcomes'. The reasons are threefold. First, information about the process of care is more generally accessible and robust than data concerning outcomes. Second, even with relatively common conditions, adverse outcomes are often sufficiently uncommon as to make individual practitioner's performance impossible to evaluate. Third, provided that the clinical audit methodology is based on valid and reliable process measures these can act as surrogates for outcomes.

6.4.2 Nevertheless, clinical audit should encompass outcomes at least so far as NHS trusts, primary care trusts, and primary care groups and local health groups are concerned. Indicators and outcomes research is currently the responsibility of the Department of Health and the NHS Executive in collaboration with the National Clinical Outcomes Group based in Oxford in England and the National Assembly for Wales. It is important, therefore, that the Institute interacts closely with these existing organisations and groups; and at some future date it may seek to secure a closer relationship.

6.5 Scotland

6.5.1 The Institute is responsible for offering guidance to health professionals in England and Wales. Separate arrangements have been made by the Scottish Parliament, for health professionals in Scotland relative to their own traditions, needs, priorities and problems. Nevertheless, the Institute wishes to work closely with its counterparts in Scotland (the Health Technology Assessment Board and the Scottish Intercollegiate Guideline Network) in order to achieve a common approach, sharing of methodologies, and co-operation in both technology appraisal and guideline construction.

6.6 Northern Ireland.

6.6.1 The Institute's responsibilities extend to England and Wales and separate arrangements have been made in Scotland (as discussed above). At the present time however, the role (if any) that the Institute might play in Northern Ireland is uncertain and is awaiting a decision by the Executive. The Institute, itself, wishes to assist health professionals in Northern Ireland by whatever means is most appropriate, and will continue constructive dialogue with the Department of Health & Social Services and with representatives of the profession.

National Institute for Clinical Excellence

June 2000