

# Annual Equality Report 2017-18

## Introduction

1. NICE's role is to improve outcomes for people using the NHS and other public health and social care services. We do this by:
  - Producing evidence based guidance and advice for health, public health and social care practitioners.
  - Developing quality standards and performance metrics for those providing and commissioning health, public health and social care services.
  - Providing a range of informational services for commissioners, practitioners and managers across the spectrum of health and social care.
2. NICE is committed to eliminating discrimination, harassment and victimisation, advancing equality of opportunity, and fostering good relations between people who share the protected characteristics defined in the Equality Act 2010 of age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, and sexual orientation, and those who do not. We aim to comply with the Human Rights Act 1998 and are concerned with tackling health inequalities associated with underlying socioeconomic factors and inequalities in access to healthcare and opportunities to improve health for certain disadvantaged groups.
3. This report covers our responsibility under Equality Act regulations to publish information annually to demonstrate our compliance with the public sector equality duty. It consists of five main sections:
  - **Summary** of key data relating to the composition of advisory committees, equality analysis in guidance production and composition of the workforce
  - **NICE's equality aims** and our formal objectives as part of the public sector equality duty
  - **Composition of, and appointments to, NICE committees:** information about the effects of our policy on recruiting members to our advisory bodies
  - **Equality issues impacting on NICE guidance:** the effects of equality analysis on NICE's guidance recommendations
  - **Workforce:** summary of the workforce profile by equality category. More detail about the workforce can be found in the annual workforce report.

4. The report covers guidance produced and appointments to the committees in the period 1 April 2017 to 31 March 2018, and the workforce profile at 31 March 2018. The survey of committee members was undertaken in May and June 2018, covering those who were a member of a committee at 31 March 2018.

## Summary

### NICE's equality objectives

5. Actions to deliver the 2016 to 2020 equality objectives are underway, coordinated by NICE's cross-Institute equality and diversity group.
6. There has been positive progress with both objectives, with increases in the proportion of committee applications that are from individuals who describe themselves as from black, Asian and minority ethnic groups, and an increase in the proportion of staff in band 7 and above from black, Asian and minority ethnic groups.

### Composition of and appointments to NICE committees

7. The survey of committee members reported that:
  - 49% of respondents were women, 50% were men and 1% indicated that it was their choice not to answer the question or gave no response (in last year's survey 50% of respondents were women, 48% were men, and 2% indicated that it was their choice not to answer the question or gave no response).
  - 9% of respondents identified themselves as disabled and 73% did not. The comparative figures in 2017 were 11% and 87%. The increase in the proportion of respondents who did not answer this question makes it difficult to assess definitively the proportion of committee members with a disability and any year-on-year change.
  - 85% of respondents identified themselves of white ethnicity, and 14% of non-white ethnicity. The proportion of respondents of non-white ethnicity has increased each year over the last three annual surveys. The proportion of respondents of black ethnicity is lower than the general population<sup>1</sup> for both lay and non-lay roles. Based on the responses, people of Asian ethnicity are underrepresented in lay roles compared to the general population, but slightly overrepresented in non-lay roles.
  - Just under half (48%) of the respondents in the 2018 survey were between 51 and 65 years old, with 87% between 36 and 65 years old. Overall, the age profile is broadly similar to the 2017 survey.

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<sup>1</sup> England and Wales, 2011 census

- 5% identified their sexual orientation as lesbian, gay, bisexual or other (the same proportion as in last year's survey). This is twice the proportion as the UK general population.<sup>2</sup>
  - The largest proportion of respondents were those who identified themselves as of no religion. This is a change from both the 2016 and 2017 surveys when the highest proportion of respondents identified themselves of Christian belief.
8. Monitoring information collected during the process to appoint members to the committees in 2017-18 indicates that:
- The proportion of applicants who describe themselves of non-white ethnicity has continued to increase, which is one of NICE's equality objectives.
  - The conversion rate of applications to appointments was lower for applicants of non-white ethnicity than those of white ethnicity, with this disparity greater for lay roles than non-lay roles. It will therefore be important to ensure the committee recruitment processes are not indirectly disadvantaging applicants of non-white ethnicity, undermining the increase in applications from people in black, Asian and minority ethnic groups.
  - For the other protected characteristics, broadly similar proportions of people sharing the various protected characteristics were appointed to advisory bodies as applied across the roles overall.
9. The profile of committee members in terms of the protected characteristics varies between lay and non-lay roles. Lay roles have higher proportions of members who are women; are younger than 35 years old and older than 65 years old; who identify themselves as disabled; of white ethnicity; are heterosexual; and have no religion. Some of this variation may partly be due to the different skills and experience sought for lay and non-lay roles.
10. The profile of committee members in terms of the protected characteristics continues to vary between the advisory bodies. For example:
- The proportion of respondents who were women ranged from 66% on the guideline committees hosted by the National Guidelines Alliance to 11% on the Interventional Procedures Advisory Committee; and
  - The proportion of respondents who identified themselves of non-white ethnicity ranged from 30% on the Highly Specialised Technologies Evaluation Committee to 0% on the Patient Access Scheme Liaison Unit Expert Panel.

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<sup>2</sup> 2016 Annual Population Survey published by the Office for National Statistics

11. The proportion of committee applicants who returned an equalities monitoring form, but did not disclose the requested information has increased across all of the protected characteristics. It will therefore be important in 2018-19 to revisit the information provided to applicants to explain why NICE asks for this information and how it is used.

## Guidance production

12. Equality considerations continue to be taken into account in the development of NICE guidance. In 2017-18:
  - There was an increase in the number of potential equality issues identified and also those which subsequently impacted on recommendations compared to 2016-17, both in absolute terms and in proportion to the number of guidance publications.
  - As in previous years, age, disability and race account for the greatest number of equality issues both in terms of initial identification and those which subsequently impacted on recommendations.

## Workforce

13. Just over half (55%) of NICE staff are 40 years old or less, and just over two thirds (69%) are women. 77% of staff identify themselves as of white ethnicity and 3.5% of the workforce identified themselves as disabled.

## NICE's equality objectives

14. In line with our obligations under the public sector equality duty, NICE sets equality objectives. In 2016 the Board agreed the following equality objectives covering the period 2016 to 2020:
  - **Objective 1:** To increase the proportion of advisory body position applications that are from individuals who describe themselves as from black, Asian and minority ethnic groups.
  - **Objective 2:** To increase the proportion of staff from black, Asian and minority ethnic groups in senior roles (agenda for change band 7 and above) across the organisation.

## Equality objective 1

### Rationale for setting the objective in 2016

15. NICE guidance is developed by independent advisory bodies made up of health, social care and public health professionals and practitioners; people using services, their unpaid carers and other lay people; academics; health and

social care commissioners; local authority elected members; and other experts on the topics covered by guidance including from the life sciences industry.

16. We seek diverse membership so that advisory bodies are representative of the population and provide a wide range of viewpoints and experiences to inform guidance and improve its quality. This helps us meet our equality duty to have 'due regard' to the need to eliminate discrimination, advance equality of opportunity, and foster good relations between different people when carrying out our activities.
17. The information in the 2014-15 annual equality report indicated that broadly similar proportions of people sharing protected characteristics were appointed to the advisory bodies as applied. However, the report indicated that compared to the overall population, there was underrepresentation of people who describe themselves as from black, Asian and minority ethnic groups.
18. NICE cannot positively discriminate in favour of applicants based on ethnicity or other protected characteristic, but it is acceptable to encourage a diverse range of applicants. Therefore the Board agreed an objective to increase the diversity of applicants to our advisory bodies. Specifically, we are seeking year on year increases in the proportion of the advisory body position applications that are from individuals who describe themselves as from black, Asian and minority ethnic groups.

#### **Progress to date and further planned actions**

19. Progress continues with the action plan to deliver this multi-year objective.
20. In 2017-18 the Public Involvement Programme (PIP) met with Diabetes UK, Macmillan Cancer Support, Mind, Race Equality Foundation, Race on the Agenda (ROTA), and Voice4Change to discuss methods to encourage and increase applications for lay member roles from black, Asian and minority ethnic groups. The NICE equality and diversity group considered a summary report with considerations and recommendations arising from these meetings in January 2018.
21. Following the report PIP ran 3 regional workshops in Manchester, West Bromwich and London to review the lay member application process. Working with local black, Asian and minority ethnic group organisations over 100 individuals attended to review the recruitment documents. The findings will be used by PIP to review the recruitment process and documentation for lay members in 2018-19.
22. The committee recruitment pages on the NICE [website](#) have been comprehensively redesigned to provide information in a more accessible format and therefore encourage applications from those who have not previously been

involved with NICE. The pages explicitly reference NICE’s commitment to increasing applications from black, Asian and minority ethnic groups, and are receiving positive feedback. Blogs from a [committee member](#) and [senior staff member](#) have been added, encouraging people from black, Asian and minority ethnic groups to apply for committee roles and jobs at NICE.

23. To support this enhanced web-presence, the ‘get involved’ slide used by the Field Team in their presentations has been updated to include further information on committee recruitment. This highlights NICE’s commitment to diversity on the committees and the equality objective, when the team are speaking to audiences of health and care professionals.
24. Letters to those unsuccessful in applications for NICE committee roles now include a link to an anonymous feedback survey on the application process. Respondents are given the opportunity to indicate their ethnicity, which enables us to consider whether the appointment process is negatively affecting particular groups.
25. Actions for 2018-19 include reviewing the committee recruitment documentation and process in response to the PIP workshops, and further enhancing the committee recruitment pages on the website.
26. The ethnicity of applicants, and those appointed, to NICE’s advisory committees in the last three years is outlined below. There has been a year on year increase in the proportion of applicants from black, Asian and minority ethnic groups.

**Table 1: Ethnicity of applicants to NICE advisory committees**

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

## Equality objective 2

### **Rationale for setting the objective in 2016**

27. Our second objective recognises the centrality of our staff to the successful delivery of our functions. A diverse workforce supports the delivery of the general equality duty and enables us to draw upon the widest pool of talent.
28. Data indicated that the diversity of our workforce in our management roles did not fully reflect the diversity of the wider population. The majority of staff at NICE from black, Asian and minority ethnic groups occupied junior roles (agenda for change bands 4 and 5) and we did not have a clear strategy for recruiting and developing talent into more senior roles.
29. The Board therefore agreed a specific objective focused on increasing the number of staff from black, Asian and minority ethnic groups in management roles through targeted development programmes and resourcing strategies. We are seeking year on year increases in the proportion of staff from black, Asian and minority ethnic groups in senior roles (agenda for change band 7 and above) across the organisation.

### **Progress to date and further planned actions**

30. We have increased our vacancy advertising reach by posting all jobs to Indeed and Total Jobs (two of the UK's leading jobs boards). Additionally, all roles at Band 7 and above are now advertised on LinkedIn. Some senior roles have been advertised on national specialist jobs boards including The Guardian and the British Medical Journal. This additional advertising ensures we are reaching a wider candidate pool than advertising through NHS Jobs alone. We are also increasingly using social media to widen our advertising reach.
31. The number of black, Asian and minority ethnic staff in senior roles (band 7 and above) has increased by 8.4% since last year – from 59 staff at 31 March 2017 to 64 staff at 31 March 2018. This increased the proportion of staff in band 7 and above from black, Asian and minority ethnic groups from 13% to 15%.
32. In 2018 we appointed a dedicated in-house Recruitment Manager who is working with line managers and the wider HR team to review job adverts to ensure they are attractive and appealing to candidates from a diverse range of backgrounds.
33. NICE is committed to supporting staff regardless of their background, and in addition to our Disability Confident Committed status, this year we became Stonewall Diversity Champions (which supports LGBT staff) and signed the Time to Change pledge (which aspires to end mental health discrimination). We

have also advertised the NHS Leadership Academy [“Ready Now”](#) programme, aimed at senior BAME leaders, and have one staff member accepted onto the course.

34. NICE is committed to continuing to promote opportunities to potential candidates and existing staff. We are building relationships with other organisations with a view to sharing development opportunities such as vacancies, secondments, training and forums. This will strengthen further the support we are able to offer our staff.
35. We are actively engaging with staff members to get feedback on how to improve our recruitment practises for applicants from black, Asian and minority ethnic groups, or have other or additional protected characteristics.
36. In 2018-19 we will be redesigning our recruitment and selection training with an increased focus on understanding unconscious bias.

### NICE equality and diversity group (NEDG)

37. The NICE equality and diversity group supports NICE to deliver its obligations under the Equality Act in relation to guidance production. The group meets quarterly and includes members from each centre/directorate, plus the Public Involvement Programme, Corporate Office and Field Team. It is chaired by a Programme Director from the Centre for Guidelines.
38. In addition to overseeing the delivery of our equality objectives and coordinating input to the annual equality report, the NEDG seeks to share good practice across NICE and provide a forum for discussing and proposing solutions to cross-institute equality issues. It also complements the arrangements to support equality considerations within guidance producing programmes.
39. This year the group has reviewed work to assess the accessibility of the NICE website, and the accessibility audit of the website commissioned by the Digital Services team. The planned improvements in response to this audit will start with ensuring PDFs are set up to be accessible, and the accessibility statement on the website will be updated. A working group to consider NICE’s approach to producing documents in alternative formats is updating our position statement on accessible information about our guidance at publication.
40. The group discussed the information in last year’s equality report regarding the variation in the number of equality issues identified across the guidance programmes. Having looked at the equality impact process across the programmes the group felt that the variation appears largely to be reflection of the type of guidance being developed. However, the group could not rule out that there could be areas where the equality impact process is influencing the decision-making differently at both a developer and committee level. The group

will therefore review what training is provided by individual directorates to their developers and committees and look to harmonise these approaches. The group will also review the figures for 2018-19 at the end of the year.

41. The group has continued to consider terminology to use in NICE guidance, this year focusing on transgender issues. A colleague from Stonewall attended the group in July 2018 to share best practice.

## Composition of and appointments to NICE committees

42. As noted above, diversity in advisory body membership contributes to the aims of NICE's equality programme and improves the quality of guidance. It also supports the public sector equality duty of fostering good relations between those sharing protected characteristics and those who do not.
43. We collect information on the background of those applying for positions on our committees. We compare this to the background of those subsequently appointed to positions. This enables us to monitor the impact of our recruitment processes.

### Equalities monitoring of 2017-18 applications and appointments

44. Across the roles overall, broadly similar proportions of people sharing the various protected characteristics were appointed to advisory bodies as applied, with the exception of ethnicity where data indicates material variation in the ratio of lay applications to successful appointments between different ethnic groups. Further information, by protected characteristic, is outlined below.

#### **Gender**

45. Women accounted for the highest proportion of applicants and appointees for both lay and non-lay roles, although there was greater gender balance for non-lay roles. 60% of lay applicants and 52% of lay appointees were women. 45% of the non-lay applicants and 46% of the non-lay appointees were women.

#### **Disability**

46. The proportion of applicants and appointees who identified themselves as disabled was higher for lay roles than non-lay roles. 34% of all lay applicants and 32% of lay appointees identified themselves as disabled. This compares to 6% for non-lay applicants and 7% of non-lay appointees (up from 2% for non-lay applicants and appointees last year).
47. It is positive to note that the proportion of disabled applicants who were appointed was similar to the overall field of applicants. This provides an indication of the non-discriminatory nature of the recruitment process and

reflects the reasonable adjustments NICE will make to the recruitment process to take account of applicants' specific circumstances.

### Ethnicity

48. As shown in the table below, the proportion of applicants and appointees who identified themselves of white ethnicity was higher for lay roles than non-lay roles.
49. The conversion rate of applications to appointments is lower for those identifying themselves of non-white ethnicity compared to those of white ethnicity. This disparity is greater for lay roles than non-lay roles. As outlined later in the report, this is also seen in staff recruitment where the conversion rate is lower for applicants of non-white ethnicity.

**Table 2: Ethnicity of advisory committee applicants and appointees**

	% of all applicants	% of all appointees
<b>Lay roles</b>		
White	82%	83%
Non-white	14%	6%
<i>Not disclosed/not held</i>	4%	11%
<b>Non-lay roles</b>		
White	69%	74%
Non-white	19%	16%
<i>Not disclosed/not held</i>	12%	11%

### Age

50. The majority of applicants and appointees were between 36 and 65 years old:
  - Lay applicants: 61%
  - Lay appointees: 54%
  - Non-lay applicants: 77%
  - Non-lay appointees: 81%.
51. As in 2016-17, the proportion of applicants and appointees between 18 and 35 years old and over 65 years old is higher for lay roles than for non-lay roles. This reflects that many non-lay positions require the appointee to hold a current senior role in the health and care system.

### **Sexual orientation**

52. As in previous years, the majority of applicants and appointees for both lay and non-lay roles identified themselves as heterosexual:
- Lay applicants: 82%
  - Lay appointees: 78%
  - Non-lay applicants: 79%
  - Non-lay appointees: 79%.

### **Religion or belief**

53. The proportion of applicants and appointees who stated they did not have a religion has continued to increase: from 14% and 12% in 2015-16, to 20% and 19% in 2016-17, and 22% and 25% in 2017-18.
54. In 2017-18, those identifying themselves as of Christian belief represented the largest group of non-lay applicants and appointees.
- Non-lay applicants: 37%
  - Non-lay appointees: 36%.
55. Similarly, those identifying themselves of Christian belief accounted for the highest proportion of lay applicants (42%). However, the proportion of lay appointees who identified themselves of Christian belief (32%) was lower than the proportion who identified themselves of no religion (35%).

### **Data quality**

56. It is not compulsory to provide equalities monitoring information when applying for a committee role. Prior to 2016 one of NICE's equality objectives sought to more clearly explain to prospective employees and members of advisory bodies why we collect data on the protected characteristics under equality legislation, to better inform their decisions on whether or not to declare this information in our monitoring forms. We also sought to strengthen internal processes to collate and manage the data provided by applicants to our committees to address gaps in the data.
57. It is therefore positive that the data quality has continued to improve with monitoring forms returned for 97% of applicants and 98% of all appointees in 2017-18, up from 94% and 93% respectively in 2015-16. However, the proportion of respondents who returned a monitoring form, but did not disclose the information has increased across all of the protected characteristics. It will therefore be important in 2018-19 to revisit the information provided to applicants to explain why NICE asks for this information and how it is used, in

particular that it is aggregated anonymously and not shown to the recruitment panel.

## The Picker survey of current committee members

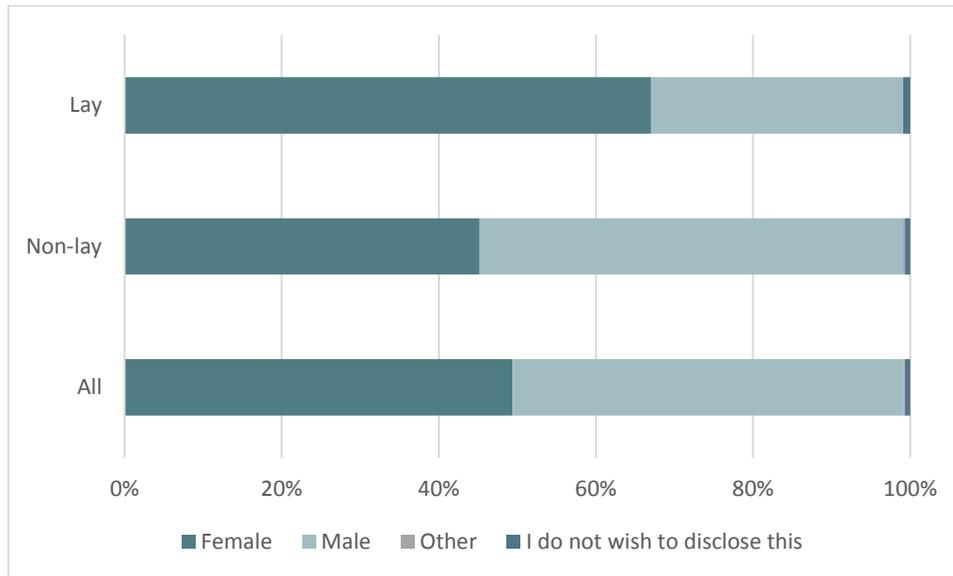
58. As in previous years, we commissioned Picker to carry out a web based survey to provide a snapshot of the makeup of the NICE committees. This provides us with a view of the current composition of the advisory bodies, in addition to the data outlined above that reports on applications and appointments over the last year.
59. This year the survey ran online from 19 April to 17 May 2018. An email invitation was sent out to 959 committee members. The overall response rate was 71% with 682 responses received. This is slightly higher than in 2017 (69%), but lower than 2016 (78%). We asked respondents whether they were a committee member appointed for their lay expertise or were appointed for their professional expertise (referred to as non-lay members in this report). Of the 682 responses:
- 106 (16%) were from lay members
  - 544 (80%) were from non-lay members
  - 32 (5%) did not answer whether they were a lay or non-lay member.<sup>3</sup>
60. The responses for each of the protected characteristics are outlined below.

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<sup>3</sup> In the charts below the 'total' category includes all 682 respondents, including the 32 respondents who did not identify whether they were a lay or non-lay member

## Gender

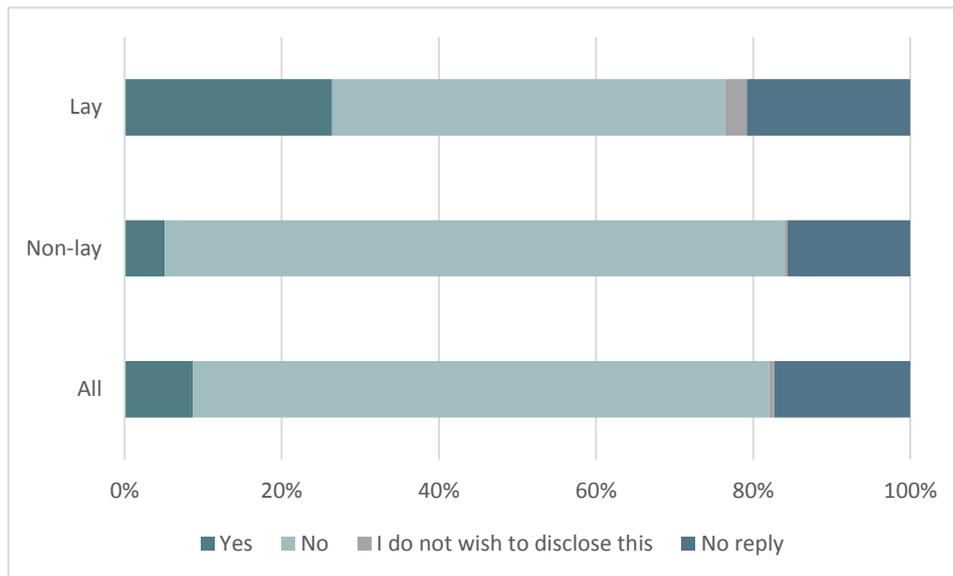
**Chart 1: Gender: advisory committee members**



61. In the 2018 survey 49% of respondents were women and 50% were men. There is difference in the gender balance between lay and non-lay positions, with women accounting for 67% of lay respondents and 45% of non-lay respondents.
62. There is variation in the gender balance across the advisory bodies. As in 2017, the proportion of respondents who were women was lowest on the Interventional Procedures Advisory Committee (11%), Diagnostics Advisory Committee (21%), and Medical Technologies Advisory Committee (24%). The National Guidelines Alliance guideline committees and the Highly Specialised Technologies Evaluation Committee had the highest proportion of respondents who were women (66% and 60% respectively).

## Disability

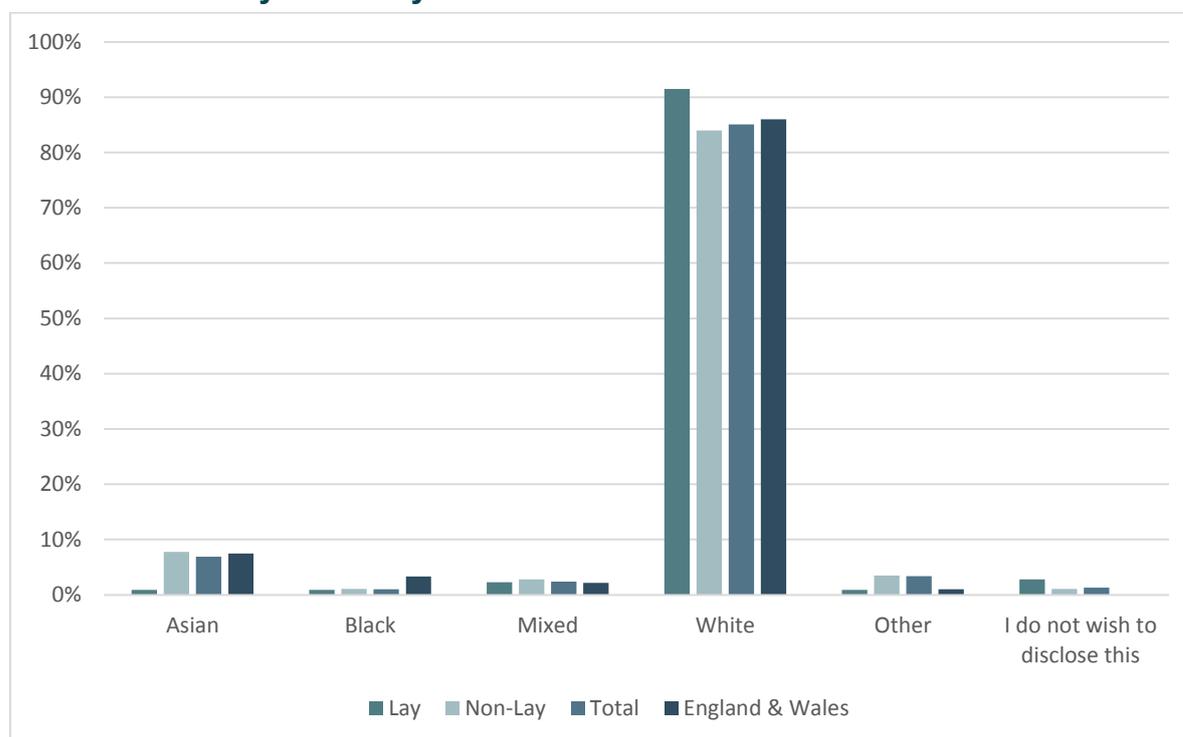
**Chart 2: Disability: advisory committee members**



63. In the 2018 survey, 9% of respondents identified themselves as disabled and 73% did not. The comparative figures in 2017 were 11% and 87%. Therefore whilst the proportion of respondents stating they had a disability has decreased, so has the proportion stating they did not have a disability. This is due to the increase in the proportion of respondents who did not answer this question in this year's survey. This makes it difficult to assess definitively the proportion of committee members with a disability, and changes since last year.
64. As in 2017, a higher proportion of lay members identified themselves as disabled (26%) than non-lay members (5%). As noted earlier in the report, this difference between lay and non-lay roles is also reflected in the committee recruitment in 2017-18.
65. In comparison, 82% of the England and Wales population in the 2011 census did not have an activity limiting health problem or disability.
66. The Diagnostics Advisory Committee, Highly Specialised Technologies Evaluation Committee, Interventional Procedures Advisory Committee, and the Patient Access Scheme Liaison Unit Expert Panel had no respondents who identified themselves as disabled. The proportion of respondents who identified themselves as disabled was highest on the Quality Standards Advisory Committees (15%) and Indicator Advisory Committee (13%).

## Ethnicity

**Chart 3: Ethnicity: advisory committee members**



67. In the 2018 survey, 85% of respondents identified themselves of white ethnicity, and 14% of non-white ethnicity. As shown in the table below, the proportion of respondents of non-white ethnicity has increased each year over the last three surveys.

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

Ethnicity	% of all respondents		
	2016	2017	2018
Asian or Asian British	5.3%	5.9%	6.9%
Black or Black British	1.4%	1.3%	1.0%
Mixed	1.8%	2.2%	2.3%
Other	2.1%	2.4%	3.4%
<i>Total: all non-white</i>	<i>10.6%</i>	<i>11.8%</i>	<i>13.6%</i>
White	88.1%	85.9%	85.1%
Did not disclose or answer	1.2%	2.5%	1.3%

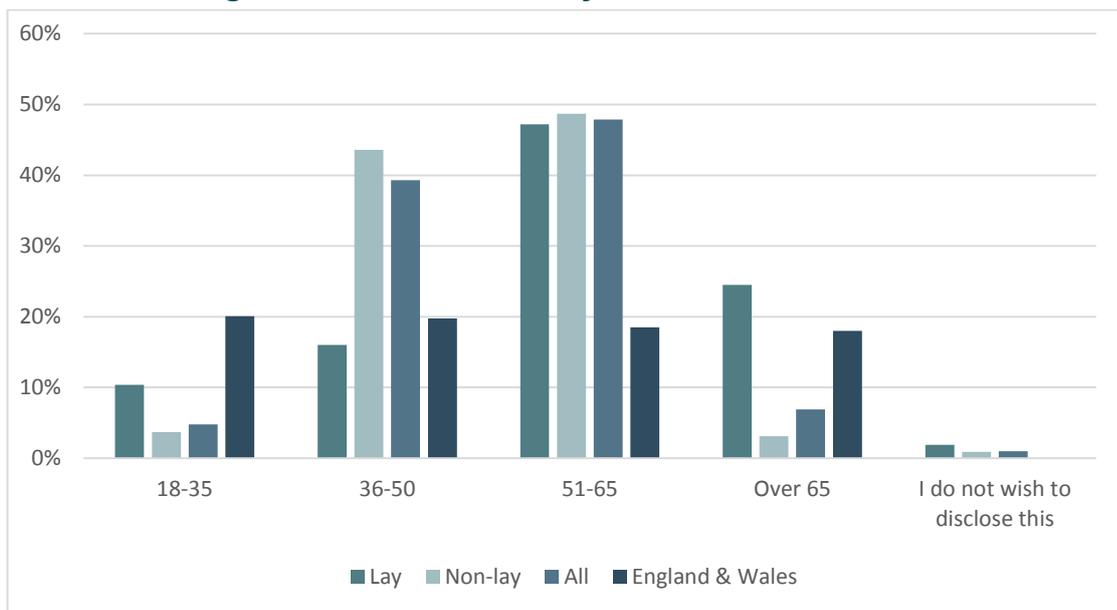
68. The proportion of respondents who identified themselves of non-white ethnicity was higher amongst non-lay members (15%) than lay members (6%). The proportion of respondents of Black ethnicity is lower than the general population (England and Wales, 2011 census) for both lay and non-lay roles. Based on the

responses, people of Asian ethnicity are underrepresented in lay roles compared to the general population, but the proportion of non-lay members of Asian ethnicity is slightly higher than the general population.

69. The proportion of respondents who identified themselves of non-white ethnicity was highest on the Highly Specialised Technologies Evaluation Committee (30%) and Medical Technologies Advisory Committee (24%).

## Age

**Chart 4: Age distribution: advisory committee members**



70. Just under half (48%) of the respondents in the 2018 survey were between 51 and 65 years old, and 87% between 36 and 65 years old. Overall, the age profile is broadly similar to that in the 2017 survey.
71. The proportion of respondents between 51 and 65 years old was similar for lay and non-lay roles. However the spread of responses across the other age bands varied between lay and non-lay roles.
72. The proportion of respondents between 18 and 35 years old was higher for lay members (10%) than non-lay members (4%), as was the proportion of respondents over 65 years old (25% of lay members and 3% of non-lay members).
73. Compared to the general population (England and Wales, Office for National Statistics 2016 estimates) committees are under-representative of those under 35 years old and over 65 years old.<sup>4</sup> This is a likely consequence of seeking

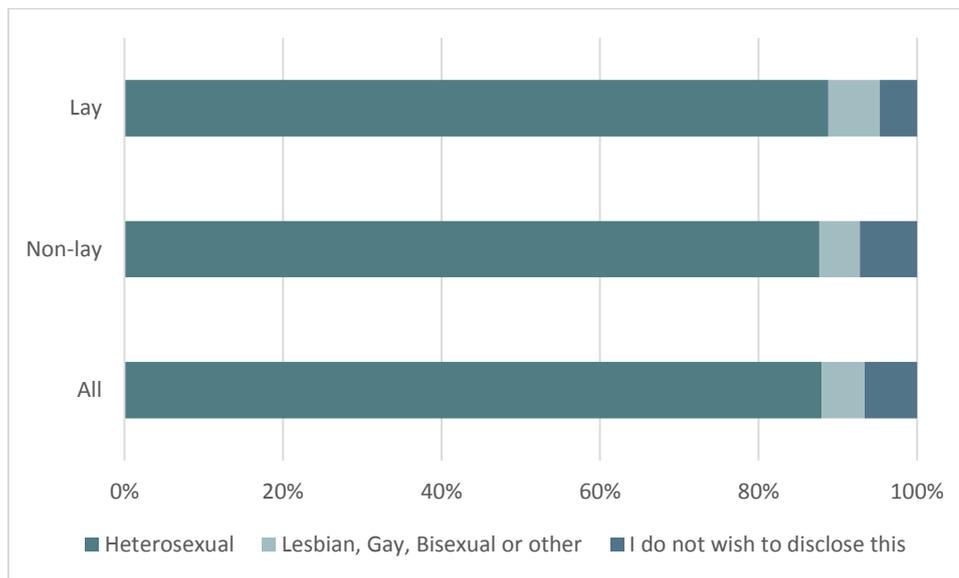
<sup>4</sup> Due to the format for the availability of data from the Office of National Statistics, the England and Wales data uses the following categories: 20-34 years old, 35-49 years old, 50-64 years old, over 65 years old

very experienced and currently practising health and social care professionals for non-lay roles. Lay roles, which do not require a current senior level role in the health and care services, have a higher proportion of respondents under 36 years old and over 65 years old.

74. The proportion of respondents between 51 and 65 years old was highest on the Medical Technologies Advisory Committee (71%) and Diagnostics Advisory Committee (64%). It was lowest on the Highly Specialised Technologies Evaluation Committee (40%), and the guidelines committees hosted by the Centre for Guidelines (43%).

### Sexual orientation

**Chart 5: Sexual orientation: advisory committee members**

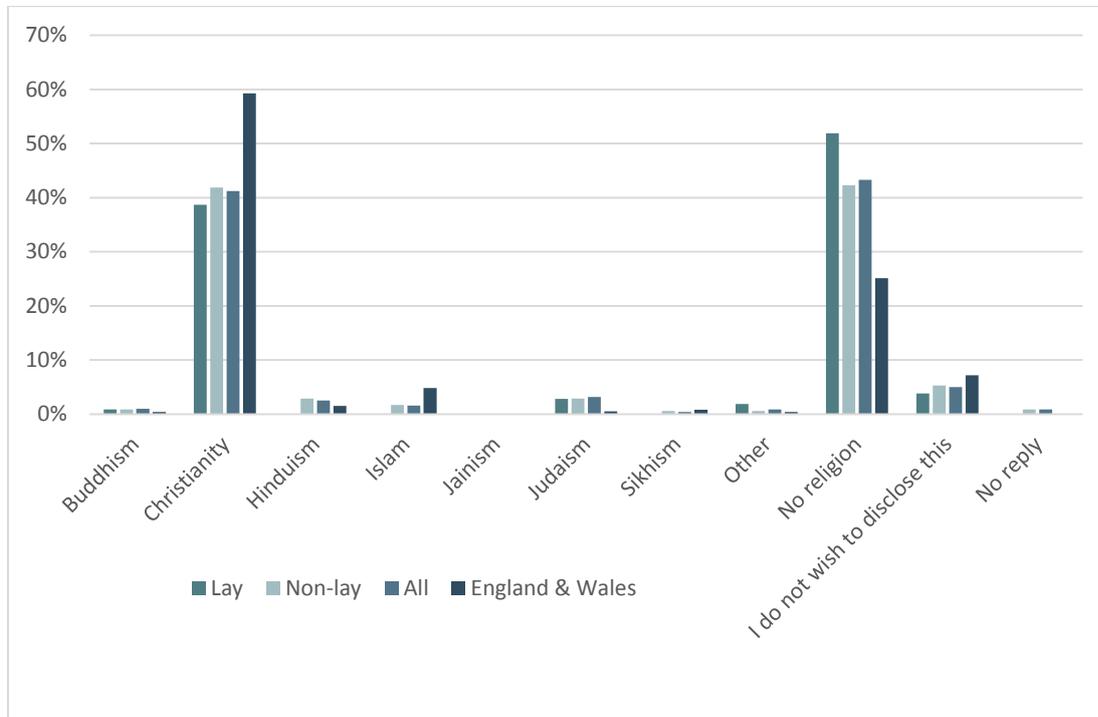


75. In the 2018 survey 88% of respondents stated their sexual orientation to be heterosexual, 5% lesbian, gay, bisexual or other, and 7% did not answer or provide this information. In the 2017 survey, 5% of respondents identified themselves as lesbian, gay, bisexual or other, with 86% stating their sexual orientation to be heterosexual and 9% not providing this information.
76. As in 2017, the proportion of respondents who stated their sexual orientation as lesbian, gay, bisexual or other was higher for lay members (7%) than non-lay members (5%). However the difference is smaller than last year when the figures were 9% and 4% respectively.
77. Estimates from the 2016 Annual Population Survey published by the Office for National Statistics, showed that 93% of the UK population identified themselves

as heterosexual; 2% as lesbian, gay, or bisexual; 0.5% other; and 4.1% did not know or answer.

## Religion or belief

**Chart 6: Religion or belief: advisory committee members**



78. The largest proportion of respondents to the 2018 survey identified themselves as of no religion. This is a change from both 2016 and 2017 when the highest proportion of respondents identified themselves of Christian belief. This is consistent with the information outlined earlier in the report and the year on year increases in the proportion of applicants and appointees who stated that they did not have a religion.
79. Compared to the general population (England and Wales, 2011 census) NICE's committees are under-representative of those of Christian and Muslim belief, and over-representative of those without a religion. Over half (52%) of lay respondents declared they had no religion, compared to 25% of the general population.
80. The proportion of respondents who identified themselves of Christian belief was highest on the Indicator Advisory Committee (67%) and Medical Technologies Advisory Committee (65%). It was lowest on the Diagnostics Advisory Committee (21%) and Technology Appraisal Committees (25%), which both had the highest proportion of respondents who identified themselves of no religion (64% and 60% respectively).

## Rurality

81. When reviewing the 2016-17 annual equality report, a Board member highlighted inequalities arising from rurality, particularly in terms of access to services. It was suggested that information is collated on the geographical spread of committee members, in particular the proportion drawn from urban and rural areas.
82. The table below outlines the spread of committee members' (lay and non-lay) home addresses between urban and rural areas in England.<sup>5</sup> Where a home address was not held, a committee member's work address was used.

**Table 4: Distribution of advisory committee members in England between rural and urban areas**

	% of NICE committee members	% of population in England
Urban	86	82
Rural	15	18

83. The table indicates there is a higher proportion of NICE committee members drawn from urban areas, and a lower proportion drawn from rural areas compared to the overall population of England.

## Benchmarking performance

84. NICE is unique in the way it uses advisory bodies and in the number it creates, so it is difficult to find information for purposes of comparison on bodies elsewhere with a similar function. Public bodies are probably the nearest equivalent when it comes to the capabilities required of members, even if they may have less need of the concentration of technical knowledge evident in NICE's advisory bodies.
85. Table 5 compares the composition of the NICE advisory bodies (using the results of the 2018 Picker survey) with the population of England (using the 2011 census), and statistics published by the Commissioner for Public

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<sup>5</sup> Urban areas are the connected built up areas identified by Ordnance Survey mapping that have resident populations above 10,000 people (2011 Census), and rural areas are those areas that are not urban, i.e. consisting of settlements below 10,000 people or are open countryside. For further information see: <https://www.ons.gov.uk/methodology/geography/geographicalproducts/ruralurbanclassifications/2011ruralurbanclassification>

Appointments (CPA) on regulated appointments made by Ministers between 1 April 2016 and 31 March 2017 (the latest available data)<sup>6</sup>.

86. The CPA information does not include religion/belief or sexual orientation of members of public bodies, and information on ethnicity is reported in less granularity. It is also important to note the non-disclosure rate for the CPA appointments.
87. The data indicates that:
- The proportion of women on NICE committees is higher than for the CPA appointments in 2016-17 in both the NHS and overall.
  - The proportion of members of non-white ethnicity on NICE's committees is twice that for the CPA appointments in 2016-17, but this may in part be due to the non-disclosure rate for these CPA appointments.
  - The proportion of people identifying themselves as disabled on NICE's committees is higher than for CPA appointments in both the NHS and all public bodies, although this remains lower than the overall population.

**Table 5: NICE compared with 'benchmark' organisations**

	NICE advisory bodies 2018	All public bodies 2016-17	NHS public bodies 2016-17	England population 2011
	%	%	%	%
<b>Gender</b>				
Men	50	53	60	49
Women	49	44	37	51
Undisclosed / not known	1	2	3	0
<b>Ethnicity</b>				
Black, Asian & minority ethnic group (includes mixed)	14	7	9	14
White	85	72	87	85
Undisclosed / not known	1	21	4	0

<sup>6</sup> <https://publicappointmentscommissioner.independent.gov.uk/wp-content/uploads/2018/04/OCPA-Annual-Survey-Results.pdf>

Disability				
Yes	9	5	4	18
No	73	71	92	82
Undisclosed / not known	18	24	3	0

## Equality issues impacting on NICE guidance

88. For the purposes of the public sector equality duty, NICE treats each item of its guidance as an individual policy which requires an equality impact assessment. The aim of this analysis is to ensure that, wherever there is sufficient evidence, NICE's recommendations support local and national efforts to eliminate discrimination, advance equality of opportunity, and foster good relations. We take account of the inputs of organisations and individuals with an interest in equality. Similarly, we take equality issues into account when developing our advice products.
89. In assessing the clinical and cost effectiveness of interventions and the validity of quality standards and indicators, we consider their impacts on:
- people sharing the characteristics protected by the 2010 Equality Act
  - population groups experiencing health inequalities arising from socioeconomic factors
  - 'other' groups of people whose health may be affected because they have particular circumstances, behaviours or conditions in common.
90. 'Other' groups identified in guidance and quality standards development during the year include:
- people living in socially deprived areas
  - immigrant populations
  - people with drug misuse problems
  - people in prison
  - people whose first language is not English
  - people who are homeless
  - people with long term health conditions.
91. Identification of 'other' groups is an aspect of NICE's compliance with both general public law requirements to act fairly and reasonably and human rights

obligations. Article 14 of the European Convention on Human Rights, as affirmed in the Human Rights Act 1998, prohibits discrimination in relation to Convention rights and freedoms that go beyond the Equality Act in that they include grounds of 'other status', by which is meant any definable common characteristic.

92. People may share more than one protected characteristic, be affected by socioeconomic factors, and be in an 'other' group, so our equality analysis has to accommodate many permutations.
93. Table 6 provides a breakdown by protected and other characteristics of the findings of the equality analyses carried out in 2017-18 on NICE guidance, NICE quality standards, and indicators, and the effects of this analysis on final recommendations. It indicates for example, that during the production of the 4 pieces of diagnostic guidance published in 2017-18, 14 potential equality issues were identified, 3 of which related to age. Two of the 14 potential issues subsequently impacted on recommendations.

**Table 6: Summary of equality analysis of published guidance**

Guidance type (number of items of guidance published)	Number of equality issues identified	Breakdown of potential equality issues identified by protected, socioeconomic, and 'other' characteristic											Number with an impact on recommendations
		Age	Disability	Gender reassignment	Pregnancy and maternity	Race	Religion or belief	Sex	Sexual orientation	Socio-economic	Other		
<b>DG</b> (4)	<b>14</b>	3	7	0	2	1	0	1	0	0	0	<b>2</b>	
<b>HST</b> (3)	<b>3</b>	0	0	0	0	2	0	0	0	0	1	<b>1</b>	
<b>IPG</b> (31)	<b>112</b>	23	27	0	2	18	9	21	0	10	2	<b>0</b>	
<b>MTG</b> (4)	<b>3</b>	1	2	0	0	0	0	0	0	0	0	<b>0</b>	
<b>TA</b> (80)	<b>48</b>	7	7	0	2	10	4	1	1	3	13	<b>12</b>	
<b>CG</b> (13)	<b>64</b>	7	11	0	3	11	5	3	1	8	15	<b>48</b>	
<b>PHG</b> (4)	<b>35</b>	5	4	1	2	3	1	1	2	4	12	<b>11</b>	
<b>IAC</b> (13)	<b>4</b>	1	0	0	0	3	0	0	0	0	0	<b>0</b>	
<b>QS</b> (23)	<b>70</b>	9	11	2	1	7	2	2	5	4	27	<b>34</b>	
<b>APG</b> (3)	<b>9</b>	3	3	0	3	0	0	0	0	0	0	<b>3</b>	
<b>SC</b> (4)	<b>67</b>	6	7	1	0	7	3	5	4	4	30	<b>59</b>	
<b>CGU</b> (11)	<b>45</b>	3	11	0	1	9	2	4	0	5	10	<b>13</b>	
<b>Total</b> <b>(193)</b>	<b>474</b>	<b>68</b>	<b>90</b>	<b>4</b>	<b>16</b>	<b>71</b>	<b>26</b>	<b>38</b>	<b>13</b>	<b>38</b>	<b>110</b>	<b>183</b>	

**DG:** Diagnostics guidance

**PHG:** Public health guidelines

**IPG:** Interventional procedures guidance

**Indicators:** Indicator set

**MTG:** Medical technologies guidance

**APG:** Antimicrobial prescribing guidelines

**TA:** Technology appraisals

**QS:** Quality standards

**CG:** Clinical guidelines

**SC:** Social care guidelines

**HST:** Highly specialised technologies evaluations

**CGU:** Clinical guideline updates

94. Table 7 summarises the potential equality issues identified and their impact on recommendations by protected and other characteristics, and compares this year with previous years.

**Table 7: Impact on recommendations by protected and other characteristic**

Protected characteristic	Number & % of equality issues found				Number & % of issues with impact on recommendations			
	2014-15	2015-16	2016-17	2017-18	2014-15	2015-16	2016-17	2017-18
Age	79 (21%)	87 (19%)	64 (18%)	68 (14%)	32 (18%)	30 (15%)	15 (13%)	18 (10%)
Disability	72 (19%)	85 (19%)	56 (16%)	90 (19%)	30 (17%)	41 (21%)	37 (33%)	33 (18%)
Gender reassignment	5 (1%)	10 (2%)	11 (3%)	4 (1%)	1 (1%)	4 (2%)	3 (3%)	3 (2%)
Pregnancy & maternity	13 (3%)	18 (4%)	7 (2%)	16 (3%)	3 (2%)	2 (1%)	2 (2%)	7 (4%)
Race	58 (15%)	54 (12%)	46 (13%)	71 (15%)	28 (16%)	26 (13%)	10 (9%)	21 (11%)
Religion or belief	22 (6%)	21 (5%)	15 (4%)	26 (5%)	9 (5%)	13 (7%)	8 (7%)	11 (6%)
Sex	28 (7%)	46 (10%)	34 (10%)	38 (8%)	11 (6%)	11 (6%)	3 (3%)	8 (4%)
Sexual orientation	10 (3%)	9 (2%)	9 (3%)	13 (3%)	4 (2%)	4 (2%)	3 (3%)	5 (3%)
Socio-economic	32 (8%)	37 (8%)	21 (6%)	38 (8%)	19 (11%)	18 (9%)	8 (7%)	10 (5%)
Other	66 (17%)	80 (18%)	85 (24%)	110 (23%)	42 (23%)	45 (23%)	24 (21%)	67 (37%)
<b>Total number of issues</b>	<b>385</b>	<b>447</b>	<b>348</b>	<b>474</b>	<b>179</b>	<b>194</b>	<b>113</b>	<b>183</b>
<b>Total guidance produced</b>	<b>163</b>	<b>191</b>	<b>163</b>	<b>193</b>				

95. In 2017-18, 474 potential equality issues were identified during the development of the 193 pieces of published guidance. The outcome of advisory bodies' equality analysis was that consideration of 183 (39%) of the issues identified had an impact on recommendations, whereas consideration of 291 (61%) issues did not. Between 2016-17 and the 2017-18, there was an increase in:

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

96. Age, disability and race continue to account for the greatest number of equality issues both in terms of initial identification and those which impacted on recommendations.

97. There is variation in the number of potential equality issues identified between guidance programmes. The number of potential equality issues identified per guidance topic was highest for the guidelines programmes, and lowest on the indicators, technology appraisals, and medical technologies programmes. The extent that these identified issues then impacted on recommendations also varies between programmes. 48 of the 64 identified potential equality issues (75%) impacted on recommendations in the social care guidelines. 112 potential equality issues were identified in the Interventional Procedures programme, but none subsequently impacted on guidance recommendations.
98. As noted earlier in the report, the cross-Institute equality and diversity group have looked at this variation, and believe it largely reflects the different nature of the guidance programmes and the guidance topics, but will review what training is provided by individual directorates to their developers and committees to seek to harmonise these approaches.
99. Examples of how equalities considerations impacted recommendations in guidance published in 2017-18 are outlined below.

#### **NG90: Physical activity and the environment**

100. During development of the guideline it was noted that some people's ability to undertake physical activity is limited due to disability. These individuals' ability to undertake some incidental physical activity may actually be facilitated by owning, or having an environment which facilitates use of, a car. Walking to and from the car, when compared to doing no physical activity, is likely to be beneficial.
101. The committee discussed that for many people, owning or having an environment which facilitates use of a car may mean a reduction in the physical activity they do. Therefore, measures to reduce how 'car-friendly' the environment is (for example, reducing parking) may increase their physical activity if they switch to another, more active, travel mode. However, while this may benefit those people who are not disabled by their environment, it could disadvantage those that are.
102. To address this issue, the committee agreed that:
- No recommendations would specifically prevent people from using cars or make use of cars less convenient
  - Recommendation 1.2.5, which states that modes of transport that involve physical activity should be given highest priority, also includes measures to facilitate those with mobility aids to move around their local area (for example, widening footways).

### **PH38: Type 2 diabetes: prevention in people at high risk**

103. The following equality issues were identified during development:

- People with physical and/or learning disabilities may be unable to participate in lifestyle programmes.
- People with a high BMI may find it difficult to access intensive lifestyle change programmes because of stigma associated with undertaking exercise.

104. At consultation, it was noted that it may not be appropriate to offer intensive life changing programmes for certain patients such as those with dementia because they may lack capacity to consent and/or they may not be able to undertake lifestyle change. It was also recognised that individuals with mental illnesses often have poorer physical health and there will be a number of those who would benefit from testing and intervention to prevent progression of diabetic disease.

105. To address those people identified during development as finding it difficult to, or being unable to, access lifestyle programmes, the following recommendation was made:

- “A.4 Use clinical judgement on whether (and when) to offer metformin to support lifestyle change for people whose HbA1c or fasting plasma glucose blood test results have deteriorated if:
  - this has happened despite their participation in intensive lifestyle-change programmes, or
  - they are unable to participate in an intensive lifestyle-change programme particularly if they have a BMI greater than 35.”

106. In relation to the issues around disability raised at consultation, an extra recommendation was added (recommendation 1.5.6) to enable as many people as possible to access and participate in intensive lifestyle-change programmes.

### **NG70: Air pollution: outdoor air quality and health**

107. During scoping and development, inequalities were identified in relation to vulnerable groups and outdoor air quality. Distribution of exposure to poor air quality may be linked with measures of socioeconomic disadvantage, and those with pre-existing conditions were likely to be particularly affected by air pollution. The committee addressed this issue in several ways.

108. Recommendations on clean air zones were made (recommendation 1.3). While the committee were aware that clean air zones may mean that vulnerable groups, who are less likely to be able to afford a new vehicle with low emissions, may be disadvantaged by the changes to restrict older, more

polluting vehicles, the committee felt that removing older vehicles from the road would reduce health inequalities overall by improving air quality in particularly polluted areas, which is where more vulnerable or disadvantaged groups are more likely to live.

109. In addition, the committee made recommendations specific to vulnerable groups (1.7.7) in order to ensure that these groups are provided with information on how they can take action to minimise the effect of poor air quality on their health.

#### **NG89 - Venous thromboembolism in over 16s: reducing the risk of hospital-acquired deep vein thrombosis or pulmonary embolism**

110. The guideline developer noted that heparin is derived from pigs and cattle, which might make this intervention problematic for people with religious or personal beliefs about the use of animal derived products.
111. The draft guideline therefore contains a specific recommendation within the 'Giving information to patients and planning for discharge' section for clinicians: *"Be aware that heparins are of animal origin and this may be of concern to some people. For people who have concerns about using animal products, consider alternatives after discussing their suitability, advantages and disadvantages with the patient."*

#### **NG78 - Cystic fibrosis: diagnosis and management**

112. A stakeholder raised a potential equality issue related to a recommendation not to use high-frequency chest wall oscillation as an airways clearance technique for people with cystic fibrosis. Although the stakeholder agreed that this should not be offered as a first line treatment the stakeholder said that there were instances where it was beneficial, particularly for people with autism and people with learning disabilities and that those considerations were set out in the Standards of Care and Good Clinical Practice for the Physiotherapy Management of Cystic Fibrosis Third Edition April 2017 (Cystic Fibrosis Trust publication).
113. The committee agreed with the stakeholder and added to the recommendation *"except in exceptional circumstances, as determined by the specialist cystic fibrosis team and following the NHS England policy on Individual Funding Requests"* to ensure that provision of this technique was possible for this group if needed.

#### **QS167: Promoting health and preventing premature mortality in black, Asian and other minority ethnic groups**

114. In May 2018, we published our quality standard on promoting health and preventing premature mortality among black, Asian and other minority ethnic groups. It draws attention to some of the specific areas of inequality, such as

increased health risks, poor access to and experience of services, and worse health outcomes. It aims to support public authorities in considering their equality duty when designing, planning and delivering services.

### **QS129: Physical health of people in prison**

115. Quality statement 2 states: “People entering or transferring between prisons have a second-stage health assessment within 7 days.”
116. Following comments from stakeholders at consultation, the Quality Standards Advisory Committee wanted to highlight: *“The clinical needs of people in prison who are undergoing or have undergone gender re-assignment, particularly medicines continuity and specialist support, should be considered during the assessment.”*

### **TA481: Immunosuppressive therapy for kidney transplant in adults**

117. This was a multiple technology appraisal (MTA) of basiliximab, rabbit anti-human thymocyte immunoglobulin, immediate-release tacrolimus, prolonged-release tacrolimus, belatacept, mycophenolate mofetil, mycophenolate sodium, sirolimus and everolimus. The committee understood that some adults may not be able to swallow capsules as a result of a disability, or cannot take a particular preparation of tacrolimus or mycophenolate mofetil for religious reasons because it contains gelatine of animal origin. The committee noted that these people might need alternative formulations (such as oral suspensions or gelatine-free formulations) instead.
118. The committee noted that oral suspensions and gelatine-free formulations are available for both immediate-release tacrolimus and mycophenolate mofetil, but that the suspensions are more expensive than the capsules. It recognised that, given its recommendations covered all formulations of immediate-release tacrolimus and mycophenolate mofetil, it might be considered unfair to allow access to only the least expensive formulations because people who cannot take a particular formulation as a result of a disability or other characteristic protected under equality legislation would then be unable to have the recommended treatments. It noted that restricting access in this way might be discriminatory. The committee noted that when prescribing immediate-release tacrolimus or mycophenolate mofetil, treatment should normally be started with the least expensive product. However, treatment could be started with an alternative dosage form if the least expensive product is not suitable. This equalities consideration was reflected in the recommendations (section 1.2):

*“Immediate-release tacrolimus, when used as part of an immunosuppressive regimen, is recommended as an initial option to prevent organ rejection in adults having a kidney transplant. Treatment should normally be started with the least expensive product. However, treatment can be started with an alternative dosage form if the least expensive product is not suitable (for*

*example, if the person is not able to swallow capsules as a result of a disability or they are unable to have a particular ingredient because of allergy or religious reasons). Tacrolimus granules for oral suspension (Modigraf) should be used only if the company provides it at the same price or lower than that agreed with the Commercial Medicines Unit.”*

**TA478: Brentuximab vedotin for treating relapsed or refractory systemic anaplastic large cell lymphoma**

119. The committee restricted the recommendation for brentuximab vedotin to treating relapsed or refractory systemic anaplastic large cell lymphoma in adults, only if they have an Eastern Cooperative Oncology Group (ECOG) performance status of 0 or 1. The committee concluded that healthcare professionals should take into account any physical, sensory or learning disabilities, or communication difficulties that could affect ECOG performance status and make any adjustments they consider appropriate. This is reflected in the recommendations (section 1.2):

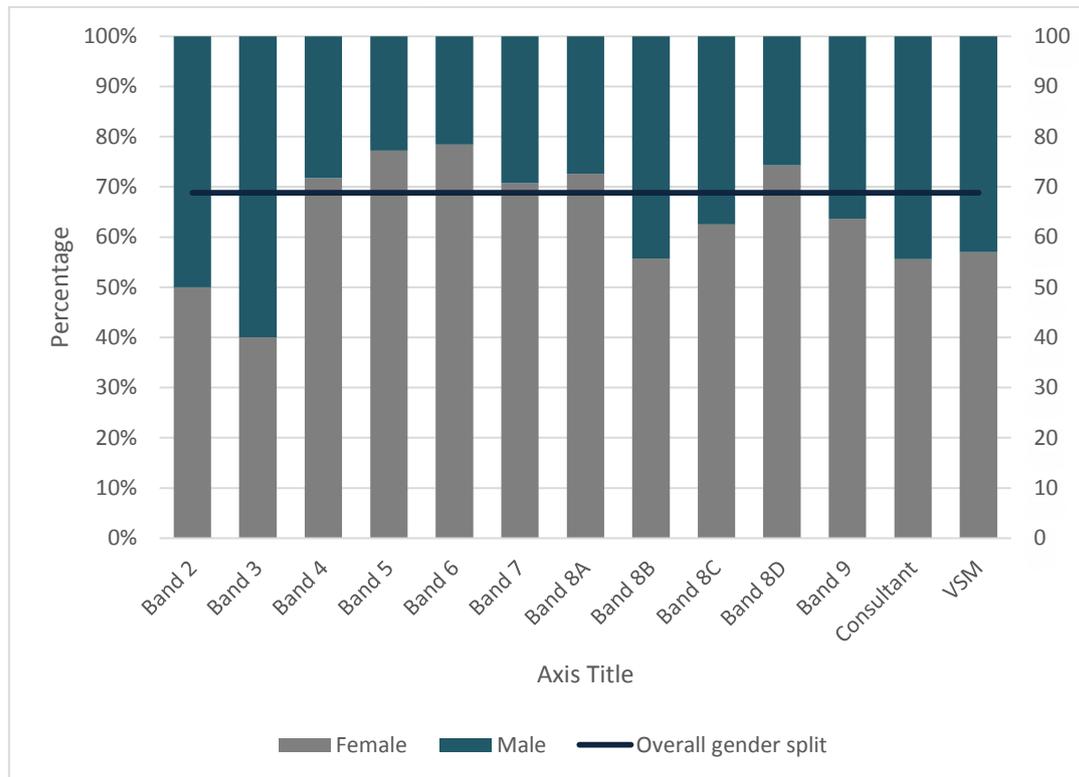
*“when using ECOG performance status, healthcare professionals should take into account any physical, sensory or learning disabilities, or communication difficulties that could affect ECOG performance status and make any adjustments they consider appropriate.”*

## **Workforce**

120. This section provides a summary of the workforce profile by equality category, as at 31 March 2018. Further information is available in the annual workforce report presented to the Board in July 2018.

## Gender

**Chart 7: Gender mix of staff by grade**



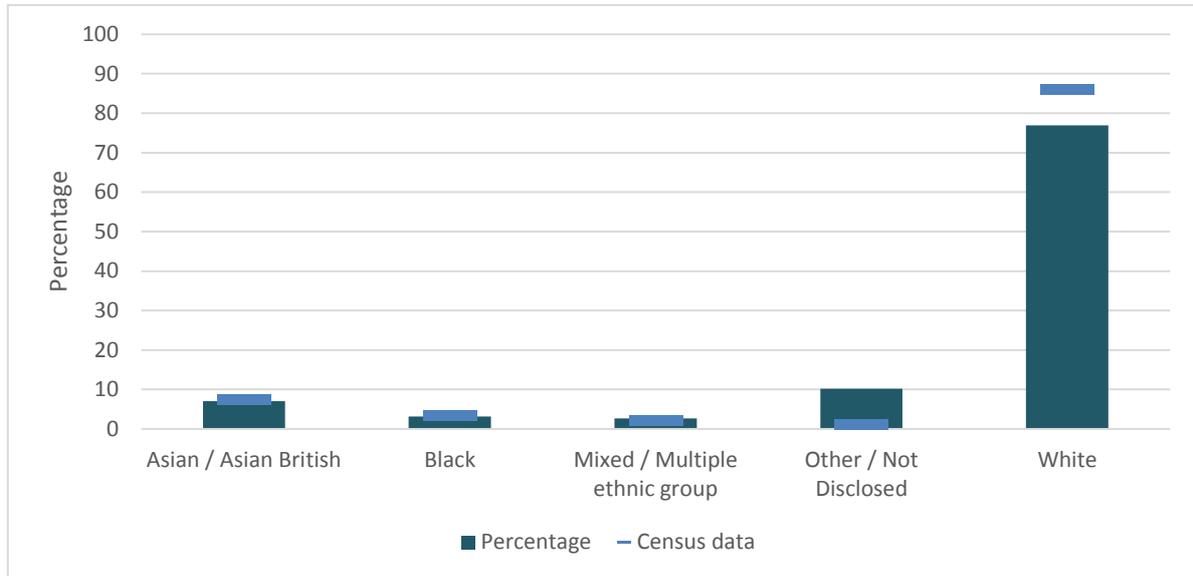
121. Compared to the overall gender split of the workforce, men are slightly over-represented in the more senior grades and most junior roles. The overall gender split of the workforce has not changed significantly over time. NICE's gender pay gap report is available on [our website](#).

## Disability

122. The range of disabilities that staff are encouraged to declare include learning disability or difficulty, long-standing illness, mental health condition, physical impairment and sensory impairment. There were 23 staff declaring a disability which is 3.5% of the workforce.

## Ethnicity

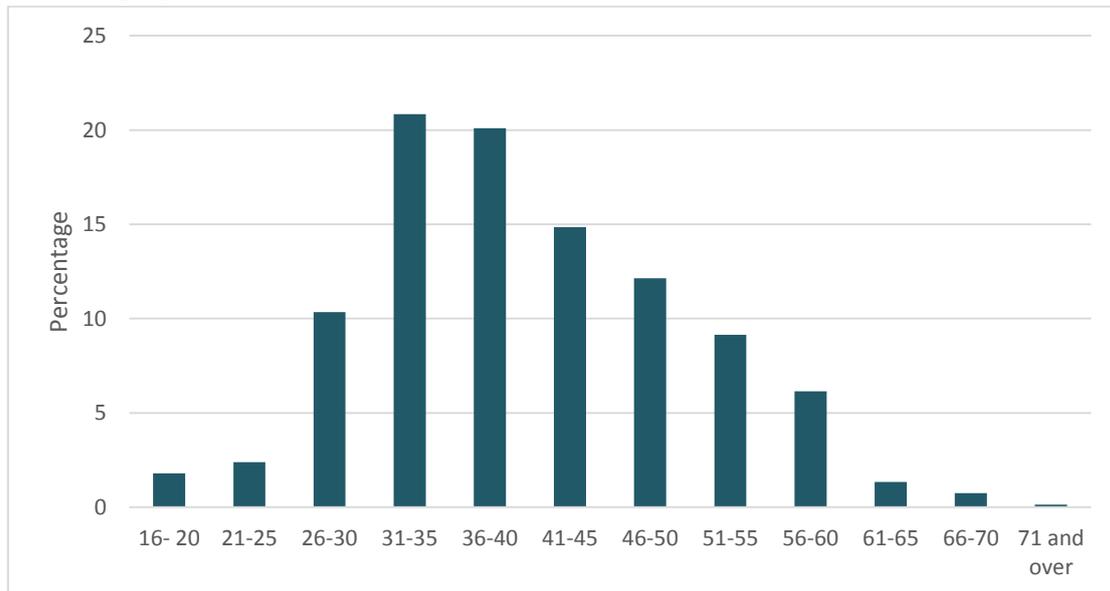
**Chart 8: Ethnicity: NICE staff**



123. The proportion of staff of white ethnicity has decreased from 79% in 2016-17 to 77% in 2017-18. In the 2011 census, the figure for England and Wales overall was 86%.

## Age

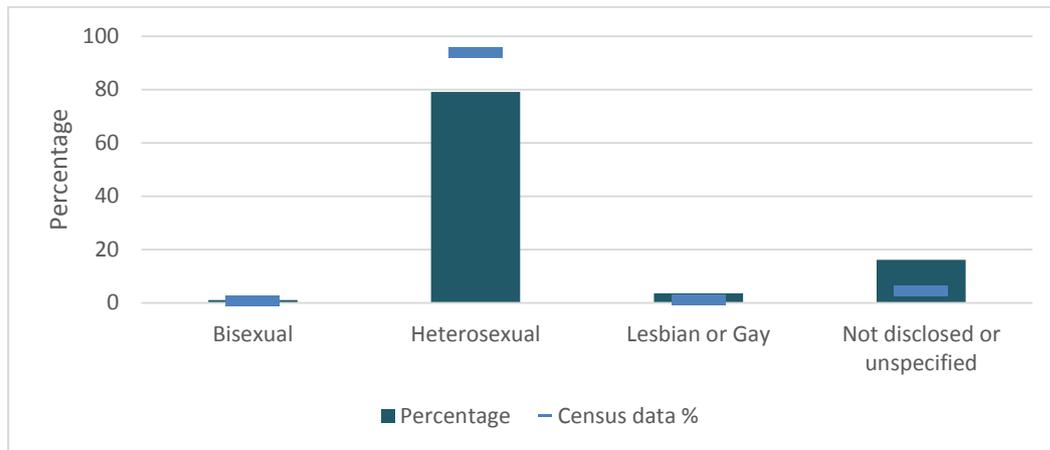
**Chart 9: Age profile: NICE staff**



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

## Sexual orientation

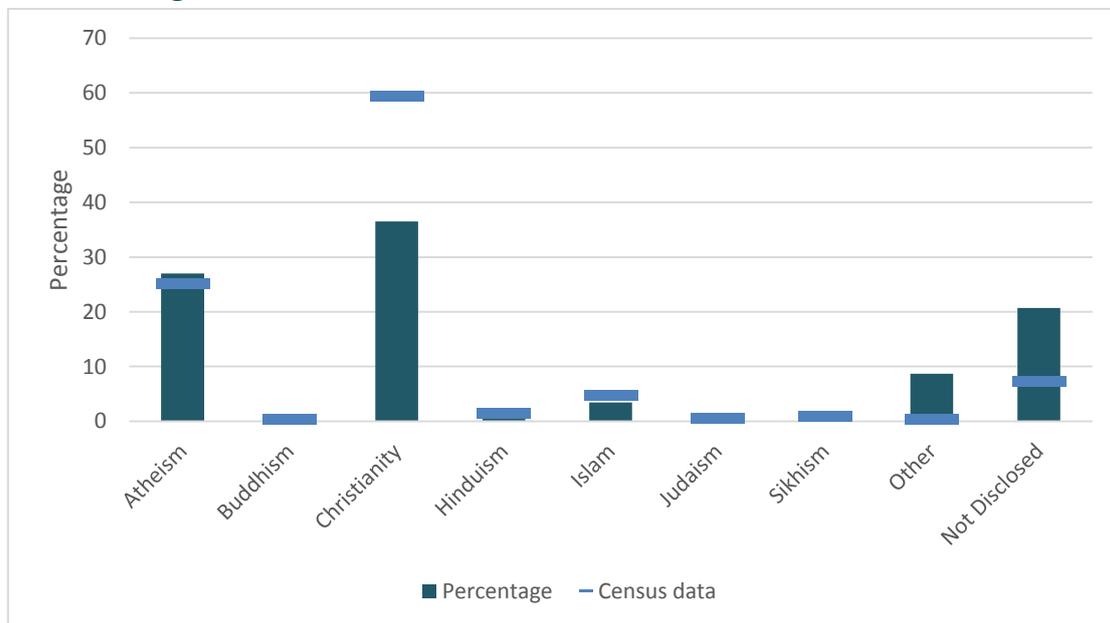
**Chart 10: Sexual orientation: NICE staff**



125. The profile is little changed from 2016-17, with a combined non-disclosure and non-specified rate of 16%. 5% of staff are lesbian, gay or bisexual. In 2017, NICE became Stonewall Diversity Champions. This is a framework designed to help employers to support lesbian, gay, bisexual and transgender employees reach their full potential in the workplace.

## Religion and belief

**Chart 11: Religion and belief: NICE staff**



126. Of the staff that disclosed their religion or belief, the largest group is Christianity (37%) and the next highest is no religion (27%), which is similar to last year.

## Employment applicants and appointees

127. Data on employment applicants and appointees is gathered via the equality profile of individuals when they complete their application on the TRAC recruitment system. This data is now automatically transferred to the Electronic Staff Record (ESR) system. There was a total of 5,336 applications for 155 posts which were advertised in 2017/18.

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

- Ethnicity: 51% of applicants identified themselves of white ethnicity, compared to 79% of those appointed.
- Age: Those aged between 25 and 34 years old accounted for 44% of applicants and 54% of appointees. 13% of applicants were under 25 years old, compared to 4% of appointees.

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

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August 2018