NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

ANNUAL GENERAL MEETING / PUBLIC BOARD MEETING

20 July 2016 at 1.45pm in the Education Centre, Conquest Hospital, The Ridge, St Leonards-on-sea, East Sussex TN37 7RD

AGENDA

16/057 Apologies for Absence
To receive apologies for absence

16/058 Declarations of Interests
To record any conflicts of interest

16/059 Minutes of the Board Meeting
To approve the minutes of the meeting held on 18 May 2016

16/060 Matters Arising
To consider matters arising from the minutes of the last meeting

16/061 Chief Executive’s Report
To receive the Chief Executive’s report
Professor Gillian Leng, Deputy Chief Executive and Director, Health and Social Care Directorate

16/062 Finance and Workforce Report
To receive a report on NICE’s financial position to the end of June 2016 and an update on the workforce strategy
Ben Bennett, Director, Business Planning and Resources

16/063 Annual Report and Accounts
Subject to laying before Parliament, to receive the annual report and accounts 2015-16
Professor Gillian Leng, Deputy Chief Executive and Director, Health and Social Care Directorate

16/064 Annual Revalidation Report and Medical Appraisal and Revalidation Policy
To receive the annual report and approve the updated policy
Professor Gillian Leng, Deputy Chief Executive and Director, Health and Social Care Directorate

16/065 Triennial Review: ‘One Year On’ Progress Report
To receive the report on the action taken in response to the Triennial Review
Professor Gillian Leng, Deputy Chief Executive and Director, Health and Social Care Directorate
Proposed Changes to Patient and Public Participation in Developing NICE Guidance and Standards  
To consider and approve the proposals for consultation  
Professor Gillian Leng, Deputy Chief Executive and Director, Health and Social Care Directorate  
(Item 7)

Office for Market Access Safe Harbour Service  
To receive an update  
Professor Carole Longson, Director, Centre for Health Technology Evaluation  
(Item 8)

Audit and Risk Committee Membership  
To agree the amended membership  
Professor David Haslam, NICE Chair  
(Item 9)

Directors’ Reports for Information  
Centre for Guidelines  
(Item 10)

Centre for Health Technology Evaluation  
(Item 11)

Communications Directorate  
(Item 12)

Evidence Resources Directorate  
(Item 13)

Health & Social Care Directorate  
(Item 14)

Committee minutes  
To receive the unconfirmed minutes of the Audit and Risk Committee held on 20 June 2016  
(Item 15)

Any Other Business  
To consider any other business of an urgent nature  
(Oral)

Date of the Next Meeting  
To note the next Public Board meeting will be held on  
Wednesday 21 September 2016 in Nottingham Council House, Old Market Square, Nottingham, NG1 2BS
NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

Public Board Meeting held on the 18 May 2016 at the National Centre for Deafblindness, Cygnet Road, Peterborough, PE7 8FD

These notes are a summary record of the main points discussed at the meeting and the decisions made. They are not intended to provide a verbatim record of the Board’s discussion. The agenda and the full documents considered are available in accordance with the NICE Publication Scheme.

Present

Professor David Haslam  Chair
Dr Rosie Benneyworth  Non-Executive Director
Professor David Hunter  Non-Executive Director
Elaine Inglesby-Burke  Non-Executive Director
Tim Irish  Non-Executive Director
Professor Finbarr Martin  Non-Executive Director
Andy McKeon  Non-Executive Director
Bill Mumford  Non-Executive Director
Linda Seymour  Non-Executive Director
Jonathan Tross  Non-Executive Director

Executive Directors

Sir Andrew Dillon  Chief Executive
Professor Gillian Leng  Health and Social Care Director and Deputy Chief Executive
Professor Carole Longson  Centre for Health Technology Evaluation Director

Directors in attendance

Professor Mark Baker  Centre for Clinical Practice Director
Jane Gizbert  Communications Director
Alexia Tonnel  Evidence Resources Director

In attendance

David Coombs  Associate Director – Corporate Office (minutes)
Catherine Wilkinson  Associate Director – Finance and Facilities

16/040 APOLOGIES FOR ABSENCE

1. Apologies were received from Ben Bennett who was represented by Catherine Wilkinson.
16/041 CONFLICTS OF INTEREST

2. None.

16/042 MINUTES OF THE LAST MEETING

3. The minutes of the meeting held on 16 March 2016 were agreed as a correct record.

16/043 MATTERS ARISING

4. The Board reviewed the actions arising from the Board meeting held on 16 March 2016. It was noted that:
   - The 2016-17 business plan was updated in line with the Board’s discussion and subsequently approved by the Department of Health.
   - NICE has continued to work with NHS England to finalise the Standard Operating Procedure for the Cancer Drugs Fund, which is due for NHS England’s approval shortly.
   - Andrew Dillon is reviewing how NICE’s commitment to equality and diversity is publicised on the NICE website.
   - The target for the two equality objectives will be to seek year on year improvements in the relevant proportions.
   - The minutes of the advisory bodies, which are available on the NICE website, set out any interests declared by committee members and the action taken in response.
   - In future, the Non-Executive Directors will be informed of upcoming Implementation Strategy Group meetings.
   - Consideration is still being given as to a suitable engagement success criteria indicator relating to integrated care.

5. It was agreed that given the level of interest in this issue, the planned update on NICE’s support for disinvestment should be brought forward to the next Board meeting.

   **ACTION:** Gillian Leng

16/044 CHIEF EXECUTIVE’S REPORT

6. Andrew Dillon presented his report, describing the main programme activities and financial position to the end of March 2016.

7. Linda Seymour asked that the diabetes prevention strategy takes account of the increased rates of diabetes amongst adults with mental health conditions.
8. Linda Seymour also asked that the appeal panel members are informed when the final technology appraisal guidance following an appeal is published. Andrew Dillon agreed that such a process would be put in place.

**ACTION**: David Coombs

9. The Board received the report.

**16/045 FINANCE AND WORKFORCE REPORT**

10. Catherine Wilkinson presented the report which outlined the financial position as at 31 March 2016 and provided an update on the workforce strategy. Subject to completion of the external audit, the year-end financial position was an underspend of £0.5m against the revenue budget. A £3.7m underspend on expenditure, largely due to pay underspends, was offset by two significant liabilities. One was the provision for potential redundancy costs of staff affected by future management of change exercises, whilst the other was the accrual for the backdated VAT liability that was noted at the last Board meeting.

11. The Board discussed the underspend against the pay budgets. Whilst this provides a positive platform for the reductions in income in 2016-17, Board members noted the potential impact of these vacancies on staff, particularly in the guidance producing programmes. Mark Baker, Carole Longson, Gillian Leng and Alexia Tonnel outlined their perspective of staff morale in these programmes. The Board noted that the forthcoming staff survey will be an important insight into the impact on staff of the financial challenges. Likewise, sickness absence is also an important measure; whilst this increased slightly in 2015-16 it still compares very favourably to the NHS. In the context of the financial challenges and the upcoming management of change exercises, it was noted that staff appraisals will be particularly important in maintaining morale. It was agreed to provide the Board with the appraisal completion rate.

**ACTION**: Ben Bennett

12. Linda Seymour welcomed the launch of the workforce planning and change management guidance and stated that it would be helpful for the Board or Audit and Risk Committee to receive a report next year on the guidance’s impact.

13. Andy McKeon highlighted NICE’s performance against the Better Payment Practice Code. Catherine Wilkinson confirmed that 2015-16 was the first year NICE did not meet the target within the code. She explained the reasons for this, noting that the primary factor was the delay in paying two large invoices for the National Collaborating Centres. In addition, there were some resourcing issues within the finance department. She confirmed that additional monitoring has been put in place to improve performance.

14. The Board received the report.
16/046 PUBLIC INVOLVEMENT PROGRAMME ANNUAL REPORT 2015

15. Gillian Leng presented annual report from the Public Involvement Programme and Victoria Thomas, Head of Public Involvement, summarised the key points of note.

16. Bill Mumford welcomed the work with local Healthwatch organisations, which he hoped would be rolled out nationally. He asked how the impact of this could be measured. Victoria Thomas confirmed that the aim is to extend the pilot to other Healthwatch organisations, utilising NICE’s Field Team. Gillian Leng stated that she would look at how this work could be incorporated into the six monthly impact reports to the Board.

**ACTION**: Gillian Leng

17. The Board received the report and approved it for wider publication.

18. The Board discussed the review of public involvement that is due to conclude and report to the Board shortly. Board members suggested a number of issues to be included when the review reports back to the Board. In particular, Board members asked that the review sets out who NICE is seeking to engage with and the benefits of doing so. It was requested that the review puts the public involvement team’s activities in the context of wider public involvement across NICE. Also, given the resource constraints, there should be an evidence-based approach to targeting the public involvement activities.

19. A patient group representative in the audience highlighted the importance of closing the feedback loop and advising the public of the outcome of their contribution to NICE.

16/047 ABBREVIATED TECHNOLOGY APPRAISAL PROPOSAL

20. Carole Longson presented the proposal for an abbreviated technology appraisal (ATA) process for health technologies that provide similar or greater health benefits at a similar or lower cost than technologies already recommended in NICE guidance for the same indication.

21. Carole Longson responded to a number of queries from the Board on the proposals. She assured the Board that no reduction in the robustness of the scrutiny of the data is proposed. The ATA process will usually be for technologies that have recently received marketing authorisation and therefore the NICE appraisal will draw heavily on the scrutiny of technology’s benefits during that process. The ATA will only be used for technologies that provide similar or greater health benefits at the same or lower cost; this cost will take account of the full costs to the NHS, such as administering the technology. Arrangements will be in place to transfer the technology to the standard appraisal process if in the course of the ATA, it becomes apparent that the costs are higher than an existing technology and / or the benefits are less. The topic
selection processes to identify technologies suitable for consideration under the ATA will in general be the same as the equivalent processes for the single technology appraisal.

22. The Board:
   - Supported the development of a new process to appraise health technologies that provide similar or greater health benefits at a similar or lower cost than technologies already recommended in NICE guidance for the same indication.
   - Approved the accompanying process and methods statements for public consultation.
   - Noted that the final proposals will be brought back to the Board for approval following the consultation.

   **ACTION: Carole Longson**

23. Following a question from a member of the audience, Carole Longson provided further information about the circumstances whereby it may be appropriate to switch to the standard technology appraisal process once an ATA is underway. However, such circumstances are not envisaged to be frequent.

16/048 CITIZEN’S COUNCIL

24. Carole Longson presented the report from the 2015 Citizen’s Council which considered the use of anonymised information derived from personal care records as part of the evaluation of treatments and the delivery of care. She highlighted the direct relevance of the topic to NICE’s guidance production and stated that the report, and the consultation responses, raise important issues regarding communicating with patients on the collation and use of ‘real world’ data.

25. Calvin Beck, a member of the Citizen’s Council, gave his perspective on the topic and highlighted the differing views amongst Council members.

26. In response to a question from the Board, Carole Longson advised that the refresh of the social value judgements document and the development of accompanying scientific value judgements have been delayed by resource constraints within the Centre for Health Technology Evaluation. The scope for utilising additional capacity for this work is therefore being explored.

27. The Board received the report and approved it for wider publication. The Board placed on record its thanks to the Citizen’s Council.

28. A member of the audience from a local Healthwatch noted NICE’s extensive work to engage with the public through activities such as joining the Citizen’s Council or committees. He asked though how NICE is engaging with members of the public who may prefer shorter and more informal engagement. David Haslam agreed that it is important to proactively engage with members of the
public who are less inclined to participate in formal mechanisms such as joining committees, and stated that the Board continues to be mindful of this issue.

**16/049 AUDIT AND RISK COMMITTEE ANNUAL REPORT 2015-16**

29. Jonathan Tross presented annual report from the Audit and Risk Committee, which set out the committee’s work over the 2015-16 financial year and its conclusions on the risk and control framework. He outlined the risks and challenges identified by the committee and stated that overall the committee’s conclusions on NICE’s governance and management arrangements are positive.

30. Jonathan Tross outlined the committee’s two recommendations to the Board. Firstly, that the Board engages more regularly with the risks facing NICE and specifically, reviews the strategic risks facing NICE once these have been updated. Secondly, that the Board should agree early warning indicators to identify stresses in three areas: loss of impact in terms of the guidance products, delivery of the work plan in terms of timeliness or quality, and stress or morale in the workforce.

31. Elaine Inglesby-Burke welcomed the report and the recommendations, particularly in relation to risk management. She stated that it would be helpful for the Directorate reports to include greater reference to risk management.

32. Andrew Dillon stated that he would give further consideration to the potential indicators that could be used in respect of the issues raised by the committee. Also, he agreed that it would be helpful to review the format for the Directorate reports to ensure greater consistency and reference to risk management.

**ACTION: Andrew Dillon**

**16/050 DIRECTOR’S REPORT FOR CONSIDERATION**

33. Alexia Tonnel presented the update from the Evidence Resources Directorate. She drew the Board’s attention to key items of note in the report, including the strengthening of the processes to maintain and continuously improve NICE’s digital services, the collaborations with key stakeholder organisations on the provision of evidence services, and the establishment of a small business development team to explore commercial opportunities.

34. The Board received the report and thanked Alexia Tonnel for the work of the Directorate.

**16/051-16/054 DIRECTORS’ REPORTS FOR INFORMATION**

35. The Board received the Directors’ Reports.
16/055 COMMITTEE MINUTES

36. The Board received the unconfirmed minutes of the Audit and Risk Committee held on 20 April 2016.

16/056 ANY OTHER BUSINESS

37. None.

NEXT MEETING

38. The next public meeting of the Board will be the Annual General Meeting held at 1.45pm on 20 July 2016, in the Education Centre, Conquest Hospital, The Ridge, Saint Leonards-on-sea, TN37 7RD.
This report provides information on the outputs from our main programmes and the financial position for the 3 months to the end of June 2016, and comment on other matters of interest to the Board.

The Board is asked to note the report.

Andrew Dillon
Chief Executive
July 2016
Chief Executive’s report

1. This report sets out the performance of the Institute against its business plan objectives and other priorities, for the 3 months ending 30 June 2016. It also reports on guidance published since the last public Board meeting in May and refers to business issues not covered elsewhere on the Board agenda.

Performance

2. The current position against a consolidated list of objectives in our 2016-17 business plan, together with a list of priorities identified by the Department of Health, is set out in Appendix 1.

3. Extracts from the Directors’ reports, which refer to particular issues of interest, are set out at Appendix 2. The performance of the main programmes between April and June 2016 is set out in Graphs 1 and 2, below.

Graph 1: Main programme outputs: April to June 2016

Notes to Graph 1:

a) IP refers to Interventional procedures (minimally invasive surgery)
b) HST refers to the highly specialised technologies programme (drugs for very rare conditions)
c) Medicines summaries consist of both summaries (information on indications, harms and costs) of newly licensed medicines, and advice on the use of licensed medicines in diseases and conditions for which they are not licensed

d) The variance is the difference between the target output for the reporting period, as set out in the business plan and the actual performance

e) ‘Additional’ topics are either those which should have published in the previous financial year, or that have been added since the publication of the business plan

4. Details of the variance against plan are set out at Appendix 3. Guidance quality standards and other advice published since the last Board meeting in May is set out Appendix 4.

5. The performance of other Institute programmes is set out in Graph 2, below.

Graph 2: Advice programmes main outputs: April 2015 to March 2016

Notes:

a) MIBs (medtech innovation briefings) are reviews of new medical devices
b) QP and Cochrane reviews report on opportunities for making better use of resources
c) Medicines summaries provide information on new medicines and on the unlicensed or off label use of medicine
Finance position (Month 3)

6. The financial position for the 3 months from April 2016 to the end of June 2016 is an under spend of £0.8m (5.5%) against a budget of £14.3m. The position of the main budgets is set out in Graph 3. Further information is available in the Business Planning and Resources Director’s report.

Graph 3: Main programme spend: March 2016 to June 2016 (£m)
**Appendix 1: Business objectives for 2016-17**

In managing its business, NICE needs to take account of the objectives set out in its business plan, the organisational and policy priorities for NICE set out by the Department of Health. In addition, NICE shares responsibility, with other national agencies, for the governance of NHS England’s Five Year Forward View. The Accelerated Access Review, when published, will add additional tasks. The table below consolidates and tracks progress with the main elements of these influences on our work in 2016-17.

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<td>Publish guidance, standards and indicators, and provide evidence services against the targets set out in the Business Plan and in accordance with the metrics in the balanced scorecard.</td>
<td>Guidance, standards and evidence services published and provided in accordance with the schedule set out in Appendix 2 and the balanced score card Delivery within the range allowed for in the balanced scorecard</td>
<td>Performance against our business plan objectives is set out elsewhere in the Chief Executive's report. The balanced score card report will be published with the Board papers in November.</td>
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<td>Develop plans to ensure that NICE’s guidance products meet the needs of social care providers and commissioners. This includes adapting NICE’s methods and processes to ensure that they are appropriate in a social care context and, for public health, ensuring alignment with PHE priorities and ensuring NICE guidance supports local public health services.</td>
<td>Continue to engage with the social care and public health sectors to understand their needs and expectations of NICE guidance Redesign processes and methods to better deliver against these expectations and produce definitive plans by September 2016</td>
<td>This work is being taken forward as part of an updated, Institute-wide implementation strategy. The leadership role for engaging with the social care communities rests with the Health and Social Care Director. She is supported in this by Jane Sylvester who is remaining in the directorate following the transfer of the social guidelines development function into the new Centre for Clinical Guidelines.</td>
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<td>Develop and then implement the first year of a three year strategy to reshape the offer from NICE, to take account of the reduction in Department of Health Grant-in Aid funding.</td>
<td>Strategy agreed with the Board and principal stakeholders by July 2016 Actions monitored through regular reports to the Senior Management Team and the Board Balanced budget set for 2017-18</td>
<td>The Board agreed the strategic basis for NICE’s offer to the health and care system at its meeting in October 2015 and through discussion at subsequent meetings. It received a report at its June meeting on the detail of the structural changes and the associated savings which will be necessary to enable this strategic vision to be achieved.</td>
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<td>Develop the methods, processes and capacity to implement the new Cancer Drugs Fund, in conjunction with NHS England.</td>
<td>CDF transition arrangements completed, in accordance with the schedule for 2016-17 agreed with NHS England New methods and processes operational from April 2016 Additional capacity in place by end July 2016</td>
<td>We are on track to implement the transitional arrangements from the old CDF, with the first review topics going to committee in July. The changes to our methods and processes are in place and we are well advanced in recruiting to the additional posts which have been funded by NHS England. The Standard Operating Procedure for the new CDF has been published by NHS England.</td>
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<td>Manage the change from the existing to the new commissioning arrangements for social care guidance efficiently and sympathetically.</td>
<td>Agree the terms of the transition process with the current contractor by July Put in place the 2016-17 actions in the transition process</td>
<td>Arrangements have been agreed with the Social Care Institute for Excellence on the transfer of their work in developing NICE social care guidelines by the end of 2018. A schedule for the completion of current guideline development work has been agreed.</td>
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<td>Implement the relevant recommendations in the final report of the Accelerated Access</td>
<td>Assess and report to the Board on the financial, operational and reputational</td>
<td>We are waiting for the publication of the final report. In the meantime, we are</td>
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| Review                                                                   | implications of the final report for NICE guidance programmes  
Develop an implementation plan and report to the Board on progress with its implementation                                                                                                                                                                                                                                           | engaging actively with the Office for Life Sciences and have been able to comment on final draft versions of the report.                                                                                                                                                           |
| Review options for the long term development of NICE International's health systems development work in low and middle income economies | Identify and evaluate the options for the long term future of NICE International Board consideration of the preferred option in June  
Complete the actions for the preferred option by December                                                                                                                                                                                                                                                                         | The Board received a report on the options for the future of NICE international's work in low and middle income economies at its June meeting.  
The NICE International team will transition to Imperial College in September, to develop the Gates and DFID-funded work on the International Decision Support Initiative. The NICE International brand and the other international work currently underway will remain with NICE. |
<p>| Engagement                                                               | Regular participation in the governance arrangements (the main Board and its programme groups) of the Five Year Forward View Strategies and policies, developed by the Five Year Forward View Board are informed, where appropriate, by NICE and its outputs                                                                                                                                                                                                 | The Chief Executive and Deputy Chief Executive attend the Five Year Forward View Board meetings and NICE is represented on the associated programme boards. We have been engaged with the development of the Sustainability and Transformation local planning process, at a national level and locally, through the Implementation |</p>
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| Ensure that all new guidance topics that are commissioned align with a health and care system priority, strategy or policy and that each guidance publication clearly articulates the case for adoption for its key audiences. | Each topic associated with a system priority, strategy or policy  
System owner identified for each topic  
The case for adoption published for each topic | A senior clinical lead in NHS England exists for each clinical guideline. All guidance topics have been confirmed as priority topics with the Department of Health and/or NHS England. |
| Identify and operate systems and processes, with NHS England and Public Health England, which ensure that business critical functions are delivered, duplication avoided and opportunities to contribute to and participate in complementary activity are identified and acted on. | Identify the key business relationships between the two organisations by April 2016  
Develop and track metrics to assess and monitor the successful operation of these relationships in line with updated partnership agreements | All relationships between NICE and NHS England and Public Health England (PHE) have been mapped, and an updated Partnership Agreement has been signed with PHE.  
We are tracking progress in the relationships through regular quarterly meetings. |
<p>| Work with the MHRA, the Office for Life Sciences and NIHR to ensure timely technology appraisal guidance on EAMS products is delivered on the timeline agreed with the Department of Health | Ensure the timeline for all EAMS designated products in the technology appraisal programme is consistent with the Scheme’s expectations | Our process for engaging with companies and the MHRA on EAMS (Early Access to Medicines Scheme) products is in place and was applied successfully to the first EAMS drug. |
| Ensure that NICE is compliant with its duties | Publish annual equality report in | The annual equality report is currently |</p>
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<td>under the Equalities Act 2010</td>
<td>September 2016 Develop an action plan to deliver equality objectives</td>
<td>being drafted and is on track for consideration at the September 2016 Board meeting. The newly established cross Institute equality and diversity group has met for the first time and considered actions to deliver the equality objectives.</td>
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**Adoption and Impact**

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<td>Develop a consolidated set of metrics and data to assess the uptake and impact of the guidance and evidence services provided by NICE.</td>
<td>Measure and report against a set of indicators that enable the Senior Management Team and the Board to exercise a judgement about the uptake and use of a defined range of guidance and evidence services.</td>
<td>A consolidated set of adoption and impact metrics has been developed and will be reported to the Board in September and March.</td>
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<td>Continue to work with CQC to ensure that NICE quality standards and guidelines complement and reinforce essential standards, building on existing work to map NICE Quality Standards into the CQC inspection work.</td>
<td>Agree with CQC on the extent of use of relevant guidance and quality standards in their inspection regime. Put in place a process for sampling the use made of the guidance and standards.</td>
<td>NICE and CQC are holding a joint workshop on 21 July to review how we are working together, and to consider the extent to which guidance and standards might be used in the future. This will include a process for sampling.</td>
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<td>Redesign and promote, in conjunction with NHS Improvement, NHS England and the Local Government Association, a comprehensive resource for commissioners and providers on the use of NICE guidance to help make savings, improve productivity and promote optimal use of interventions.</td>
<td>Redesigned resource available from April 2016 Usage monitored and reported to the senior Management Team and the Board</td>
<td>There is an ongoing project to improve the online NICE disinvestment resource so it provides a more useful experience for users. This is combined with a more strategic review, in conjunction with partners, to determine the best role for NICE in identifying significant</td>
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<td>Subject to the release of budget for this programme of work, Contribute to the National Information Board Framework for Action through the development of an endorsement scheme for health apps, working closely with Public Health England and HSCIC.</td>
<td>Secure the resources necessary for NICE to be able to make a meaningful contribution to the work Subject to adequate resourcing, agree a programme of work with the key partners Deliver against the 2016-17 elements of the agreed work plan</td>
<td>Arrangements for the distribution of funds and the delegation of their management are still in discussion. However, some funds were released in July, which will enable us to maintain our commitment to developing a system for evaluating digital apps.</td>
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<td>Take into account the views and concerns expressed by key stakeholders through the government-wide RepTrak reputation research project</td>
<td>Report RepTrak metrics to the Senior Management Team and the Board</td>
<td>The 4th wave of the Reptrak survey of informed public was reported to us this month. NICE’s reputation amongst the informed public was calculated by measuring the organisation’s strength in several dimensions including product/services, governance, leadership, performance, and positive impact on society. The survey found that NICE has a strong reputation (70.4), which is significantly above that of the UK Public Sector average (62.7) Across the 64 ALBs and government departments that were ranked in this wave, NICE is within the top 15. Work on the separate Reptrak pilot project to assess the views of key stakeholders (beyond the informed public) is progressing.</td>
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<td><strong>Productivity</strong></td>
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<td>Operate within resource and cash limits in 2016-17. Actively manage the appropriate application of any non-recurrent funding as early as practicable in the financial year.</td>
<td>Performance against plan for all budgets monitored and reported to the Senior Management Team and the Board</td>
<td>The Institute is on track to operate within its resource and cash limits. Further information is available in the Business Planning and Resources Director’s report.</td>
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<td>Complete the implementation of the Cabinet Office’s Triennial Review recommendations published in July 2015</td>
<td>Review progress and complete a ‘one year on’ report in July 2016 Complete all actions by December 2016</td>
<td>Most of the recommendations have now been actioned. A full progress report is included with the papers for the July Board meeting.</td>
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<td>Promote a culture of continuous improvement within the organisation and uphold the ambition to remain a world-renowned organisation, benchmarking where possible its systems, processes and outcomes against best players internationally</td>
<td>Identify the programmes which might be suitable for benchmarking and assess what, if any, international benchmarking is possible by September Identify 10 publications in peer reviewed international journals which assess and provide an opinion on one or more aspects of NICE’s work and submit to the Board for consideration in March</td>
<td>A report will be available to the Board at its meeting in November.</td>
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<td>Implement the first year of a three year strategy to manage the reduction in the Department of Health’s Grant-In-Aid funding and plan for a balanced budget in 2017-18.</td>
<td>Centres and directorates identify savings in order enable the Institute to manage within the reduced Grant in aid funding it received from DH by April Management of change exercises completed in accordance with a schedule agreed and monitored by the SMT</td>
<td>The savings required for the first year (2016-17) have been achieved and we are currently on track to achieve the structural changes and savings required for 2017-18. The SMT devotes a full meeting each month to the savings plan and the Board receives a written or oral update at each meeting.</td>
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<td>Put in place arrangements to charge the cost of the technology appraisal programme to industry users, from April 2017</td>
<td>Key stakeholder agreement to charging obtained by September Board regularly appraised of the financial, operational and reputational risks Financial and operational arrangements designed and tested by April 2017 Charging arrangements are able to go live from September 2017 at the latest</td>
<td>Project management arrangements, including appropriate resources are in place. Costing and pricing analyses have been completed. A timeline for seeking the necessary Treasury and Parliamentary approvals has been agreed with the Department of Health. Engagement with industry stakeholders is underway. Subject to the necessary approvals, we are on track to begin charging in April 2017.</td>
</tr>
<tr>
<td>Develop a strategic plan to grow the commercial activity over the next 10 years. This should explore, for example, offering advice, digital protocols, assessments or a subscription service to other countries.</td>
<td>Identify and evaluate the options for increasing income from non-Grant-in-Aid sources, inside and beyond the UK Evaluate the options for the most effective vehicle for delivering this activity, by June 2016 Prepare business cases for each element of the programme by December 2016</td>
<td>Arrangements are in place to review NICE’s international offer following the transfer of the international Decision Support Initiative work, together with the associated staff, to Imperial College in September. Discussions will take place at the Board meetings in July and August.</td>
</tr>
<tr>
<td>Enthuse and enable staff to deliver on the Institute’s objectives, ensuring that every member of staff has a clear set of personal objectives, a personal development plan and an annual appraisal.</td>
<td>All staff have clear objectives supported by personal development plans Staff are fully briefed on the strategy to manage the changes needed to reshape NICE as a consequence of the reduction of Department of Health Grant-in-Aid funding Current global job satisfaction index in the annual staff survey is maintained or</td>
<td>Arrangements are in place for all staff to have objectives and an annual appraisal. Briefings at Institute and team level have taken place on the changes associated with the Institute’s business plan and the savings programme. The latest global satisfaction index (percentage of staff who think that NICE is a good, very good or excellent place</td>
</tr>
<tr>
<td>Objective</td>
<td>Actions</td>
<td>Update</td>
</tr>
<tr>
<td>---------------------------------------------------------------------------</td>
<td>---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Develop an approach to succession planning and attracting and retaining talent and recruiting appropriately skilled staff to key posts, including achieving the specified 2.3% of apprenticeships</td>
<td>As an addition to the workforce strategy, develop a proposal for the Board which defines succession planning as it should apply to NICE, together with a set of actions to deliver on its objectives Secure compliance with the target for apprentices by July 2016</td>
<td>We are now fully engaged with the Department of Health and Arm’s Length Body-wide arrangements for talent management. At the Board’s request, a review is underway of the arrangements for securing leadership continuity in the Institute’s centres and directorates. The outcome of this will be reported to the Board in September. We currently have 8 apprentices against a target of 15, which we are confident will all be employed by the end of the financial year.</td>
</tr>
</tbody>
</table>
## Appendix 2: Extracts from the Directors’ reports

<table>
<thead>
<tr>
<th>Director</th>
<th>Featured section</th>
<th>Section/para</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health and social care</td>
<td>The internal Social Care Forum continues to provide oversight of the action plan for social care engagement. Progress from the plan includes development of a ‘Quick reference Guide’ to better support those working in social care. This output will be based on relevant Quality Standards and guidance and will be produced with the Social Care Institute for Excellence (SCIE). A product specification is in the final stages of development and a project group is being established to oversee delivery.</td>
<td>14</td>
</tr>
<tr>
<td>Guidelines</td>
<td>We continue to attract interest from students and researchers seeking short-term placements to gain experience in clinical guideline development. We are a partner organisation of the EU-funded project ‘Methods in Research on Research (MIROR)’ as part of which we will be hosting two PhD students for short term placements in 2018. A member of staff joined interview panels in May 2016 for two studentship awards under this scheme. We have also agreed with the European Respiratory Society to host, with the Cochrane Collaboration, 2 research fellows for 3 month placements in 2016. They will pursue a guideline-related research project of their choosing while being exposed to as many NICE activities as possible.</td>
<td>33</td>
</tr>
<tr>
<td>Technology evaluation</td>
<td>Based on the current schedule and projections for incoming requests, NICE Scientific Advice anticipates recovery of all programme costs and to fully contribute to the Institute’s overhead costs. Since April, the team has worked on 19 advice projects, hosted 3 educational seminars and participated in 8 external events, with a further 12 projects scheduled to start later in 2016/17. NICE Scientific Advice continues to work closely with NICE Digital Services in the development of the Medtech Early Technical Assessment (META) Tool and will be initiating the next phase of testing in July and August.</td>
<td>7</td>
</tr>
<tr>
<td>Evidence resources</td>
<td>Return on Investment (ROI) Tools: these tools, which help commissioners and policy makers in local authorities and the NHS make better investment decisions, have now completed development. Each tool enables the user to evaluate a portfolio of interventions in their geographical area and models the economic returns that can be expected in different payback timescales. The RoI tools will go live on our website later in</td>
<td>6</td>
</tr>
<tr>
<td>Section/para</td>
<td>Communications</td>
<td>Finance and workforce</td>
</tr>
<tr>
<td>--------------</td>
<td>----------------</td>
<td>----------------------</td>
</tr>
<tr>
<td>7 and 8</td>
<td>July, following a Digital Standards Service Assessment by the Department of Health.</td>
<td>There has been much recent editorial activity to support the changes in technology appraisals, including the appraisals of the cancer drug fund topics and the consultation on the abbreviated technology appraisal process. We have finalised shorter ACD and FAD templates and discussed ways to make the discussion sections of ACDs and FADs shorter and easier to write and read. Road testing of the new guideline template is complete and we are working with the guidelines team to schedule its introduction for forthcoming topics.</td>
</tr>
<tr>
<td></td>
<td>Section/para: 13 and 14</td>
<td>There are currently 42wte vacant posts in a budgeted establishment of 669wte, which equates to 6.3% of the total budgeted workforce. This does not include vacancies arising from new but unconfirmed work streams such as Commissioning Support Documents. This is a decrease of 4wte compared to the figure reported at year end. It should also be noted that over half these vacancies are currently being actively recruited to with the remainder under review as part of the 2020 savings programme. Recruitment, unless by exception, is internal only. As such the level of under spend due to vacancies is expected to level off. In addition to vacancies due to the normal turnover of staff, there are vacant posts relating to new work programmes (for example the Cancer Drugs Fund). As at 30 June there were also a number of vacant posts in the Evidence Resources directorate due to the ongoing management of change.</td>
</tr>
</tbody>
</table>
### Appendix 3: Guidance development: variation against plan April - June 2016

<table>
<thead>
<tr>
<th>Programme</th>
<th>Delayed Topic</th>
<th>Reason for variation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical Guidelines</td>
<td>No variation against plan 2016-17</td>
<td></td>
</tr>
<tr>
<td>Interventional procedures</td>
<td>No variation against plan 2016-17</td>
<td></td>
</tr>
<tr>
<td>Medical technologies</td>
<td>No variation against plan 2016-17</td>
<td></td>
</tr>
<tr>
<td>Public Health</td>
<td>No variation against plan 2016-17</td>
<td></td>
</tr>
<tr>
<td>Quality Standards</td>
<td>2 topics delayed</td>
<td>Obesity: clinical assessment and management (adults) - Extra development time required to resolve issue with specialist committee members. Publication now expected in July 2016 (Q2 2016-17).</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Obesity: clinical assessment and management (children and young people) - Extra development time required to resolve issue with specialist committee members. Publication now expected in July 2016 (Q2 2016-17).</td>
</tr>
<tr>
<td>Diagnostics</td>
<td>No variation against plan 2016-17</td>
<td></td>
</tr>
<tr>
<td>Technology Appraisals</td>
<td>No variation against plan 2016-17</td>
<td></td>
</tr>
<tr>
<td>Highly Specialised Technologies (HST)</td>
<td>No variation against plan 2016-17</td>
<td></td>
</tr>
</tbody>
</table>
### Appendix 4: Guidance published since the last Board meeting in May

<table>
<thead>
<tr>
<th>Programme</th>
<th>Topic</th>
<th>Recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Clinical Guidelines</strong></td>
<td>Routine preoperative tests for elective surgery</td>
<td>General guidance</td>
</tr>
<tr>
<td></td>
<td>Haematological cancers: improving outcomes</td>
<td>General guidance</td>
</tr>
<tr>
<td></td>
<td>Neonatal jaundice (standing committee update)</td>
<td>General guidance</td>
</tr>
<tr>
<td></td>
<td>Crohn's disease (standing committee update)</td>
<td>General guidance</td>
</tr>
<tr>
<td></td>
<td>Psychosis in children and young people (standing committee update)</td>
<td>General guidance</td>
</tr>
<tr>
<td><strong>Interventional procedures</strong></td>
<td>Percutaneous transforaminal endoscopic lumbar discectomy for sciatica</td>
<td>Standard arrangements</td>
</tr>
<tr>
<td></td>
<td>Percutaneous interlaminar endoscopic lumbar discectomy for sciatica</td>
<td>Standard arrangements</td>
</tr>
<tr>
<td></td>
<td>Balloon pulmonary angioplasty for chronic thromboembolic pulmonary</td>
<td>Standard arrangements</td>
</tr>
<tr>
<td></td>
<td>hypertension</td>
<td>- Pulmonary endarterectomy unsuitable</td>
</tr>
<tr>
<td></td>
<td>Microwave ablation for treating liver metastases</td>
<td>Standard arrangements</td>
</tr>
<tr>
<td></td>
<td>Transcutaneous electrical stimulation of the supraorbital nerve for</td>
<td>Special arrangements</td>
</tr>
<tr>
<td></td>
<td>treating and preventing migraine</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Biodegradable subacromial spacer insertion for rotator cuff tears</td>
<td>Context of research</td>
</tr>
<tr>
<td></td>
<td>Endovenous mechanochemical ablation for varicose veins</td>
<td>Standard arrangements</td>
</tr>
<tr>
<td></td>
<td>Microstructural scaffold (patch) insertion without autologous cell</td>
<td>Special arrangements</td>
</tr>
<tr>
<td></td>
<td>implantation for repairing symptomatic chondral knee defects</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Transcervical extracorporeal reverse flow neuroprotection for</td>
<td>Standard arrangements</td>
</tr>
<tr>
<td></td>
<td>reducing the risk of stroke during carotid artery stenting</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Ultrasound-guided percutaneous radiofrequency ablation for benign</td>
<td>Standard arrangements</td>
</tr>
<tr>
<td></td>
<td>thyroid nodules</td>
<td></td>
</tr>
<tr>
<td>Medical technologies</td>
<td>GreenLight XPS for treating benign prostatic hyperplasia</td>
<td>Case for adoption is partially supported</td>
</tr>
<tr>
<td>----------------------</td>
<td>--------------------------------------------------------</td>
<td>------------------------------------------</td>
</tr>
<tr>
<td>Diagnostics</td>
<td>ImmunoCAP ISAC 112 and Microtest for multiplex allergen testing</td>
<td>Research only</td>
</tr>
</tbody>
</table>
|                      | PIGF-based testing to help diagnose suspected pre-eclampsia (Triage PIGF test, Elecsys immunoassay sFlt-1/PIGF ratio, DELFIA Xpress PIGF 1-2-3 test, and BRAHMS sFlt-1 Kryptor/BRAHMS PIGF plus Kryptor PE ratio) | Recommended - Triage PIGF test  
Recommended - Elecsys immunoassay sFlt-1/PIGF ratio  
Research only - DELFIA Xpress PIGF 1-2-3 test  
Research only - BRAHMS sFLt-1 Kryptor/BRAHMS PIGF pluc Kryptor PE ratio |
<p>| Public Health        | None planned | |
| Quality Standards    | Antimicrobial stewardship | Sentinal markers of good practice |
|                      | Breast cancer (update) | Sentinal markers of good practice |
|                      | Stroke in adults (update) | Sentinal markers of good practice |
|                      | Bronchiolitis in children | Sentinal markers of good practice |
|                      | Home care for older people | Sentinal markers of good practice |
|                      | Antenatal care (update) | Sentinal markers of good practice |</p>
<table>
<thead>
<tr>
<th>Technology Appraisals</th>
<th>Adalimumab for treating moderate to severe hidradenitis suppurativa</th>
<th>Recommended</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Alirocumab for treating primary hypercholesterolaemia and mixed dyslipidaemia</td>
<td>Optimised</td>
</tr>
<tr>
<td></td>
<td>Evolocumab for treating primary hypercholesterolaemia and mixed dyslipidaemia</td>
<td>Optimised</td>
</tr>
<tr>
<td></td>
<td>Ceritinib for previously treated anaplastic lymphoma kinase positive non-small-cell lung cancer</td>
<td>Recommended</td>
</tr>
<tr>
<td></td>
<td>Trametinib in combination with dabrafenib for treating unresectable or metastatic melanoma</td>
<td>Recommended</td>
</tr>
<tr>
<td></td>
<td>Belimumab for treating active autoantibody-positive systemic lupus erythematosus</td>
<td>Recommended</td>
</tr>
<tr>
<td></td>
<td>Canagliflozin, dapagliflozin and empagliflozin as monotherapies for treating type 2 diabetes</td>
<td>Recommended</td>
</tr>
<tr>
<td></td>
<td>Cabazitaxel for hormone-relapsed metastatic prostate cancer treated with docetaxel</td>
<td>Recommended</td>
</tr>
<tr>
<td></td>
<td>Abiraterone for treating metastatic hormone-relapsed prostate cancer before chemotherapy is indicated</td>
<td>Recommended</td>
</tr>
<tr>
<td></td>
<td>Sacubitril valsartan for treating symptomatic chronic heart failure with reduced ejection fraction</td>
<td>Optimised</td>
</tr>
<tr>
<td></td>
<td>Topotecan, pegylated liposomal doxorubicin hydrochloride, paclitaxel, trabectedin and gemcitabine for treating recurrent ovarian cancer</td>
<td>Three recommended; three not recommended</td>
</tr>
<tr>
<td>Highly Specialised Technologies (HST)</td>
<td>None planned</td>
<td></td>
</tr>
<tr>
<td>Evidence summaries – new medicines</td>
<td>Complicated urinary tract infections: ceftolozane/tazobactam</td>
<td>Summary of best available evidence</td>
</tr>
<tr>
<td></td>
<td>Complicated intra-abdominal infections: ceftolozane/tazobactam</td>
<td>Summary of best available evidence</td>
</tr>
<tr>
<td></td>
<td>Visual impairment due to myopic choroidal neovascularisation: aflibercept</td>
<td>Summary of best available evidence</td>
</tr>
<tr>
<td>Evidence summaries – unlicensed/off label medicines</td>
<td>None planned</td>
<td></td>
</tr>
<tr>
<td>Medtech Innovation Briefings (MIB)</td>
<td>S-Cath System for suprapubic catheterisation</td>
<td></td>
</tr>
<tr>
<td></td>
<td>CareLink network service for remote monitoring of people with cardiac devices</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Prolaris gene expression assay for assessing long-term risk of prostate cancer progression</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Secca System for faecal incontinence</td>
<td></td>
</tr>
<tr>
<td></td>
<td>LATITUDE NXT Patient Management System for monitoring cardiac devices at home</td>
<td></td>
</tr>
<tr>
<td>Evidence Surveillance Reviews</td>
<td>Stable angina: management</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Chronic obstructive pulmonary disease in over 16s: diagnosis and management</td>
<td></td>
</tr>
<tr>
<td>Quality and Productivity case studies</td>
<td>Cardiovascular disease: integrated care pilot to improve patient outcomes closer to home</td>
<td></td>
</tr>
<tr>
<td>Cochrane case studies</td>
<td>Abdominal drainage versus no drainage post-gastrectomy for gastric cancer</td>
<td>Not recommended</td>
</tr>
</tbody>
</table>
This report gives details of the financial and workforce position as at 30 June 2016 and the forecast outturn for 2016-17.

The Board is asked to review the report.

Ben Bennett
Director, Business Planning and Resources
July 2016
Summary

1. Table 1 summarises the financial position as at 30 June 2016. There is a full analysis in Appendix A.

<table>
<thead>
<tr>
<th></th>
<th>Year to date</th>
<th>Estimated Outturn</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Budget £m</td>
<td>Expenditure £m</td>
</tr>
<tr>
<td>Guidance &amp; Advice</td>
<td>13.4</td>
<td>13.1</td>
</tr>
<tr>
<td>Corporate</td>
<td>3.2</td>
<td>3.3</td>
</tr>
<tr>
<td>Income</td>
<td>(2.8)</td>
<td>0.0</td>
</tr>
<tr>
<td>Reserves</td>
<td>0.5</td>
<td>0.0</td>
</tr>
<tr>
<td>Net Operational Total</td>
<td>14.3</td>
<td>16.4</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Year to date</th>
<th>Estimated Outturn</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Budget £m</td>
<td>Expenditure £m</td>
</tr>
<tr>
<td>NICE International</td>
<td>0.0</td>
<td>1.2</td>
</tr>
<tr>
<td>Scientific Advice</td>
<td>(0.1)</td>
<td>0.2</td>
</tr>
<tr>
<td>NICE Total</td>
<td>14.3</td>
<td>17.9</td>
</tr>
</tbody>
</table>

Table 1: Financial Position at 30 June 2016

2. The current position shows a total under spend of £0.7m (5.2%) for the first three months of 2016-17. The net operational total, which excludes NICE International and Scientific Advice, shows an under spend of £0.8m (5.5%). This is attributable to vacant posts (42wte / 6.3% of the workforce) and small under spends on the non-pay budget.

3. The full year forecast outturn is a £1.8m (3.1%) under spend against the revenue resource limit. The reasons for material variances are detailed in this report.

4. Work is progressing across the whole organisation to manage the 30% reduction in our Department of Health grant funding by 2019-20. Plans are in place for this to be achieved.

5. Progress on the implementation of the workforce strategy is detailed in Appendix B.
Financial Position as at 30 June 2016

6. Appendix A shows that net operational expenditure for the first three months of 2016-17 was £13.5m. This was a £0.8m (5.5%) under spend against budget. This is partly attributable to vacant posts resulting in lower pay costs (£0.4m).

7. NHS England fund a number of work programmes at NICE resulting in funding in excess of £5.0m for 2016-17. This currently consists of funding for Medical Innovation Briefings (£0.5m), the Observational Data Unit (£0.6m), Mental Health Access and Waiting Times Standards (£1.5m) and the Cancer Drugs Fund (£2.9m). Income and expenditure are in line with expectations for MIBs, ODU and Access and Waiting Times showing break-even positions for these work programmes.

8. The Cancer Drugs Fund is showing a year to date under spend of £0.4m, of which £0.3m relates to slippage on pay and £0.1m relates to under spends against the contract with the National Institute for Health Research (NIHR) for additional technology assessment reviews. This under spend on Cancer Drugs Fund activity means less funding will be required from NHS England for 2016-17, causing an adverse year-to-date variance of £0.4m against the Income budget.

9. After setting aside the variances within the Cancer Drugs Fund detailed above this leaves an under spend of £0.5m against pay, £0.27m against non-pay and additional income of £0.08m.

10. There is more detail on expenditure, income and reserves later in this report.

Pay

11. Net operational pay expenditure for the first three months of 2016-17 was £8.3m, which was £0.7m (7.9%) under spent against budget. Of this, £0.3m is currently allocated to pay reserves as part of the vacancy pay slippage exercise completed at the start of the year. The Cancer Drugs Fund is showing pay under spends of £0.3m. There were 30 new posts added to the budget for 2016-17 with 10 still to be filled.

12. As at 30 June 2016 there were 604 whole time equivalent (wte) substantive employees on payroll, plus 22 agency and contractor staff in post.

13. There are currently 42wte vacant posts in a budgeted establishment of 669wte, which equates to 6.3% of the total budgeted workforce. This does not include vacancies arising from new but unconfirmed work streams such as Commissioning Support Documents. This is a decrease of 4wte compared to the figure reported at year end. It should also be noted that over half these vacancies are currently being actively recruited to with the remainder under review as part
of the 2020 savings programme. Recruitment, unless by exception, is internal only. As such the level of under spend due to vacancies is expected to level off.

14. In addition to vacancies due to the normal turnover of staff, there are vacant posts relating to new work programmes (for example the Cancer Drugs Fund). As at 30 June there were also a number of vacant posts in the Evidence Resources directorate due to the ongoing management of change.

Non-Pay expenditure

15. Net operational non pay expenditure in the first three months of 2016-17 was £8.1m, which was an under spend of £0.4m (4.9%) against budget.

16. Most sub-categories of non-pay are close to break-even, with the exceptions being under spends arising from the knock-on effect of vacancies and committee costs. Notable examples are lower than budgeted travel, subsistence and programme support costs (£0.1m under spent against a budget of £0.8m). The remainder relates to an under spend against the contract with the National Institute for Health Research (£0.1m) mentioned above.

17. We have also received two refunds relating to unspent monies on 2015-16 slots with the National Collaborating Centres (Royal College of Psychiatrists and Royal College of Physicians), which has been allocated to non-pay reserves (£0.2m).

Other operating income

18. Other operating income is showing a deficit of £0.3m for the first three months of the year. Setting aside funding for the Cancer Drugs fund, other income is showing as £0.1m greater than expected. This is due to unbudgeted income for the Office for Market Access, as their drive towards being self-funding continues, and the IMI GetReal project.

Forecast outturn

19. The net operational forecast under spend for 2016-17 is £1.7m (2.9%). Of this, £1.1m relates to pay and the vacancies across the Institute noted above. At the start of the year any anticipated pay slippage is moved centrally to reserves and a part year effect pay budget is allocated to teams. This forecast makes assumptions about the likely dates posts will be recruited to, but if there is any slippage in these timescales, or teams recruit from elsewhere within the institute (therefore creating a knock-on vacancy), an under spend within the team’s pay budget arises.
20. Non-pay is expected to under spend by £1.0m by the end of the year. Of this,

- The Centre for Health Technology Evaluation are expected to under spend by £0.4m on non-pay, against a budget of £5.1m. The main reasons for this are for the NIHR element of CDF funding (£0.3m) as well as an under spend against the RSU contract in SP&R (£0.1m), although this latter under spend is being used for additional temporary staffing in 2016-17.

- The Centre for Clinical Practice is forecast to under spend due to lower than budgeted costs for committees (£0.1m), mainly in the Internal Updates team.

- The Communications and Business Planning and Resources directorates are forecasting an under spend of £0.1m per team. The Communications directorate under spend is due to reduced spend on external communications and market research, whilst the Business Planning and Resources under spend is mainly due to unutilised course fee budgets held by HR and computer software licences purchased by IT.

- The remaining under spend on non-pay is due to unutilised reserves of £0.3m.

21. A full year income deficit of £0.4m is forecast due to less income than originally budgeted for the Cancer Drugs Fund programme of work as explained above (£0.6m). This deficit is offset by additional income forecast for BNF print recharges to the developed administrations as well as ad-hoc additional income for grants and travel / speaker fee reimbursements.

22. The forecast assumes that £1.0m of reserves will be utilised in order to meet liabilities arising relating to uncertainties around ongoing restructures and other non-recurrent costs associated with organisational change consultations.

23. NICE International currently has a £51k deficit in 2016/17 due to business development and other non-chargeable costs incurred during quarter 1. It is expected this level of deficit will be retained for the rest of the financial year. An accumulated reserve of £386,000 has been carried over from previous financial years.

24. Scientific Advice is currently forecast to generate a surplus of £105,000 in 2016-17 as well as carrying an accumulated reserve of £232,000 from previous financial years.

25. The Board is reminded that under the particular financial framework that NICE operates within it is not permissible to exceed the revenue resource limit in any year under any circumstances. This is therefore a risk that has to be very cautiously managed and this is done by maintaining some contingency in the projected year end position.
26. Work on the NICE 2020 project is ongoing. Overall the project is risk rated “green”. A brief update on 2020 work is as follows.

27. Table 2 below details the projected variance with the savings achieved to date and the expected variance according to the savings plan. The top part of the table shows the savings we have already achieved against the projected deficit. These savings are built into our current budget and will result in a planned under spend in the current year of £1m. This will provide some contingency. Without further savings our projected deficit in 2017-18 is £2.9m growing to £11.9m by 2020. The lower part of the table profiles our current savings plan against the projected deficit. It shows that we expect to reach a balanced position by 2019-20 while maintaining some headroom in the preceding financial years.

<table>
<thead>
<tr>
<th>Savings achieved to date</th>
<th>2016-17</th>
<th>2017-18</th>
<th>2018-19</th>
<th>2019-20</th>
</tr>
</thead>
<tbody>
<tr>
<td>Projected cumulative deficit</td>
<td>-0.2</td>
<td>-4.4</td>
<td>-7.9</td>
<td>-14.0</td>
</tr>
<tr>
<td>Cumulative savings achieved</td>
<td>1.2</td>
<td>1.5</td>
<td>1.7</td>
<td>2.1</td>
</tr>
<tr>
<td>Projected budget variance</td>
<td>1.0</td>
<td>-2.9</td>
<td>-6.2</td>
<td>-11.9</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Planned savings</th>
<th>2016-17</th>
<th>2017-18</th>
<th>2018-19</th>
<th>2019-20</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cumulative budget variance - July 2018</td>
<td>1.0</td>
<td>-2.9</td>
<td>-6.2</td>
<td>-11.9</td>
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<tr>
<td>Cumulative planned savings</td>
<td>4.2</td>
<td>6.6</td>
<td>11.9</td>
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</tr>
<tr>
<td>Expected budget variance</td>
<td>1.0</td>
<td>1.4</td>
<td>3.4</td>
<td>0.0</td>
</tr>
</tbody>
</table>

Table 2: Savings achieved and planned

28. On the 1 July 2016, a number of changes were implemented within the Centre for Clinical Practice and the Health and Social Care Directorate, to better align functions within directorates. The main changes involved the Medicines Prescribing Programme moving to the Health and Social Care Directorate and the Public Health and Social Care Guidance teams moving into the Centre for Clinical Practice (to be rebranded as the NICE Centre for Guidelines). However, there will be no change in team functions as a result of the moves. These changes to directorate structures will be reflected in the next report.

29. Two Management of Change processes are currently underway within Evidence Resources. These restructures are expected to yield savings in the region of £0.5m and bring a headcount reduction of c10wte. A further three Management of Change processes are scheduled for later in 2016-17 within Centre for Guidelines, Health and Social Care and Communications. These restructures are
expected to yield savings in the region of £1.8m and bring a headcount reduction of c38wte.

30. The planned headcount reductions will not result in the equivalent number of redundancies as vacancies will contribute to the savings total and staff will be offered redeployment opportunities where available.

31. There are several income streams expected to contribute to the reducing grant in aid budget. These include:

- Technology Appraisals cost recovery. This is currently rated overall amber. Work is underway and charging expected to begin towards the end on 2017-18.
- New work streams such as the Cancer Drugs Fund and Commissioning Support Documents.
- Science Policy and research grant income.
- Commercial income exploration.

32. There are a number of other work streams at various stages of completion including the CHTE 2020 review; reduction and merger of National Collaborating Centres; Evidence resources non pay and contractor reductions and a review of the services provided by the Editorial and Publishing team.

33. Strategically the 2020 projects are rated “green” with some projects rated amber. There are three risk areas within the projects currently rated red as follows:

- In relation to Technology Appraisal cost recovery. The volatility of volumes of TAs and HSTs, i.e. difficulty of ensuring a steady income stream. Mitigation for this is to ensure cost estimates are accurate.
- In relation to the accelerated access review. An increase in outputs may be requested in absence of any additional funding. Mitigation is that funding sources need to be identified either from increased income or reprioritisation of outputs.
- Up to £135k of Evidence Resources non pay savings are at risk due to a change to HMRC interpretation in relation to VAT. This is being appealed against.

Better Payment Practice Code

34. As a public sector organisation NICE is required to pay all non-NHS trade creditors in accordance with the Better Payment Practice Code. The target is to pay 95% of all valid invoices by the due date or within 30 days of receipt of the
goods, whichever is the later. NICE’s performance against this code is shown in table 2 below.

35. Annually NICE pays 96% of its invoices to Non NHS Suppliers and 4% to NHS Bodies. Payments to Non NHS Suppliers are twice weekly by BACs and to NHS Bodies twice monthly.

36. There has been an improvement in the payment of Non NHS invoices within 30 days by both number and value of 0.6% and 3.6% respectively in Quarter 1 compared to the end of the last financial year with continued improvement anticipated.

37. A daily report of ‘Invoices at Risk of Failure’ is now utilised to reduce the risk of late payments and increased efforts are being made across the team to speed up the approval process, this includes communicating with budget holders about the impact of delaying invoice approvals.

<table>
<thead>
<tr>
<th>Table 3: BPPC - 2016/17</th>
<th>Number</th>
<th>£000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total non-NHS bills paid 2016/17</td>
<td>832</td>
<td>7,327</td>
</tr>
<tr>
<td>Total non-NHS bills paid within target</td>
<td>767</td>
<td>6,914</td>
</tr>
<tr>
<td>Percentage of non-NHS bills paid within target</td>
<td>92.2%</td>
<td>94.4%</td>
</tr>
<tr>
<td>Total NHS bills paid 2016/17</td>
<td>24</td>
<td>86</td>
</tr>
<tr>
<td>Total NHS bills paid within target</td>
<td>18</td>
<td>82</td>
</tr>
<tr>
<td>Percentage of NHS bills paid within target</td>
<td>75.0%</td>
<td>95.3%</td>
</tr>
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</table>
## Appendix A – Summary of financial position as at 30 June 2016

### Comparison of budget with expenditure and year end projection - 30th June 2016

<table>
<thead>
<tr>
<th>Centre / Directorate</th>
<th>Budget £000s</th>
<th>Year to Date Expenditure £000s</th>
<th>Variance £000s</th>
<th>Variance %</th>
<th>Budget £000s</th>
<th>Estimated Outturn £000s</th>
<th>Variance £000s</th>
<th>Variance %</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Centre for Clinical Practice</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pay</td>
<td>1,355</td>
<td>1,392</td>
<td>37</td>
<td>2.7%</td>
<td>5,532</td>
<td>5,603</td>
<td>71</td>
<td>1.3%</td>
</tr>
<tr>
<td>Non pay</td>
<td>2,644</td>
<td>2,592</td>
<td>(52)</td>
<td>(2.0%)</td>
<td>11,785</td>
<td>11,703</td>
<td>(82)</td>
<td>(0.7%)</td>
</tr>
<tr>
<td>Income</td>
<td>(176)</td>
<td>(184)</td>
<td>(8)</td>
<td>(4.4%)</td>
<td>(654)</td>
<td>(751)</td>
<td>(97)</td>
<td>(14.8%)</td>
</tr>
<tr>
<td>Total</td>
<td>3,823</td>
<td>3,800</td>
<td>(22)</td>
<td>(0.6%)</td>
<td>16,663</td>
<td>16,555</td>
<td>(108)</td>
<td>(0.7%)</td>
</tr>
<tr>
<td><strong>Centre for Health Technology Evaluation</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pay</td>
<td>2,009</td>
<td>1,693</td>
<td>(316)</td>
<td>(15.7%)</td>
<td>8,503</td>
<td>7,999</td>
<td>(504)</td>
<td>(5.9%)</td>
</tr>
<tr>
<td>Non pay</td>
<td>1,377</td>
<td>1,221</td>
<td>(156)</td>
<td>(11.3%)</td>
<td>5,508</td>
<td>5,099</td>
<td>(409)</td>
<td>(7.4%)</td>
</tr>
<tr>
<td>Income</td>
<td>(76)</td>
<td>(119)</td>
<td>(43)</td>
<td>(55.9%)</td>
<td>(470)</td>
<td>(515)</td>
<td>(45)</td>
<td>(9.6%)</td>
</tr>
<tr>
<td>Total</td>
<td>3,310</td>
<td>2,795</td>
<td>(515)</td>
<td>(15.5%)</td>
<td>13,541</td>
<td>12,583</td>
<td>(958)</td>
<td>(7.1%)</td>
</tr>
<tr>
<td><strong>Health and Social Care</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pay</td>
<td>2,234</td>
<td>2,121</td>
<td>(113)</td>
<td>(5.1%)</td>
<td>9,039</td>
<td>8,743</td>
<td>(296)</td>
<td>(3.3%)</td>
</tr>
<tr>
<td>Non pay</td>
<td>1,146</td>
<td>1,126</td>
<td>(19)</td>
<td>(1.7%)</td>
<td>4,583</td>
<td>4,555</td>
<td>(28)</td>
<td>(0.6%)</td>
</tr>
<tr>
<td>Income</td>
<td>0</td>
<td>(11)</td>
<td>--</td>
<td></td>
<td>0</td>
<td>(19)</td>
<td>(19)</td>
<td>--</td>
</tr>
<tr>
<td>Total</td>
<td>3,379</td>
<td>3,237</td>
<td>(143)</td>
<td>(4.2%)</td>
<td>13,622</td>
<td>13,279</td>
<td>(343)</td>
<td>(2.5%)</td>
</tr>
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<td></td>
</tr>
<tr>
<td>Pay</td>
<td>1,539</td>
<td>1,545</td>
<td>7</td>
<td>0.4%</td>
<td>6,213</td>
<td>6,189</td>
<td>(24)</td>
<td>(0.4%)</td>
</tr>
<tr>
<td>Non pay</td>
<td>1,391</td>
<td>1,441</td>
<td>51</td>
<td>3.6%</td>
<td>5,563</td>
<td>5,599</td>
<td>36</td>
<td>0.6%</td>
</tr>
<tr>
<td>Income</td>
<td>(8)</td>
<td>(28)</td>
<td>(21)</td>
<td>(275.3%)</td>
<td>(45)</td>
<td>(88)</td>
<td>(43)</td>
<td>(95.6%)</td>
</tr>
<tr>
<td>Total</td>
<td>2,922</td>
<td>2,958</td>
<td>37</td>
<td>1.3%</td>
<td>11,731</td>
<td>11,700</td>
<td>(31)</td>
<td>(0.3%)</td>
</tr>
<tr>
<td><strong>Subtotal Guidance and Advice</strong></td>
<td>13,434</td>
<td>12,791</td>
<td>(643)</td>
<td>(4.8%)</td>
<td>55,558</td>
<td>54,117</td>
<td>(1,441)</td>
<td>(2.6%)</td>
</tr>
<tr>
<td><strong>Communications</strong></td>
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<tr>
<td>Pay</td>
<td>911</td>
<td>926</td>
<td>15</td>
<td>1.6%</td>
<td>3,769</td>
<td>3,794</td>
<td>25</td>
<td>0.7%</td>
</tr>
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<td>Non pay</td>
<td>103</td>
<td>81</td>
<td>(21)</td>
<td>20.7%</td>
<td>390</td>
<td>324</td>
<td>(66)</td>
<td>17.0%</td>
</tr>
<tr>
<td>Total</td>
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<td>1,007</td>
<td>(6)</td>
<td>(0.6%)</td>
<td>4,159</td>
<td>4,118</td>
<td>(41)</td>
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<td><strong>Business Planning and Resources</strong></td>
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</tr>
<tr>
<td>Pay</td>
<td>656</td>
<td>627</td>
<td>(29)</td>
<td>(4.4%)</td>
<td>2,658</td>
<td>2,606</td>
<td>(52)</td>
<td>(2.0%)</td>
</tr>
<tr>
<td>Non pay</td>
<td>1,435</td>
<td>1,404</td>
<td>(30)</td>
<td>(2.1%)</td>
<td>5,803</td>
<td>5,709</td>
<td>(94)</td>
<td>(1.6%)</td>
</tr>
<tr>
<td>Income</td>
<td>(196)</td>
<td>(199)</td>
<td>(3)</td>
<td>(1.3%)</td>
<td>(785)</td>
<td>(806)</td>
<td>(22)</td>
<td>(2.7%)</td>
</tr>
<tr>
<td>Total</td>
<td>1,895</td>
<td>1,833</td>
<td>(62)</td>
<td>(3.3%)</td>
<td>7,676</td>
<td>7,569</td>
<td>(167)</td>
<td>(2.2%)</td>
</tr>
</tbody>
</table>
### Appendix A (Continued)

<table>
<thead>
<tr>
<th>Centre / Directorate</th>
<th>Budget £000s</th>
<th>Year to Date Expenditure £000s</th>
<th>Variance £000s</th>
<th>Variance %</th>
<th>Budget £000s</th>
<th>Estimated Outturn Expenditure £000s</th>
<th>Variance £000s</th>
<th>Variance %</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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<td></td>
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</tr>
<tr>
<td><strong>Income / Overheads</strong></td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Overheads</td>
<td>(11)</td>
<td>(15)</td>
<td>(4)</td>
<td>37.4%</td>
<td>(45)</td>
<td>(45)</td>
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<td>0.0%</td>
</tr>
<tr>
<td>Income</td>
<td>(2,741)</td>
<td>(2,318)</td>
<td>423</td>
<td>15.4%</td>
<td>(10,607)</td>
<td>(10,000)</td>
<td>600</td>
<td>5.7%</td>
</tr>
<tr>
<td>Total</td>
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<td>(2,334)</td>
<td>418</td>
<td>(15.2%)</td>
<td>(10,652)</td>
<td>(10,045)</td>
<td>600</td>
<td>(5.6%)</td>
</tr>
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<td></td>
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<td></td>
</tr>
<tr>
<td>Non pay</td>
<td>250</td>
<td>250</td>
<td>0</td>
<td>0.0%</td>
<td>1,000</td>
<td>1,000</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td>Total</td>
<td>250</td>
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<td>0</td>
<td>0.0%</td>
<td>1,000</td>
<td>1,000</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td><strong>Reserves</strong></td>
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<td></td>
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<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Pay</td>
<td>316</td>
<td>0</td>
<td>(316)</td>
<td>(100.0%)</td>
<td>330</td>
<td>(330)</td>
<td>(100.0%)</td>
<td>(24.0%)</td>
</tr>
<tr>
<td>Non pay</td>
<td>183</td>
<td>0</td>
<td>(183)</td>
<td>(100.0%)</td>
<td>1,316</td>
<td>1,000</td>
<td>(316)</td>
<td>(24.0%)</td>
</tr>
<tr>
<td>Total</td>
<td>499</td>
<td>0</td>
<td>(499)</td>
<td>(100.0%)</td>
<td>1,646</td>
<td>1,000</td>
<td>(646)</td>
<td>(39.3%)</td>
</tr>
<tr>
<td><strong>NICE Operational Total</strong></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pay</td>
<td>9,019</td>
<td>8,305</td>
<td>(715)</td>
<td>(7.9%)</td>
<td>36,044</td>
<td>34,934</td>
<td>(1,110)</td>
<td>(3.1%)</td>
</tr>
<tr>
<td>Non pay</td>
<td>8,516</td>
<td>8,101</td>
<td>(416)</td>
<td>(4.9%)</td>
<td>35,904</td>
<td>34,944</td>
<td>(960)</td>
<td>(2.7%)</td>
</tr>
<tr>
<td>Income</td>
<td>(3,197)</td>
<td>(2,858)</td>
<td>339</td>
<td>10.6%</td>
<td>(12,560)</td>
<td>(12,179)</td>
<td>375</td>
<td>3.0%</td>
</tr>
<tr>
<td>Total</td>
<td>14,339</td>
<td>13,547</td>
<td>(792)</td>
<td>(5.5%)</td>
<td>59,388</td>
<td>57,699</td>
<td>(1,695)</td>
<td>(2.9%)</td>
</tr>
<tr>
<td><strong>NICE International</strong></td>
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<td></td>
</tr>
<tr>
<td>Pay</td>
<td>215</td>
<td>171</td>
<td>(45)</td>
<td>(20.8%)</td>
<td>862</td>
<td>800</td>
<td>(62)</td>
<td>(7.2%)</td>
</tr>
<tr>
<td>Non pay</td>
<td>692</td>
<td>1,041</td>
<td>348</td>
<td>50.3%</td>
<td>2,769</td>
<td>2,800</td>
<td>31</td>
<td>1.1%</td>
</tr>
<tr>
<td>Income</td>
<td>(908)</td>
<td>(1,160)</td>
<td>(253)</td>
<td>(27.8%)</td>
<td>(3,631)</td>
<td>(3,800)</td>
<td>31</td>
<td>0.9%</td>
</tr>
<tr>
<td>Total</td>
<td>0</td>
<td>51</td>
<td>51</td>
<td>n/a</td>
<td>0</td>
<td>0</td>
<td>(0)</td>
<td>n/a</td>
</tr>
<tr>
<td><strong>Scientific Advice</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Pay</td>
<td>211</td>
<td>207</td>
<td>(3)</td>
<td>(1.5%)</td>
<td>880</td>
<td>888</td>
<td>8</td>
<td>0.9%</td>
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<tr>
<td>Non pay</td>
<td>72</td>
<td>16</td>
<td>(57)</td>
<td>(78.1%)</td>
<td>290</td>
<td>281</td>
<td>(9)</td>
<td>(3.1%)</td>
</tr>
<tr>
<td>Income</td>
<td>(352)</td>
<td>(290)</td>
<td>63</td>
<td>17.8%</td>
<td>(1,410)</td>
<td>(1,560)</td>
<td>(150)</td>
<td>(10.7%)</td>
</tr>
<tr>
<td>Total</td>
<td>(69)</td>
<td>(67)</td>
<td>3</td>
<td>n/a</td>
<td>(240)</td>
<td>(391)</td>
<td>(151)</td>
<td>n/a</td>
</tr>
<tr>
<td><strong>NICE Grand Total</strong></td>
<td>14,269</td>
<td>13,531</td>
<td>(738)</td>
<td>(5.2%)</td>
<td>59,148</td>
<td>57,308</td>
<td>(1,847)</td>
<td>(3.1%)</td>
</tr>
</tbody>
</table>
Appendix B – Workforce Strategy Update at 30 June 2016

The workforce strategy was approved at the July 2015 Board meeting. Work is continuing to progress activities in all five areas of demand that were identified, which will develop further over the coming year. The table below outlines activity that is currently underway.

### Transformational change
- **Enabling change**
- **Business and workforce planning**

Workforce Planning and Change Management guidance has now been launched and is being used across the institute. This guidance supports a revised Organisational Change Policy which is now in place.

Short learning sessions (called Bitesize Learning) have been developed for change management to help managers understand how best to manage change. These sessions have been provided at senior team meetings and in lunchtime learning sessions and are well attended. A learning model for change management has been developed and will be launched with NICE’s Learning Management System (LMS) later this year.

A process map has been developed which identifies all tasks and responsibilities in the change process has been developed and is available on the intranet.

### Resourcing
- **Recruitment**
- **Retention**
- **Innovation**

A new recruitment system (TRAC) is being introduced which automates the recruitment approval process and improves the portal between NICE and its recruitment provider NHSBSA. This should greatly improve the recruiting managers’ experience as the system is designed to be simpler to use. The system is currently being tested and is planned for implementation on 18th July 2016.

### Maximising potential
- **Leadership and management**
- **Managing performance**
- **Succession planning and talent management**

The NICE Manager core competencies have been developed and training and support is being provided to help managers assess themselves and their staff against these competencies.

We continue to invest in the DH Health Care Leaders Scheme (HCLS) and currently have one programme director on the scheme and two other senior managers are engaged in the selection process for the next cohort in the autumn of 2016. This programme is designed for senior managers aspiring to a Director role. In addition NICE has committed to funding two leadership placements on the Civil Service Leadership Scheme and three placements on the REACH Higher scheme for BAME staff.
The design stage of NICE’s new Learning Management System is complete and work is underway to populate the content before roll out to manager self-service later in the year. This system will provide managers with a resource for e-appraisal and in addition we are investigating how it can support talent management and succession planning.

A programme of work continues to implement talent management and succession planning at NICE and this is due to roll out in late summer.

**Pay and Reward**

- Total reward
- Pay review

The new ESM (Executive Senior Management) Pay Framework has been approved by DH and will be reviewed by the Remuneration Committee when it meets in September.

Non-pay benefits continue to be investigated with a view to increasing the offerings available for staff. These will be promoted in new innovative ways for employees, to improve engagement (and attraction of new staff to NICE).

**Culture**

- Engaged workforce
- Inclusive workforce
- Wellbeing at work

The staff survey for 2016 has been completed with a response rate of 78%. This is the highest response rate since 2008 (80%). A full report of findings and recommendations for actions will be submitted to the Board at its meeting in September 2016.

The mentoring scheme now has 42 register mentors and 40 mentees. The scheme has received very positive feedback and is currently being reviewed.

The Health and Wellbeing Strategy group meet regularly to continue to support employee wellbeing at work, and to meet our obligations in line with NICE Guidance.
Annual Report

The Board is asked to:

- Accept the report noting that it may be shared, along with the annual audit, with the higher level RO (the Chief Medical Officer for England).
- Approve the ‘statement of compliance’ (appendix A), confirming that the organisation, as a designated body, is in compliance with the regulations.
- Following approval, the Chief Executive is required to sign the ‘statement of compliance’ (appendix A).

Appraisal and revalidation policy

The Board is asked to:

- Approve the Medical Appraisal and Revalidation Policy

Professor Gillian Leng
Deputy Chief Executive and Director, Health and Social Care Directorate
July 2016
Executive summary

1. The NICE Board is required to receive annual assurance that revalidation is being properly implemented in line with policy and relevant guidance. This is the third annual report to be presented to the board and relates to the appraisal cycle for 1st April 2015 – 31st March 2016.

2. Since the last annual board report for 2014-2015, processes and protocols for the management of medical appraisal and revalidation recommendations have been implemented. The web based system used for medical appraisal at NICE has been replaced by a simpler appraisal form, following user feedback.

3. A peer review of NICE’s systems for medical appraisal and revalidation was completed in April 2016.

4. The table below summarises activity for the 2015-2016 appraisal cycle.

| Registered medical practitioners with a prescribed connection with NICE | 6 |
| Medical appraisals completed | 5 |
| Medical appraisals outstanding | 1 |
| Number of registered medical practitioners that were due to revalidate in 2015 – 2016 | 2 |
| Revalidation recommendations made | 2 |

Table 1: Revalidation activity 1st April 2015 – 31st March 2016

5. All annual medical appraisals were completed on time for the 2015-2016 appraisal cycle with the exception of one appraisal, which was delayed due to extended leave.

6. Positive feedback was received from appraisees and appraisers on the NICE appraisal systems and processes for the 2015-2016 period.

7. All revalidation recommendations for the 2015-2016 cycle were positive and made on time.
8. The Board is advised that NICE remains compliant with its own policy, national
guidance and the quality assurance requirements for revalidation and can
respond positively to all the statements detailed in the document Annex E -
Statement of Compliance, attached as Appendix A.

9. NICE made a number of preparations for Nurse and Midwife revalidation ahead
of it going live on 1st April 2016 and has explained the levels of support that it
will offer to registered nurses and midwives at NICE that are seeking
revalidation.

10. NICE continues to monitor developments in relation to the revalidation of other
professional health and social care groups, such as pharmacists.

Purpose of the report

11. The purpose of this report is to provide the required assurance to the Board
that NICE has policies, systems and processes in place that support the
appraisal and revalidation of its registered medical practitioners and that these
policies, systems and processes are subject to regular monitoring, evaluation
and quality assurance.

12. The report responds to the requirements in the Statement of Compliance
(Appendix A) to be submitted to the Department of Health.

Background

13. Medical Revalidation was launched in December 2012 to strengthen the way
that registered medical practitioners are regulated, with the aim of improving
the quality of care provided to patients, improving patient safety and increasing
public trust and confidence in the medical system.

14. All licensed doctors are required to demonstrate, every 5 years, that they are
up to date and fit to practise. This is demonstrated through participation in
annual medical appraisal, based on the GMC’s core guidance for doctors,
Good Medical Practice.

15. Revalidation recommendations at the end of each 5 year cycle are made to the
GMC by the NICE Responsible Officer.

16. As a designated body NICE has a statutory duty to support its Responsible
Officer in discharging her duties under The Medical Profession (Responsible
Governance Arrangements

17. Professor Gillian Leng was appointed as the Responsible Officer (RO) for NICE in 2012 and has attended all of the training required to operate in the role. Professor Leng oversees the design and implementation of NICE’s policies and processes relating to revalidation.

18. NICE also has a Deputy RO and Appraisal Lead, Dr Judith Richardson. The Deputy RO is supported by the Revalidation Advisor, Jeremy Shaw.

19. The revalidation committee and the revalidation management group meet on an alternating bi-monthly basis. The revalidation management group comprises of the RO, Deputy RO, Associate Director of HR, Revalidation Advisor, and the Nurse and Midwife Revalidation lead. The revalidation committee is comprised of the management group plus a non-executive board member. Dr Maggie Halliwell was the non-executive board member of the revalidation committee until November 2015, when she was replaced by Professor Finbarr Martin, who is the current non-executive board member.

20. The medical appraisal and revalidation policy is compliant with national guidance. The policy is supported by a Medical Appraisal and Revalidation guidance document, which was published in December 2014.

21. A protocol and process for the review of appraisal portfolios, revalidation recommendations and medical appraisal scheduling were agreed by the revalidation committee in the 2014-2015 appraisal cycle and are now in use.

22. Appraisal scheduling, planning and monitoring is managed by the Revalidation Advisor, who is notified by Human Resources of new employees subject to revalidation that will have a prescribed connection with NICE.

23. Progress is reported via a summary data table to the revalidation committee and management meetings, with greater detail provided when requested. Any day-to-day issues that arise are escalated to the Deputy RO where appropriate.

24. The Annual Organisational Audit (AOA) form, which collects data from organisations on their governance arrangements and activity for revalidation, was completed and returned to NHS England on the 20th May 2016, ahead of the deadline of 31st May 2016.

Medical Appraisal

Performance Data

25. Six doctors currently have a prescribed connection to NICE. Five doctors completed an annual medical appraisal with a trained appraiser at NICE for the
2015-2016 cycle. One doctor started their employment at NICE in November 2015 and completed an annual medical appraisal at their previous designated body. One doctor completed their appraisal at NICE, then moved to a new role outside of NICE and was transferred to a new designated body.

26. One doctor did not complete an annual appraisal for the 2015-2016 cycle due to an extended period of special leave. The doctor will complete an appraisal as soon as possible on their return.

27. There are no doctors with a prescribed connection to NICE that are undergoing remediation or disciplinary procedures.

**Appraisers**

28. Three medical appraisers led appraisals for the 2015-2016 appraisal cycle. All appraisers are registered medical practitioners that have completed core appraiser training modules. The appraisers all meet the core competencies of the NICE role description for Medical Appraisers, which is based on guidance from the NHS England document ‘Quality Assurance of Medical Appraisers’.

29. One appraiser relinquished their licence to practise and was asked to step down from the appraiser role, in line with the NICE Medical Appraisal and Revalidation Policy. The policy requires medical appraisers to hold a licence to practice. The appraiser was replaced by a doctor that joined NICE in November 2015. The doctor is an experienced medical appraiser and successfully completed appropriate medical appraisal training with their previous employer. The doctor meets the NICE job specification for medical appraisers.

30. Further appraisal training and workshops are available to appraisers. Appraisers are also encouraged to participate in relevant CPD activities that support their role as a medical appraiser. Appraisers also complete a self-assessment to identify any areas where they may have a specific training requirement.

**Quality Assurance**

31. The quality assurance of the appraisal process is managed by the deputy RO and assisted by the Revalidation Advisor.

32. The quality assurance processes are detailed in the medical appraisal and revalidation policy and include the review of appraisal inputs and outputs, and the assessment of appraiser performance. The performance of the appraisal system is also monitored through the use of appraisee feedback forms.
33. A Peer review of medical appraisal and revalidation systems was completed in April 2016, following the closure of the 2015-2016 appraisal cycle

Access, security and confidentiality

34. Data stored relating to appraisals are held securely. Access to, and the use of, data adheres to the requirements of the Data Protection Act (1998). Under the Freedom of Information Act (2000), appraisal documentation is classed as data of a personal or confidential nature and is not accessible under the act.

35. NICE required all appraisees to use the Medical Appraisal Guide (MAG) example form for the 2015-2016 cycle. The MAG form and the NICE medical appraisal and revalidation policy state that patient identifiable data should not be included as supporting information for appraisal.

36. No information breaches were identified between April 2015 and March 2016

Revalidation Recommendations

37. Two revalidation recommendations were made between April 2015 and March 2016. Both recommendations were positive and were completed on time.

Recruitment and engagement background checks

38. All required pre and post-employment checks were completed.

Responding to Concerns and Remediation

39. No areas of concern requiring reference to the remediation steps outlined in the medical appraisal and revalidation policy were raised between April 2015 and March 2016. In the event of concerns about a registered medical practitioner’s practice being raised, the RO will investigate and ensure appropriate measures are taken to address and remediate the issue. The process which will be followed and the outcomes which may result are detailed within the medical appraisal and revalidation policy.

Feedback and review

Peer review of systems and processes

40. A peer review of NICE systems and processes was completed by NHS Professionals in April 2016, after the closure of the 2015-2016 appraisal cycle.
The format of the review was based on a template provided for use by NHS England North.

41. The review template was amended by the Revalidation Advisor to fit the NICE setting, and was approved by the NICE Revalidation committee and the review team from NHS Professionals.

42. The review consisted of the following stages:

   I. Desk based review
   II. Face to face meeting with key staff
   III. Production of a review report with recommendations
   IV. Formal feedback session and acceptance of the final review report

43. The review outcomes were positive and broadly supportive of the systems and processes followed by NICE. The peer review report is included in this report for reference, as appendix 2

44. The following strengths were identified in the review:

   - Appraisal and revalidation processes are well managed
   - Evidence of a good level of support from the HR team within the organisation
   - Involvement of a Deputy RO to support the role of the RO and revalidation team
   - Good use of a guidance document to support the implementation of the appraisal and revalidation policy
   - Excellent quality assurance processes
   - Issues and risks are identified and mitigated
   - NICE appraisers are extremely engaged and keen to develop on their skills as appraisers
   - Appraisers are ‘in-house’ which enables direct lines of communication
   - Appraisers have a good understanding of the setting in which the appraisee works

45. Some suggested areas for development were identified, which have been listed in the following action plan
<table>
<thead>
<tr>
<th>Review</th>
<th>Review observation</th>
<th>Impact</th>
<th>Possible Action and date</th>
<th>Completion by</th>
</tr>
</thead>
<tbody>
<tr>
<td>5 and 9</td>
<td>Details of how revalidation issues are communicated to doctors</td>
<td>Low</td>
<td>Amend and clarify existing policy and guidance at next review</td>
<td>July 16</td>
</tr>
<tr>
<td>6</td>
<td>Evidence of process for dealing with non-engagers</td>
<td>Low</td>
<td>Amend and clarify existing policy and guidance at next review</td>
<td>July 16</td>
</tr>
<tr>
<td>6</td>
<td>Definition of requirements that need to be fulfilled for a doctor to make a connection to NICE as his/her DB</td>
<td>Low</td>
<td>Amend and clarify existing policy and guidance at next review</td>
<td>July 16</td>
</tr>
<tr>
<td>6</td>
<td>Whether there is a need for sample templates of letters to be included in documents</td>
<td>Low</td>
<td>Consider creating a template letter for confirmation of revalidation requirements</td>
<td>December 16</td>
</tr>
<tr>
<td>10</td>
<td>Responding to concerns policy. It was agreed in the telephone review of the report that this was a complex matter and whilst the documentation does not currently exist NICE and NHSP will share information around developing a policy that is suitable for a small organisation. Any such policy will look at incorporating / applying the principles of MHPS taking into account individual organisational structures.</td>
<td>Medium</td>
<td>NHS Professionals to lead on this action and share in the development of policy/guidelines once completed. NICE can review any NHSP policy and amend to meet the organisations own needs.</td>
<td>Autumn 2016</td>
</tr>
<tr>
<td>11 and 12</td>
<td>Following discussion of the existing appraisal and revalidation policy whether there was an action to look at some of the wording at the next review date to identify areas that may be</td>
<td>Low</td>
<td>Amend and clarify existing policy and guidance at next review</td>
<td>July 16</td>
</tr>
</tbody>
</table>
Table 2: Peer review action plan

<table>
<thead>
<tr>
<th></th>
<th>14 NICE do not currently have a formal learning log</th>
<th>Low</th>
<th>Log created to record any future significant events for reporting to the audit committee.</th>
<th>Complete</th>
</tr>
</thead>
<tbody>
<tr>
<td>15</td>
<td>NICE appraisers do not currently undertake formal peer review or calibration of professional judgements</td>
<td>Low</td>
<td>Book review meetings and implement learning activities for medical appraisers</td>
<td>Autumn 16</td>
</tr>
</tbody>
</table>

46. Any required changes will be implemented by the Deputy Responsible Officer and Revalidation Advisor, with the oversight of the revalidation committee. The revalidation committee will approve the changes and receive regular progress updates from the Revalidation Advisor.

**Feedback on system and processes**

47. All appraisals for the 2015-2016 appraisal cycle were completed on the Medical Appraisal Guide (MAG) model appraisal form. The MAG form fulfils the regulatory requirements for revalidation and replaced the online PreP appraisal system that was used for the 2014-2015 appraisal cycle.

48. Feedback from appraisees and appraisers on the MAG appraisal form was positive. Users indicated that they found the MAG form easy to use and an improvement on the previous web-based appraisal system.

49. An appraisal feedback questionnaire was completed by the medical practitioners that had completed a medical appraisal. All respondents felt that their appraisal had been positive, useful and productive. All questions were rated as ‘satisfactory’ or above. Appraiser performance was rated overall as ‘good’ or ‘very good’ in all areas of the questionnaire.

50. Appraisees felt that:

- The appraisal process was satisfactory and that the administrative support offered met their needs
There was sufficient protected time for the appraisal discussion

They had access to the necessary materials and an appropriate venue for the appraisal

They could collect the necessary supporting information

The appraisal was useful for their personal and professional development

The appraisal was useful for their preparation for revalidation

The appraisal would help to promote quality improvement in the doctor’s work

**Risk and Issues**

51. As the organisation has a small number of appraisers, there is a risk of a delay to appraisal completion should any appraisers leave the organisation or become unable to complete appraisals. The risk of reciprocal appraisal would also increase. This risk could be mitigated through the use of external appraisers that are suitably qualified and approved, should the need arise.

52. The recent peer review of NICE’s appraisal and revalidation systems by NHS Professionals highlighted that the current arrangements for responding to concerns about doctors that have NICE as a designated body need development. The medical appraisal and revalidation policy states that ‘Maintaining High Professional Standards’ (MHPS) should be used as a mechanism to investigate manage and remediate any concerns. The review suggested that the application of MHPS could be difficult and unwieldy to apply in the NICE setting.

53. This could present a risk to NICE because if concerns about a doctor with a prescribed connection to NICE are raised, it could be difficult for NICE to manage the process effectively within the current policy arrangements.

54. However, there is a low probability of such a concern arising at NICE that could not be dealt with through the use of existing non-revalidation specific policies (such as the disciplinary policy). In response to this risk, a responding to concerns policy will be developed jointly by NHS Professionals and NICE.
Revalidation of other professional groups

Nurse and midwife revalidation

55. Nurse and Midwife revalidation is the process that all nurses and midwives in the UK will need to follow to maintain their registration with the NMC. The revalidation of Nurses and Midwives took effect from April 2016. NICE employs 14 NMC registrants, of which 6 are considering revalidation.

56. The revalidation committee appointed a nurse and midwife revalidation lead, Christine Carson, in spring 2015, and a standing item has been added to the committee and management group agendas to keep abreast of any developments.

57. NICE does not specifically employ nurses and midwives in roles that require them to act as such. Completing the revalidation process is the responsibility of nurses and midwives themselves and unlike medical revalidation, there is no statutory duty for NICE to provide any specific support to the nurses and midwives it employs.

58. It was agreed by the revalidation committee in November 2015 that the minimum level of support would be offered to those intending to maintain their registration. This is in line with the NMC guidance ‘Employers’ guide to revalidation’

59. The support offered to nurses and midwives at NICE is listed below:
   - Dedicated page and links to useful documents and contacts on NICE Space
   - Position statement shared with nurses and midwives, that lists the level of support available from NICE, that includes, who at NICE is able to provide information and support and can act as a confirmer and/or reflective discussion partner. The position statement is included in appendix c
   - Revalidation event for Nurses and midwives at NICE, held in March 2016. The event included a Q&A session with a nurse and midwife revalidation pilot lead and expert

Revalidation of other professional groups

60. An assessment process for confirming the continuing fitness to practice of Pharmacists is due to be piloted by the General Pharmaceutical Council (GPhC) this year.
61. The GPhC are working to the following timeline:

- 2015/16 - testing and research
- 2016/17 - piloting and evaluation
- 2017/18 - consultation and preparation
- 2018 - implementation and evaluation

62. The Revalidation Advisor will continue to monitor progress and report any developments regarding the plans for confirming the fitness to practice of pharmacists and other professional groups to the revalidation committee.

Next steps

63. Key areas for development in the next appraisal cycle:

- Review and refinement of appraisal guidance and policy
- Completion of peer review actions, including the development of a ‘Responding to Concerns’ policy
- Share experiences of the peer review process and best practice with other similar organisations
- Ongoing training and support of those working at NICE that are subject to revalidation
- Development of appraiser meetings to share and calibrate knowledge
- Re-establish audit meetings to drive the creation of supporting information for medical appraisal
- Continued monitoring of developments regarding the revalidation of other professional groups.

Recommendations

64. The board is asked to accept the report noting that it may be shared, along with the annual audit, with the higher level RO (the Chief Medical Officer for England).

65. The board is asked to approve the ‘statement of compliance’ (appendix A), confirming that NICE, as a designated body, is in compliance with the regulations.
Appendix A: Statement of Compliance

Version number: 2.0

First published: 4 April 2014

Updated: 22 June 2015

Prepared by: Gary Cooper, Project Manager for Quality Assurance, NHS England

Classification: OFFICIAL

Publications Gateway Reference: 03432

**NB:** The National Health Service Commissioning Board was established on 1 October 2012 as an executive non-departmental public body. Since 1 April 2013, the NHS Commissioning Board has used the name NHS England for operational purposes.
Designated Body Statement of Compliance

The board of National Institute for Health and Care Excellence (NICE) can confirm that

- an AOA has been submitted,
- the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013)
- and can confirm that:

1. A licensed medical practitioner with appropriate training and suitable capacity has been nominated or appointed as a responsible officer;

   Yes

2. An accurate record of all licensed medical practitioners with a prescribed connection to the designated body is maintained;

   Comments:

3. There are sufficient numbers of trained appraisers to carry out annual medical appraisals for all licensed medical practitioners;

   Comments:

4. Medical appraisers participate in ongoing performance review and training / development activities, to include peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers¹ or equivalent);

   Comments:

5. All licensed medical practitioners² either have an annual appraisal in keeping with GMC requirements (MAG or equivalent) or, where this does not occur, there is full understanding of the reasons why and suitable action taken;

   Comments:

6. There are effective systems in place for monitoring the conduct and performance of all licensed medical practitioners¹ (which includes, but is not limited to, monitoring: in-house training, clinical outcomes data, significant events, complaints, and feedback from patients and colleagues) and ensuring that information about these matters is provided for doctors to include at their appraisal;

   Comments:


² Doctors with a prescribed connection to the designated body on the date of reporting.
7. There is a process established for responding to concerns about any licensed medical practitioners' fitness to practise;

Comments:

8. There is a process for obtaining and sharing information of note about any licensed medical practitioner's fitness to practise between this organisation's responsible officer and other responsible officers (or persons with appropriate governance responsibility) in other places where the licensed medical practitioner works;\(^3\)

Comments:

9. The appropriate pre-employment background checks (including pre-engagement for locums) are carried out to ensure that all licensed medical practitioners' have qualifications and experience appropriate to the work performed;

Comments:

10. A development plan is in place that ensures continual improvement and addresses any identified weaknesses or gaps in compliance.

Comments:

Signed on behalf of the designated body

[(Chief executive or chairman (or executive if no board exists)]

Official name of designated body: __ __ __ __ __ __ __ __

Name: __ __ __ __ __ __ __ Signed: __ __ __ __ __ __ __ __
Role: __ __ __ __ __ __ __
Date: __ __ __ __ __ __

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Appendix B: Peer review report

Peer Review of National Institute for Health and Care Excellence (NICE) by NHS Professionals (NHSP)

April 2016
<table>
<thead>
<tr>
<th>Peer Review of National Institute for Health and Care Excellence (NICE) by NHS Professionals (NHSP)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Peer Review Visit:</strong></td>
</tr>
<tr>
<td>Wednesday 13&lt;sup&gt;th&lt;/sup&gt; April 2016, 12.30-2.00pm</td>
</tr>
<tr>
<td>At National Institute for Health and Care Excellence, 10 Spring Gardens, London, SW1A 2BU</td>
</tr>
<tr>
<td><strong>Attendee's:</strong></td>
</tr>
<tr>
<td>National Institute for Health and Care Excellence (NICE)</td>
</tr>
<tr>
<td>• Professor Gillian Leng, Responsible Officer</td>
</tr>
<tr>
<td>• Dr Judith Richardson, Appraisal Lead and Deputy Responsible Officer</td>
</tr>
<tr>
<td>• Mr Jeremy Shaw, Revalidation Advisor</td>
</tr>
<tr>
<td>• Ms Lorna Squires, Senior HR Business Partner (joined by video conference)</td>
</tr>
<tr>
<td>NHS Professionals (NHSP)</td>
</tr>
<tr>
<td>• Dr Helen McGill, Medical Director/Responsible Officer – Lead Reviewer</td>
</tr>
<tr>
<td>• Ms Lucinda Rose, Clinical Governance Manager for Doctors</td>
</tr>
<tr>
<td><strong>Purpose and Structure of the NICE peer review:</strong></td>
</tr>
<tr>
<td>The aim of the peer review is to identify whether any modifications should be considered in the NICE revalidation process, based on the experience of a similar sized organisation, NHSP. The process included the collation and assessment of relevant documentation and information gathering from key individuals. NHSP have produced this peer review report of the NICE revalidation and appraisal processes and a follow up teleconference with the Deputy RO and Revalidation Advisor is scheduled to share feedback on Friday 29&lt;sup&gt;th&lt;/sup&gt; April 2016 at 11am. The final report will be provided to the Responsible Officer.</td>
</tr>
<tr>
<td><strong>Purpose and format of the Peer Review Meeting:</strong></td>
</tr>
<tr>
<td>To provide the opportunity for discussion, informal feedback and sharing of information between all roles within the revalidation team. Welcome and introductions took place between NICE and NHSP followed by an informal discussion around</td>
</tr>
</tbody>
</table>
the revalidation and appraisal process at NICE and clarification of any queries NHSP had with regard to the documents provided by NICE.

<table>
<thead>
<tr>
<th>Documents provided by NICE for purpose of the Peer Review:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Medical Appraisal and Revalidation Peer Review – Scope and Specification</td>
</tr>
<tr>
<td>• Annual Organisational Audit (AOA) End of Year Questionnaire 2014-15 to higher level RO</td>
</tr>
<tr>
<td>• NICE Annual Revalidation Report 2014-15 to the Board</td>
</tr>
<tr>
<td>• Medical Appraisal and Revalidation Policy (last amended June 2014)</td>
</tr>
<tr>
<td>• Medical Appraisal and Revalidation: Guidance for doctors and appraisers (last amended January 2014)</td>
</tr>
<tr>
<td>• Medical appraisal feedback questionnaire</td>
</tr>
<tr>
<td>• Medical appraisal and revalidation – data table</td>
</tr>
<tr>
<td>• Two anonymised appraisal outputs, which includes:</td>
</tr>
<tr>
<td>o Agreed Personal Development Plans;</td>
</tr>
<tr>
<td>o Summary of the Appraisal Discussion;</td>
</tr>
<tr>
<td>o Appraisal Outputs (appraiser statements, appraiser comments and appraisal sign off);</td>
</tr>
<tr>
<td>• Medical appraiser competency self-assessment tool</td>
</tr>
<tr>
<td>• Revalidation Checklist</td>
</tr>
</tbody>
</table>
### Peer Review Feedback session:
**Friday 29th April 2016, 11.00-11.30am - took place by teleconference**

### Call Participants:
- National Institute for Health and Care Excellence (NICE)
  - Dr Judith Richardson, Appraisal Lead and Deputy Responsible Officer
  - Mr Jeremy Shaw, Revalidation Advisor
  - Ms Lorna Squires, Senior HR Business Partner

- NHS Professionals (NHSP)
  - Dr Helen McGill, Medical Director/Responsible Officer – Lead Reviewer
  - Ms Lucinda Rose, Clinical Governance Manager for Doctors

### Purpose and peer review feedback session:
The aim of the peer review feedback session is to review the content and format of the structured feedback report submitted by NHS Professionals and for NICE to advise whether any modifications should be made. It also provides the opportunity to discuss actions and responses, points of good practice and next steps.
<table>
<thead>
<tr>
<th>Areas to consider and discuss</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Appraisal and recommendations</strong></td>
<td></td>
</tr>
</tbody>
</table>
| Describe your appraisal and revalidation process.  
*Including the review of a doctor’s portfolio, liaison with the RO, dealing with non-engagers/deferrals, templates and timings, how you triangulate information*  
*Consider discussing cases particularly where complex* | The ratified ‘Medical Appraisal and Revalidation Policy’[^5] and ‘Medical Appraisal and Revalidation: Guidance for doctors and appraisers’[^6] were provided which outline the policy and processes in place for the management of appraisal and revalidation at NICE. Also supplied was a log of appraisal and revalidation data for individual doctors and training data on appraisers[^7].  
The policy informs the guidance and the discussion that took place considered both documents in parallel.  
At the point at which a new doctor connects to NICE, the Medical Practitioner Information Transfer (MPIT) form is sent to the doctor’s previous Responsible Officer,(RO), /Designated body, (DB), for completion.  
It was confirmed that most of the doctors connected to the organisation as their DB work only through NICE. Information for individuals is triangulated within the organisation through the sharing of annual performance management reviews with the medical appraiser to ensure that key items are included. The Deputy RO also reviews specific appraisal outputs[^8] to provide assurance that key items identified at pre-appraisal as needing discussion have been included.  
There is excellent use of a data table to maintain information on doctors |

[^5]: Last amended June 2014, review date June 2016
[^6]: Last amended January 2014, review date June 2016
[^8]: PDP, summary of appraisal discussion
connected to NICE, those working for NICE who have an alternative designated body and NICE appraisers.

Information in the data table is RAG rated and includes:

- Current appraiser names and training status
- Connected doctors
  - Name of appraiser
  - Revalidation date and status
  - Appraisal year and last appraisal
  - Date of next MSF$^9$
- Doctors employed by NICE with an alternative DB
  - Revalidation date and status
  - Confirmation of appraisal data

RAG rating is used to identify appraisal and revalidation due dates and to provide a status update to the revalidation committee. The document includes a log of missed appraisals for which an explanation is recorded.

Figure 1, page 8, of the guidance outlines the timeline for the appraisal process and appendix A, page 18, outlines the revalidation process. The guidance document also describes the process for the allocation of appraisers and the scheduling of appraisals. Neither of these timelines describe how revalidation decisions are formally communicated with individual doctors.

At the peer review feedback session NICE identified that section 41 and 42 of the Medical Appraisal and Revalidation policy outline the process that would

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9 Multi-source feedback
be followed should the doctor or another person object to the allocated appraiser. NICE identified that this is not currently included in the guidance document.

The policy outlines when a deferral recommendation would be made due to a lack of sufficient information or an ongoing investigation and when a recommendation of non-engagement would be made when the doctor has not engaged in local processes.

The policy did not contain process information for dealing with non-engagers. Neither the policy nor the guidance documents stipulate when a doctor is, or is not able, to make a connection to NICE as their designated body. Although connecting to a designated body is defined by statute it was recognised that to make an informed recommendation for revalidation the RO has to base a decision on the ‘full scope’ of the doctor’s practice suggesting that a doctor should work a minimum number of hours with a minimum regularity over the course of an appraisal/revalidation cycle. The RO and Deputy RO had identified this as a problem when doctors working few hours for NICE e.g. on committees, had tried to make a connection to the organisation as their designated body.

No samples of template emails or letters for communicating with doctors connected to the organisation, for example when a doctor first makes a connection, or the action required when their appraisal or revalidation was due, were provided for review. Given the small number of doctors connected and the close working relationships it is anticipated that communication is well managed on an individual basis.

The policy details the handling of information for appraisal and revalidation, which complies with information governance, confidentiality and data protection requirements.

**How do you use appraisal to drive quality**

All doctors connected to NICE have been shown to engage in annual...
improvement? appsaisals and the revalidation process.

NICE have demonstrated through their policy, processes and sample appraisal outcomes that doctors collect evidence from the whole scope of their practice which includes multisource feedback and significant events, in line with the GMC guidance. This is collated and discussed during the annual appraisal and informs the Personalised Development Plan.

There is a process in place for the Deputy RO to ensure key pieces of information (such as complaints, significant events) are included in the appraisal portfolio and discussed at the appraisal meeting, so that development needs can be identified.

Of the example PDP's that were shared, the learning and development needs identified sought to drive quality improvement for the individual and the wider organisation.

<table>
<thead>
<tr>
<th>Describe your quality assurance process.</th>
</tr>
</thead>
<tbody>
<tr>
<td>The ‘Annual Revalidation Report 2014-15’ was submitted to the NICE Board to provide annual assurance that revalidation is being properly implemented in line with policy and relevant guidance and a statement of compliance submitted to the higher level RO.</td>
</tr>
<tr>
<td>The annual report outlines the quality assurance processes carried out by NICE as follows;</td>
</tr>
<tr>
<td>- Appraisal inputs: including pre-appraisal declarations and supporting information, reviewed by the Deputy RO and Revalidation Advisor</td>
</tr>
<tr>
<td>- Appraisal outputs: PDP, appraisal summary, sign off statements, reviewed by the Deputy RO and Revalidation Advisor to provide assurance that these have been completed to an appropriate standard</td>
</tr>
<tr>
<td>- Specific appraisal outputs: also reviewed by Deputy RO, as appropriate, to ensure key items identified as pre-appraisal inputs</td>
</tr>
</tbody>
</table>
| Consider recommendation data - breakdown of figures and reasons for decisions | Data provided in 2014/15 Annual Organisational Audit indicates that one doctor was due to revalidate in the appraisal year and a positive recommendation to the GMC was made. All six doctors connected to NICE had an appraisal that was considered ‘complete’.

A record of future revalidation dates of doctors connected to the organisation is provided in the medical appraisal and revalidation data table. A log is |

needing discussion have been included in appraisal outputs
- Feedback form completed by appraisee: to inform and help identify appraiser training needs and highlight any issues

Additionally the following quality assurance processes have been identified;
- A competency self-assessment is completed by the appraiser annually to identify training needs
- Appraisers are encouraged to participate in relevant CPD activity
- Supporting information checklist is used as a framework to ensure the appraisal inputs and outputs meet GMC requirements.
- NICE has a process in place to ensure doctors are able to obtain MSF, there were no reported problems in the past
- Completion of quarterly and annual organisational audits to monitor appraisal and revalidation rates

Two anonymised appraisal summaries and PDP’s were provided as evidence of the information obtained at the end of the appraisal process by NICE.

Clarification was sought on the appraisal documentation of one doctor, which stated that they had two roles. NICE confirmed that the other professional role held by the doctor was academic and not clinical confirming his connection with them as his DB.
A revalidation checklist is completed prior to each recommendation, which encompasses information for all appraisals undertaken within the five-year revalidation cycle. The document supports a consistent set of checks and assurances for each doctor.

Revalidation recommendations are made on GMC Connect by the RO. The process for communicating the revalidation recommendation to the doctor is not outlined in the guidance document but it is understood that the recommendation decision is confirmed by email by the RO.

<table>
<thead>
<tr>
<th>Other information highlighted from collation of data or during the peer review visit</th>
</tr>
</thead>
<tbody>
<tr>
<td>The information provided in the Annual Quality Audit highlighted a number of areas which were discussed and clarified at the meeting.</td>
</tr>
<tr>
<td>• <strong>Section 2.1 - Classification of doctors as 2.1.1 (Consultant)</strong></td>
</tr>
<tr>
<td>• As these doctors are not working as clinicians the question was posed as to whether the classification was appropriate for the report. It was explained that this classification was used to allow the awarding excellence awards to individuals.</td>
</tr>
<tr>
<td>• To qualify under 2.1.1 the definition of a consultant is: ‘permanent employed consultant medical staff including honorary contract holders, NHS, hospices, and government/other public body staff. Academics with honorary clinical contracts will usually have their RO in the NHS trust where they perform their clinical work’. NICE are a Non Departmental Public Body (NDPB) accountable to their sponsor the Department of Health (DH)</td>
</tr>
<tr>
<td>• NICE confirmed that they have verified the categorisation of their doctors previously and understand 2.1.1 to be correct classification.</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>---</td>
</tr>
</tbody>
</table>
| **Section 2.7** – Medical appraisers are supported in their role to calibrate and quality assure their appraisal practice.  
  - NICE confirmed that they had processes in place for feedback and quality assurance of their appraisers however there is no formal process currently in place for peer review and calibration of professional judgements  
  - The Deputy RO, who is also the lead appraiser, was only recently aware of regional appraisal meetings that precede RO network meetings  |
| **Section 3.2** – Responding to concerns policy including arrangements for the investigation and intervention for capability, conduct, health and fitness to practise concerns  
  - A responding to concerns policy was not evidenced.  |

A discussion followed concerning some elements contained in the *Medical Appraisal and Revalidation Policy* that seemed to have more of an organisational HR / contractual flavour and how these related to the principles underpinning the ethos of medical appraisal and revalidation. For example the opening policy statement, on page 3, is:

> Performance management is the foundation of good staff management. The annual performance review process, through the setting and review of objectives, contributes to achieving organisational success by explicitly defining the criteria on which success will be judged. Individuals and line managers share an obligation to achieve and contribute to the successful fulfilment of
Medical appraisal is a process of facilitated self-review supported by information gathered from the full scope of a doctor’s work. Medical appraisal can be used for four purposes:

1. To enable doctors to discuss their practice and performance with their appraiser in order to demonstrate that they continue to meet the principles and values set out in Good Medical Practice and thus to inform the responsible officer’s revalidation recommendation to the GMC.

2. To enable doctors to enhance the quality of their professional work by planning their professional development.

3. To enable doctors to consider their own needs in planning their professional development.

4. To enable doctors to ensure that they are working productively and in line with the priorities and requirements of the organisation they practise in.

The Medical Appraisal Guide acknowledges that:

‘There is a potential conflict of interest when this last purpose, which is normally part of the job planning process, is combined with the revalidation and developmental elements of appraisal. For this reason organisations should (and most do) separate the two processes of appraisal and job planning, though the outputs from each will inform the other.’

NICE advised that their Medical Appraisal Policy had originated from an HR guide to medical appraisal for revalidation in England, RST, September 2014.
policy. There was a discussion of the role of performance management from the point of view of the organisation and the appraisal process from the point of view of the doctor and the need to maintain the standards as outlined in the GMC’s Good Medical Practice – the possibility of conflict in these two areas was discussed with respect to the following areas:

- Page 3, point 3 – introduction
- Page 3, point 6 – policy statement
- Page 4, point 9 – policy statement
- Page 6, point 22 – clinical excellence awards - is this a contractual term which may not be applicable to have in the policy
- Page 6, point 24
- Page 10, points 54 and 55 – medical appraisal - refers to performance management which is not necessarily a function of the appraisal system although an appraisal may inform a performance management

NICE confirmed that this is a presentation issue within the policy and is not an actual issue.

Clarification was also sought with regard to page 7, point 33 – Responsible Officer of the policy which states ‘most of the duties of the Responsible Officer are defined by statute’. The review has suggested that the RO Regulations define the role of the Responsible Officer and any duties that are being undertaken outside the areas covered by the regulations (statute) may be more safely not referred to as RO functions.

The ‘Medical Appraisal and Revalidation: Guidance for doctors and appraisers’ documents notes on page 8, point 17 that ‘medical appraisals should be completed on the Trust approved medical appraisal system’. NICE confirmed that this needed updating and will be reviewed at next review.
<table>
<thead>
<tr>
<th>Performance</th>
<th>NHSP sought clarification with regard to role and responsibilities of the HR and the revalidation team for the purpose of appraisal and revalidation.</th>
</tr>
</thead>
</table>

**Describe your process for managing concerns**

*Including how you triangulate information*

*Consider discussing cases particularly where complex management of these groups and how this is mitigated if appropriate*

The ‘Revalidation Board Report Final 2014-15’ indicates that there were no areas of concern raised between April 2014 and March 2015.

There was no evidence provided for a responding to concerns policy, (which includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns), which is ratified by the designated body's board or an equivalent governance or executive group in line with section 3.2 of the AOA and ‘A Framework of Quality Assurance for Responsible Officers and Revalidation – Annex A- Core Standards’ – section 3.

The ‘Medical Appraisal and Revalidation Policy’, page 12, contains a section on remediation. It was considered that remediation is one of the optional remedies that may arise from a disciplinary or capability panel investigation and would be better included in a responding to concerns document.

Reference was also made in the policy to *Maintaining High Professional Standards in the Modern NHS*, (MHPS), page 12. As no disciplinary policies were reviewed it was not possible to comment on how MHPS had been applied to organisational policies. Whilst HR confirmed that there was a generic disciplinary policy that applied to NICE staff there was recognition that issues around capability of a doctor’s performance may not end in disciplinary action and may need to follow a different route e.g. ill health issues. It was also agreed that this consideration was on the periphery of an appraisal and revalidation review.

Other information highlighted from collation of data or The following items pertaining to the Medical Appraisal and Revalidation
<table>
<thead>
<tr>
<th>Other team processes</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Discuss significant events and learning log</td>
<td>NICE have identified that there were no late revalidation recommendations during 2014-15 and no other significant events of note. NICE have confirmed that they do not at present have a learning log and NHSP advised that for our organisation this would be the logging and discussion of significant events or identification of processes which are not fit for purpose and the learning and action that have arisen from this to ensure such events do not happen again.</td>
</tr>
<tr>
<td>Other information highlighted from collation of data or during the peer review visit</td>
<td>In the ‘Revalidation Board Report Final 2014-15’, NICE highlighted that they would use the Medical Appraisal Guide (MAG) model appraisal form for appraisals in 2015-16 because the previous system had proved difficult and confusing to use. The report also highlighted the potential risk to the organisation having three</td>
</tr>
<tr>
<td>ITEM 5</td>
<td></td>
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<tr>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td><strong>General</strong></td>
<td></td>
</tr>
<tr>
<td>Engagement in professional development / medical appraisal programmes</td>
<td>The ‘Revalidation Board Report Final 2014-15’ indicates that NICE have three medical appraisers that led appraisals for the appraisal cycle. NICE policy is that all their appraisers have to be registered and licensed medical practitioners that have completed core appraiser and revalidation top up training modules. The appraisers all meet the core competencies based on guidance from the NHS England document ‘Quality Assurance of Medical Appraisers’. NICE identified that because of the possible challenges with only few appraisers, such as availability and capacity issues, should the need arise appraisals would be outsourced. NICE offer annual training opportunities and appraisers are also encouraged to participate in relevant CPD activities that support their role as a medical appraiser. Appraisers complete a self-assessment annually which is used to identify any areas where there may be a specific training requirement. NICE appraisers do not currently formally undertake peer review or calibration of professional judgements as per section 2.7 of the Annual Organisational Audit.</td>
</tr>
<tr>
<td>Any areas of immediate concern that require further consideration</td>
<td>None identified</td>
</tr>
</tbody>
</table>
### Good practice which could benefit all designated bodies

- Medical Appraisal and revalidation – data table.
  
  This was felt to be an excellent tool to provide a rolling overview of appraisal and revalidation status of doctors and appraisers as a management tool and to inform the revalidation committee.

### Strengths and weaknesses (if relevant)

#### Strengths

- Appraisal and revalidation processes are well managed
  - All doctors connected to NICE received an appraisal for 2014-15
  - No late revalidation recommendations were made
  - Any missed appraisals are documented and managed proactively
  - Data sheet provides an overview of each doctor’s appraisal and revalidation status and it used to provide updates to Revalidation Committee

- Evidence of support from HR team within the organisation

- Involvement of a Deputy RO to support the role of the RO and revalidation team

- The guidance document is useful in outlining the implementation of the Medical Appraisal and Revalidation Policy

- Excellent quality assurance processes
  - Annual board reporting
  - Appraiser feedback and self-assessment to identify learning needs

- Where issues or risks have been identified these have been noted in
the Annual Revalidation Report to the Board and ways in which to mitigate the risks have been considered – this process could be formalised as a learning log going forward

Following the peer review feedback session NICE identified additional strengths in their Revalidation and Appraisal Processes which they felt had not come out of the peer review process:

- NICE appraisers are extremely engaged and keen to develop on their skills as appraisers
- As the appraisers are in house which enabling direct lines of communication
- Appraisers have a good understanding of the setting in which the appraisee works which is beneficial given the nature of the work doctors undertake through NICE being quite different to other clinicians

NHSP were in agreement with the additional strengths identified here.

### Weaknesses

- No evidence of a responding to concerns policy in line with the requirements outlined in the NHS England core standards document - consider the use of MHPS and the application of this guidance to the organisation
- Appraisers do not currently take part in peer review and calibration of professional judgements
- There is no current formal learning log for significant events and where areas for improvement of the appraisal and revalidation processes have been identified
- Appraisal and revalidation policy/guidance documents could be
strenthened/improved in the following areas:

- A review of the contractual and performance management elements of the policy
- Clarification of the management of doctors who do not engage with revalidation and appraisal processes
- Development of an organisational framework which defines when a doctor is able to make a connection to NICE as their designated body remembering that it is the DB who can accept a connection and not the doctor who can enforce the connection
<table>
<thead>
<tr>
<th>Additional questions</th>
<th>Tick ✓ if Yes</th>
<th>Comments if relevant</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is succession planning for the responsible officer and relevant team members in place?</td>
<td>✓</td>
<td>NICE have a Deputy RO in place providing support to the RO and the Revalidation Advisor. The revalidation and appraisal processes are suitably set out for business continuity and succession planning.</td>
</tr>
<tr>
<td>Is there a local mechanism in place for patient &amp; public involvement in processes for revalidation</td>
<td>✓</td>
<td>NICE have developed and outlined the process by which doctors connected to the organisation can obtain multi-source feedback, this is found in the Medical Appraisal and Revalidation Guidance Document.</td>
</tr>
<tr>
<td>Do case investigators and case managers undertake quality assurance of their roles and receive feedback on their performance?</td>
<td></td>
<td>NICE does not have Case Investigators and Case Managers appointed, however should the requirement arise the regional team would support in the identification of suitably trained individuals. NICE deems this reasonable due to the low risk.</td>
</tr>
<tr>
<td>Is there a process for triangulation of information – for both appraisal and concerns?</td>
<td>✓</td>
<td>Doctors connected to NICE do not currently practise elsewhere, however, information or concerns raised during the performance appraisal are shared with the appraiser of the medical appraisal to ensure this information is included.</td>
</tr>
</tbody>
</table>
APPENDIX C: Nurse and midwife position statement

Nurse and midwife revalidation

Position Statement:
Levels of support for nurses and midwives at NICE

Background

1. Revalidation started on 1st April 2016 and is the process that all nurses and midwives will need to go through in order to renew their registration with the NMC. Completing the revalidation process is the responsibility of nurses and midwives. However, the NMC has released a guide for employers’1which lists the level of support that could be ‘reasonably expected’ by those seeking revalidation.

2. NICE does not employ nurses and midwives into roles that require them to act as such; however, NICE does understand the organisational benefit in supporting those that wish to retain their registration whilst they are employed by NICE.

3. The NICE revalidation committee, which includes a nurse/midwife lead, have agreed the level of support that NICE will offer its nurses and midwives that are seeking revalidation. The support offered by NICE reflects the relevant recommendations in the NMC Employers’ guide to revalidation.

4. The purpose of this statement is to confirm the level of support offered by NICE to its nurses and midwives that are seeking revalidation.

Support offered by NICE

5. A dedicated nurse and midwife revalidation intranet page has been created on NICE Space, which links to useful documents, resources and contacts.

6. A Revalidation event was held in March 2016. Similar events will be held on a regular basis.

7. NICE will also support nurses and midwives seeking revalidation in the following areas:

1 ‘Employers’ guide to revalidation’ NMC 2016
**Awareness and culture**

- Raise awareness of revaluation within NICE
- Communicate the changes and requirements to nurses and midwives
- Increase organisational awareness of nurse and midwife revalidation by including an update in the annual medical revalidation board report

**Systems and processes**

- Identify and monitor revalidation application and renewal dates for NICE nurses and midwives
- Allow access to feedback and supporting evidence where it already exists

**Guidance, tools and support**

- Signpost nurses and midwives to the NMC revalidation microsite and other resources via NICE Space
- Provide information and support about who in NICE can act as a confirmer and/or reflective discussion partner
- Provide updates on any changes in requirements

**Links and resources**

- [NICE Space – Nurse and midwife revalidation page](#)
- [NMC – Revalidation microsite](#)
- [NMC – revalidation guidance and information](#)
Medical Appraisal and Revalidation Policy

<table>
<thead>
<tr>
<th>Responsible Officer</th>
<th>Deputy Chief Executive</th>
</tr>
</thead>
<tbody>
<tr>
<td>Author</td>
<td>Revalidation Advisor</td>
</tr>
<tr>
<td>Date effective from</td>
<td>August 2012</td>
</tr>
<tr>
<td>Date last amended</td>
<td>June 2016</td>
</tr>
<tr>
<td>Review date</td>
<td>June 2018</td>
</tr>
</tbody>
</table>
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INTRODUCTION

1. Medical revalidation is the process by which licensed doctors will demonstrate to the General Medical Council (GMC) that they remain up to date and fit to practise.

2. This policy is applicable to all medical staff employed by NICE who are either required to be, or wish to be, licensed to practise.

3. The purpose of this policy is to provide NICE’s medical staff with an understanding of its approach to revalidation and to provide a clear appraisal process that enables a robust annual review of performance and satisfies the requirements of medical revalidation.

4. This policy will:
   - Explain the importance and context of revalidation
   - Provide support and guidance to all those involved in the appraisals of medical staff
   - Identify key roles and responsibilities
   - Define processes and mechanisms through which the appraisal will be delivered
   - Identify the process of data collection and governance
   - Identify the process of how poor performance will be remedied.

5. Throughout this policy the term doctor is used to refer to registered medical practitioners

POLICY STATEMENT

6. NICE will support every doctor it employs, who wishes to continue to be licensed to practise, to achieve revalidation. It will support them to meet their professional commitments by facilitating an annual medical appraisal that complies with the professional standards set out by the GMC’s Good Medical Practice, the Royal Colleges and the Department of Health.

7. The outcome of annual medical appraisals will be used to form the basis of the 5-yearly revalidation recommendation. A positive recommendation for revalidation is dependent upon engagement with the annual appraisal process.
8. Each doctor that is subject to revalidation will also participate in the NICE annual performance review process. The outcome of the annual performance review will feed into the annual medical appraisal.

9. This policy is not exhaustive and is not intended to contain information on all aspects of medical appraisal and revalidation. Every effort has been made to provide relevant and up-to-date information; however, the GMC in partnership with the Department of Health continues to develop certain aspects of revalidation so some elements of this policy will be subject to change. The policy will be regularly reviewed to ensure compliance with processes set out by the GMC, the Department of Health and NHS England.

10. Further information on medical appraisal and revalidation can be found on NICE’s intranet site.

11. This policy is supported by NICE’s medical appraisal and revalidation guidance. Although the guidance is not a policy, the processes that it outlines should be adhered to.

12. The policy statement is supplemented by separate documents providing further information about medical appraisal processes or supporting compliance. These are:

- [Good Medical Practice](https://www.gmc-uk.org) (GMC)
- [Good Medical Practice (GMP) Framework for appraisal and revalidation](https://www.gmc-uk.org) (GMC)
- [The Medical profession (Responsible Officers) Regulations 2010](https://www.gov.uk/government/publications/the-medical-profession-responsible-officers-regulations-2010) (GMC)
- [Medical Profession (Responsible Officers) (Amendment) Regulations 2013](https://www.gov.uk/government/publications/the-medical-profession-responsible-officers-regulations-2013) (GMC)
- [Quality assurance of medical appraisers: recruitment, training, support and review of medical appraisers in England](https://www.england.nhs.uk/quality/safeguarding/) (NHS England)
- [Supporting Doctors to Provide Safer Healthcare](https://www.england.nhs.uk/quality/safeguarding/) (NHS England)
- [Disciplinary policy](https://www.nice.org.uk) (NICE)
- Medical Revalidation: responding to concerns policy (NICE)
EQUALITY AND DIVERSITY

13. NICE is committed to ensuring that there is equality and diversity in the workplace and as such all employees will be treated fairly and with respect regardless of age, disability, gender, marital status, membership or non-membership of a trade union, race, religion, sexual orientation, ethnic or national origin or gender re-assignment.

14. NICE is committed to ensuring that its policies and procedures comply with the Equalities Act 2010 and that none of its policies and procedures discriminate unlawfully. This policy has therefore been subject to an Equality Impact Assessment (see appendix 1).

GMC REGISTRATION AND LICENCE TO PRACTISE

15. All doctors in the UK who practise medicine are required by law to be both registered with the GMC and licensed to practise. A licence to practise gives a doctor the legal authority to undertake activities such as treating patients and prescribing. Taking a licence also means that it remains a doctor’s responsibility to be familiar with Good Medical Practice and to follow the guidance it contains. Licences require periodic renewal by revalidation. Licensed doctors are required to demonstrate to the GMC that they are practising in accordance with the generic standards of practice set by the GMC (as described in Good Medical Practice).

16. It is possible for a doctor to be registered but not hold a licence to practise and this may be appropriate, for example, if the doctor is not practising medicine and has no clinical responsibilities but yet wishes to retain their GMC registration. In these circumstances, the GMC has been clear that “Doctors must however be explicit and proactive about their GMC status. They must make it clear whether they are registered with or without a licence to practise. To present themselves as registered with or without a licence when they are not, is a criminal offence.”

17. Doctors holding registration without a licence will not be subject to the requirements of revalidation because they will have no licence to renew.

18. Any doctor who is considering relinquishing their licence to practice or registration is strongly advised to discuss the implications of such a decision with their line manager, HR and the Responsible Officer.

19. It is possible for doctors who relinquish their licence to restore it. Although doctors should be aware that even without a licence, they are still bound by the principles in Good Medical Practice as a result of their registration.

20. For more information on licensing, see frequently asked questions about licensing on the GMC website.

1 Frequently asked questions about licensing (GMC).
PRESCRIBED CONNECTION TO A DESIGNATED BODY

21. A doctor may only have one prescribed connection to a designated body and may only be revalidated through a single Responsible Officer. The connection between a doctor and their designated body is laid out in Regulation 10 of the Medical Profession (Responsible Officers) Regulations 2010. It is not possible to choose a designated body other than the one laid out in the regulations.

22. Where a doctor has NICE as their designated body they will have the following:
   - An annual performance review in line with the NICE Performance Policy and Procedure
   - An annual medical appraisal as set out in this document
   - A 5-yearly revalidation recommendation made by the Responsible Officer at NICE

23. Where a doctor has a designated body other than NICE, it is expected that they will undergo an annual performance review with their line manager at NICE, in line with HR policy. This review will form part of the evidence for their wider scope of practice review for their appraisal and revalidation recommendation by the responsible officer at their designated body. These doctors will not have a medical appraisal at NICE, or a revalidation recommendation made by the Responsible Officer at NICE.

24. NICE will support doctors who require additional evidence for their medical appraisal and revalidation at an alternative designated body. Such evidence may include, but is not limited to, multi source feedback, evidence of application of skills or knowledge, or continuing professional development.

25. Members, Chairs and Non-Executive Directors will, if they wish, receive an annual statement relating to their contribution to NICE for inclusion in their medical appraisal portfolio.

26. The Programme Director responsible for the committee will be charged with providing the information for committee chairs and members. Templates and records of doctors who have requested feedback is maintained by Corporate Office.

ROLES AND RESPONSIBILITIES

Responsible Officer

27. As a designated body, NICE needs to appoint a Responsible Officer. The Responsible Officer is a new role constituted under the Medical Profession.
(Responsible Officers) (Amendment) Regulations 2013 and was developed to support the process of revalidation. The Responsible Officer has a statutory duty to evaluate fitness to practise and to make recommendations to the GMC in respect of each doctor’s fitness to retain a licence to practise.

28. The Responsible Officer is accountable for the quality assurance of the medical appraisal and clinical governance systems in their organisation. Improving these systems will support doctors in developing their practice more effectively, which will add to the safety and quality of healthcare in the UK. It will also enable the early identification of those doctors whose practice needs attention, allowing for more effective intervention.

29. The Responsible Officer will oversee the medical appraisal process and ensure it is in line with GMC guidance and NICE policy. The Responsible Officer will be required to make a revalidation recommendation for each doctor that has a prescribed connection to NICE at least once in every 5-year cycle. The recommendation will be made to the GMC and will be based on the evidence collected through the annual appraisal cycle. The Responsible Officer for NICE is Professor Gillian Leng, Deputy Chief Executive and Director for Health and Social Care. Professor Leng can be contacted by email at Gillian.leng@nice.org.uk or by telephone on 0207 045 2061.

30. NICE has also appointed a Deputy Responsible Officer who will provide support to the Responsible Officer with respect to implementing and upholding the GMC guidelines that support the medical appraisal process. The Deputy Responsible Officer is Dr Judith Richardson, Programme Director, Leadership and Engagement. Dr Richardson can be contacted by email at judith.richardson@nice.org.uk or by telephone on 0161 219 3831.

31. The duties of the Responsible Officer are defined by statute and will be quality assessed by the GMC and NHS England. For further information relating to the role of the responsible officer, please see the Responsible Officer role description available on NICE’s intranet.

32. The Responsible Officer at NICE will have a revalidation recommendation made by the Responsible Officer at the Department of Health, as laid out in regulation 12 of the Medical Profession (Responsible Officers) (Amendment) Regulations 2013.

33. In situations where information is needed from a responsible officer in another organisation, for example, where there has been transfer of employment within a revalidation cycle, information will be shared as follows:

- Requesting information: the Responsible Officer will make a formal, written request to the organisation’s Responsible Officer, outlining the reasons for the request.
• Sharing information: when a request is received to share a doctor’s information, the doctor will be asked to provide consent for sharing of the information.

34. The Medical Practice Information Transfer Form will be completed and securely transferred between the organisations.

35. A doctor who does not provide consent to their information being exchanged may be at risk of the Responsible Officer making a request to the GMC to defer the revalidation recommendation. In instances where the doctor refuses to share information the Responsible Officer will notify the GMC that the doctor has not engaged with any of the local systems and processes that support revalidation.

Appraiser

36. The appraiser must be an individual who can accurately comment on the whole scope of the doctor’s duties.

37. Medical appraisers at NICE will be registered and licensed medical practitioners.

38. Appraisers will work in partnership with appraisees to ensure the NICE medical appraisal and revalidation policy is adhered to and undertake an annual appraisal with their appraisee. Further guidance on the role and responsibilities of appraisers is provided in NICE’s medical appraisal and revalidation guidance. Appraisers should adhere to the processes outlined in the guidance.

39. Each doctor will be allocated an appraiser by the Deputy Responsible Officer, as the NICE medical appraisal lead, who will ensure the suitability and objectivity of the appraiser. The process of selection will include confirming whether there are any reasons why it might not be appropriate to allocate a particular appraiser, for example if there is personal relationship.

40. In the event the doctor does not agree with the appraiser allocated to them the Deputy Responsible Officer will seek to resolve the conflict in liaison with the Responsible Officer. If this is not possible, the Responsible Officer will identify a suitable appraiser from the pool of appraisers mindful of the objections made. If the doctor has concerns about the objectivity of the Responsible Officer these can be raised with HR / Non-Executive Director (Clinical Revalidation Committee).

41. No more than 3 consecutive appraisals will take place with the same appraiser in any one revalidation cycle.

42. NICE will ensure that all appraisers are regularly trained and have the appropriate skills to perform medical appraisal in line with the document Quality assurance of medical appraisers: recruitment, training, support and review of medical appraisers in England.
43. Medical appraisers will have this responsibility included in their own appraisal and personal development plan to ensure their competence and performance is satisfactory.

44. All medical appraisers at NICE will have periodic meetings together to ensure consistent standards are maintained and will participate in an audit process to ensure quality assurance.

45. All medical appraisers will be provided with medical appraisal training on appointment, with refresher training every 3 years thereafter. Additional training will be provided if a training need has been identified and with the agreement of the Responsible Officer. Training completion will be recorded on the databases held in the Human Resources Department.

46. Medical appraisers will be provided with feedback on their performance in their role. The review of the quality of the outputs may be assessed by:

- An appraisee feedback questionnaire
- A review of the outputs of medical appraisal
- A review or evaluation after initial training or after a probationary period.

**Appraisee**

47. The appraisee is responsible for ensuring that their performance complies with the GMC’s [Good Medical Practice](https://www.gmc-uk.org/standards/bestPractice) guidance and the requirements of their royal college or faculty.

48. The appraisee is responsible for ensuring that they are licensed to practise and are revalidated every 5 years by a Responsible Officer in a designated body.

49. The appraisee is required to participate in a medical appraisal and ensure they understand the appraisal process and its links to medical revalidation.

50. The responsibilities of the appraisee and their duties in terms of adhering to the [Good Medical Practice Framework for appraisal and revalidation](https://www.gmc-uk.org/standards/bestPractice) is provided in NICE’s medical appraisal and revalidation guidance. Appraisees should adhere to the processes outlined in the guidance.

51. In line with [Supporting Information for Appraisal and Revalidation (GMC, 2013)](https://www.gmc-uk.org) the appraisee needs to collate a portfolio of relevant performance and quality information with evidence of reflection in readiness for the appraisal meeting.

**Medical Appraisal Lead and Revalidation Advisor**

52. The Medical Appraisal Lead and Revalidation Advisor will:
ITEM 5

- Oversee the medical appraisal and revalidation process and ensure that related procedures and practices are regularly reviewed in line with changes in legislation

- Develop and maintain appropriate protocols, processes and records to ensure that medical staff undertake annual medical appraisal and revalidation in line with national guidance

- Provide support to the Responsible Officer, appraisers and appraisees and ensure appropriate training is available

- Ensure the process and collection of data is compliant with NICE governance regulations and that data are kept secure

- Coordinate and provide administrative support to the medical appraisal and revalidation process

- Maintain a comprehensive database and provide reports as required for the purpose of medical appraisal and revalidation.

- In conjunction with Human Resources, Support the RO to exchange relevant information with other organisations where required in accordance with data protection legislation.

<table>
<thead>
<tr>
<th>When</th>
<th>What</th>
<th>Who</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alternate months</td>
<td>Reports on the conduct of appraisals to monitor activity</td>
<td>Revalidation Management Meeting</td>
</tr>
<tr>
<td>Quarterly</td>
<td>Quarterly Information return</td>
<td>Revalidation Committee Meeting</td>
</tr>
<tr>
<td>Annually</td>
<td>Annual Organisation Board Report</td>
<td>DH, NICE Board</td>
</tr>
<tr>
<td>5-Yearly</td>
<td>External Peer Review</td>
<td>DH</td>
</tr>
</tbody>
</table>

**MEDICAL APPRAISAL**

53. Doctors will have an annual NICE performance review with their line manager (in April/May) and a separate medical appraisal (once a year) with an appropriately trained medical appraiser. The medical appraiser will usually be internal to NICE and allocated by the Deputy Responsible Officer, as the NICE medical appraisal lead. In exceptional cases, an appropriately qualified appraiser will be appointed from an external source.

54. The medical appraisal is an opportunity for doctors and their medical appraiser to engage in a discussion about the employee’s performance in their role over the
preceding year and to discuss and agree what support and/or development might be required. Appraisals will be undertaken according to professional standards as outlined in *Providing a Professional Appraisal* (NHS RST, 2012).

55. Each medical appraisal should cover the doctor’s practice and performance and use supporting evidence that demonstrates that the doctor complies with the attributes laid out in the GMC’s core guidance *Good Medical Practice* (GMC, 2013).

56. A medical appraisal is not considered to have been completed without timely sign off of a mutually agreed personal development plan (within 28 days of the appraisal meeting).

57. The medical appraiser will have undergone medical appraisal training or refresher training within the 3 years prior to the appraisal taking place and will have the competencies described in *Quality assurance of medical appraisers: recruitment, training, support and review of medical appraisers in England*.

58. The medical appraisal will be based on the GMC’s *Good Medical Practice Framework for appraisal and revalidation*, which sets out the professional standards the doctor needs to demonstrate that they are meeting in their everyday practice. The framework has been modified to reflect the type of medical roles at NICE. There are 3 stages to the medical appraisal process:

1. Inputs to appraisal.
2. The confidential appraisal discussion.
3. Outputs from the appraisal.

Further detail on the stages and expectations of the process are provided in NICE’s medical appraisal and revalidation guidance. Appraisers and appraisees are required to follow this process, which is in line with GMC guidance.

59. The appraisal will assess the doctor against the four domains set out in GMP Framework for appraisal and revalidation:

- Knowledge, skills and performance
- Safety and quality
- Communication, partnership and teamwork
- Maintaining trust

60. Any points of concern identified during the medical appraisal will be raised with the Responsible Officer.
61. Doctors who are subject to capability or disciplinary procedures should continue to have an annual appraisal. The appraisal will be used to support the individual and the personal development plan should reflect the training and development needs previously identified to improve performance.

Responding to concerns and remediation

62. Most doctors maintain high standards of practice but in a small minority of cases there may be areas of concern that could result in the Responsible Officer being unable to make a positive revalidation recommendation. These concerns may come to light through appraisal or other governance processes and may relate to one or more issues around conduct, performance or health.

63. It is important that we provide effective and consistent levels of support to doctors who find themselves in difficulty through the revalidation process and in order to do this all concerns about the doctor’s practice should be raised as soon as possible with the Responsible officer who will investigate and ensure appropriate measures are taken to address and remediate the issue, in line with NICE’s Medical Revalidation: responding to concerns policy.

SUPPORTING MEDICAL REVALIDATION

Making a recommendation for revalidation

64. At the end of the 5-year revalidation cycle, for doctors who have a prescribed connection to NICE, the Responsible Officer will consult The GMC protocol for making revalidation recommendations (GMC, 2014) in order to make a recommendation on revalidation. The Responsible Officer can make 1 of the following 3 types of recommendation. They can make a:

1. ‘Recommendation to revalidate’.
   A positive recommendation that the doctor is up to date, fit to practise and should be revalidated

2. 'Recommendation to defer'.
   Request a deferral because they need more information to make a recommendation about the doctor – this might happen if the doctor has taken a break from their practice (for example, maternity or sick leave)

3. ‘Recommendation of non-engagement’.
   Notify the GMC that the doctor has not engaged with any of the local systems or processes (such as appraisal) that support revalidation.
65. The Responsible Officer’s recommendation will be based on the doctor’s appraisals over the past 5 years and other information drawn from their organisation’s clinical governance systems.

66. A recommendation for revalidation will be made on the whole scope of the doctor’s practice. The Responsible Officer will need to be assured that all aspects of any other practice have been declared in the annual appraisal process and may need to contact other organisations and share information. Designated bodies and Responsible Officers will need to ensure that information is exchanged appropriately and with due regard to data protection and freedom of information legislation.

67. The Responsible Officer will formally notify the doctor via e-mail when their revalidation recommendation has been submitted to the GMC.

68. When the GMC receives a positive recommendation from the Responsible Officer about a doctor, it will carry out a series of checks to ensure there are no other concerns about that doctor. If there aren’t any such concerns, the GMC will revalidate the doctor.

Non-Engagement

69. Failure to engage with the appraisal process will place a doctor’s employment status, and potentially their GMC licence to practice at risk. If an annual appraisal has not been completed by the doctor within 15 months of the last appraisal, and a suitable explanation has not been provided, the following steps will be followed:

- A letter will be e-mailed to the doctor from the Responsible Officer giving 28 days’ notice to complete their appraisal.

- If the doctor has not completed their appraisal within the 28 days’ notice, a second letter will be sent by the RO to the doctor, giving a further 10 days’ notice to complete their appraisal and reminding them of their professional responsibilities and the potential consequences of failing to engage with the appraisal and revalidation processes.

- The doctor’s case will be discussed with the GMC Employer Liaison Advisor at the next opportunity. The GMC will contact the doctor to remind them that they are obliged to participate in the ongoing processes that support revalidation in order to maintain their licence to practice.

- If the RO has considered that there is no reasonable excuse for the doctor not being able to participate in the medical appraisal and revalidation process, their case will be discussed again with the GMC.
Employer Liaison Advisor, and the processes detailed in Section 5 of the GMC protocol for making revalidation recommendations will be followed. If the doctor subsequently begins engaging in the appraisal and revalidation process they will follow the usual appraisal process.

ORGANISATIONAL GOVERNANCE AND OVERSIGHT

Clinical Revalidation Committee

70. The Clinical Revalidation Committee comprises:

- One non-executive director who will be medically qualified,
- Responsible Officer (RO) - Chair
- Deputy Responsible Officer (DRO)
- Associate Director - Human Resources
- Nurse and Midwife Revalidation Lead
- Revalidation Advisor

71. The committee may invite other members of staff or representatives to attend if relevant items are to be discussed.

72. The Clinical Revalidation Committee will meet six times a year to agree and monitor the implementation of NICE’s medical appraisal and revalidation policy, and provide feedback to the SMT and the Board.

Revalidation Management Group

73. A revalidation management group will meet every other month, alternating with the Clinical Revalidation Committee, to discuss and review operational matters relating to revalidation. This group comprises the:

- Responsible Officer
- Deputy Responsible Officer
- Associate Director – Human Resources
- Nurse and Midwife Revalidation Lead
- Revalidation Advisor
Information governance

74. The document Information management for medical revalidation in England describes the information management and information governance processes required to ensure revalidation is effective in its primary aims.

75. NICE will comply with the principles of data protection to control access to, and the transfer of, data. The doctor’s portfolio and appraisal information is confidential; however, the Responsible Officer can request to review the information for quality assurance purposes and in instances where disagreements have occurred between the appraiser and doctor. Access to the information is limited to the doctor, the appraiser and the Responsible Officer. Human Resources will securely store a copy of the appraisal outputs for each doctor.

76. The detail of discussions during the appraisal interview would generally be considered to be confidential to the appraisee and appraiser. However, within the context of appraisal for revalidation, the appraiser will be reporting to the Responsible Officer on the general outcomes of their appraisals. Therefore, the appraiser will need to escalate any concerns about performance that arise during the appraisal discussion, in line with NICE policies and guidelines.

77. Both NICE and the appraisee will need to retain copies of the appraisal documentation over a 5-year period.

78. The Responsible Officer has overall accountability for ensuring medical appraisal takes place for all doctors for whom they are responsible and to securely hold copies of all documentation.

79. Data stored relating to appraisals will be held securely. Access to, and use of, data will adhere to the requirements of the Data Protection Act (1998). Under the Freedom of Information Act (2000), appraisal documentation is classed as data of a personal or confidential nature and is not accessible under the Act.

Quality assurance of the appraisal process

80. Feedback from appraisers and appraisees relating to the appraisal discussion will be obtained annually and reviewed through a routine questionnaire.

81. Feedback from these questionnaires will assist the Responsible Officer with the annual evaluation of:

- Organisational engagement in medical appraisals
- Appraiser skill and training
- The quality of information being returned after the appraisal
82. As part of assuring quality, the Responsible Officer or their deputy, with the doctor’s and appraiser’s consent, may choose to observe the medical appraisal meeting. In addition, new appraisers may also observe an appraisal discussion, providing consent is given by both parties and this is arranged in advance.

83. As far as they are appropriate to the type of medical appraisals that will be undertaken at NICE (given there is no clinical component of NICE medical jobs), NICE will use the tools set out in the document Quality Assurance of Medical Appraisers: Engagement, training and assurance of medical appraisers in England to quality assure the appraisal process and to ensure that appraisal systems and processes are effective.

84. The Responsible Officer will take action to suspend from the role any appraiser who appears, in the opinion of the Responsible Officer or clinical revalidation committee, to be delivering appraisals of an insufficient standard. The Responsible Officer and senior Human Resources representative will work with the appraiser to remedy and rehabilitate the appraiser.

85. It is expected that any complaints received about the appraisal system or a specific appraiser will be investigated and resolved in a timely manner.

86. Quality Assurance will be given through internal and external reporting as defined in the Framework for Quality Assurance for Responsible Officers and Revalidation (NHS England, 2014).

Annual Review by the Responsible Officer and annual report

87. The Responsible Officer is responsible for the quality of the appraisals undertaken by NICE. To assure consistent and excellent quality, the Responsible Officer will oversee a regular audit, which will include an examination of the doctors’ portfolios of evidence, appraisal outputs and appraisers’ questionnaire responses.

88. The annual review will ensure:

- All doctors have completed their appraisal or have an acceptable reason for not having done so.
- All completed appraisal documentation has been completed and returned.
- All appraisal output forms have been signed by the appraiser and appraisee and sent to the Revalidation Advisor for secure storage.
Any concerns about performance and capability have been addressed in line with the NICE responding to concerns policy.

Revalidation recommendations are made in a timely manner, in line with the [GMC Protocol for making revalidation recommendations](#).

89. The quality of medical appraisals and revalidation will be assured through an annual board report. Other reporting information will be supplied to external groups (such as the Department of Health and NHS England) when requested.

90. The annual board report will include a summary of:

- Appraiser and appraisee feedback
- Any issues that have been reported related to the appraisal and revalidation process
- Quality assurance
- Participation in the appraisal processes, including numbers of appraisals completed across the organisation, the number of recommendations made and when a recommendation has been deferred or was unable to be made
- Any key themes that are emerging, and recommendations for improving the process and quality (if relevant) for the following year in line with national guidance.

91. The identity of doctors and appraisers will be protected and information anonymised.

92. The annual medical appraisal and revalidation board report will be presented to the Board in July

93. Implementation and audit of compliance with this policy will be the responsibility of the clinical revalidation committee and the Responsible Officer.

**POLICY REVIEW**

94. This policy will be reviewed every two years.
Appendix 1: Equality impact assessment

NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE
Internal Equality Impact Assessment Record Form 2008
(this form should be used for the assessment of new or amended internal policies, change processes, services, premises, functions and projects)

<table>
<thead>
<tr>
<th>DIRECTORATE</th>
<th>Business Planning and Resources</th>
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<tbody>
<tr>
<td>TEAM/DEPT LEADING ASSESSMENT</td>
<td>Human Resources</td>
</tr>
<tr>
<td>TITLE OF POLICY/SERVICE/FUNCTION/PROJECT BEING ASSESSED</td>
<td>Medical Appraisal and Revalidation Policy</td>
</tr>
<tr>
<td>DATE OF ASSESSMENT</td>
<td>June 2016</td>
</tr>
<tr>
<td>ASSESSOR</td>
<td>J Shaw</td>
</tr>
</tbody>
</table>

**STEP 1: IDENTIFY THE AIMS OF THE POLICY**
Describe the main aim, objectives and intended outcomes of the proposed (insert policy/project/change proposal/system/process as applicable) that is being assessed.

**How does the policy fit into the wider aims of the Institute?**
The purpose of this policy is to provide medically qualified staff with an understanding of the appraisal process and revalidation. NICE will support every doctor it employs, who wishes to continue to be licensed to practise, to achieve revalidation.

**How will this policy be put into practice and who will be responsible for it?**
This policy has been reviewed by the Responsible Officer, Deputy Responsible Officer and Human Resources. It will be put into practice following approval from SMT. The Responsible Officer will be responsible for the overall development and monitoring of this policy.

**What outcomes does the Institute want to achieve?**
- explain the importance and context of revalidation
- provide support and guidance to all those involved in the appraisals of medical staff
- identify key roles and responsibilities
- define processes and mechanisms through which the appraisal will be delivered
- identify the process of data collection and governance
- identify the process of how poor performance will be remedied.

**How will the Institute measure progress toward and/or achieve of these outcomes?**
The Responsible Officer will oversee an annual review by the Revalidation Advisor to ensure that all doctors have had their annual appraisal and all documentation has been completed and returned.

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2 This assessment tool is taken and adapted from the NHS Employers recommended Impact Assessment process.
**Who are the key stakeholders?**
Medical staff employed by NICE who are either required to be, or wish to be, licensed to practise.

**How does it relate to other NHS policies in this area?**
The policy complies with the professional standards set out by the GMC, The Royal Colleges, Department of Health and NHS England. Most of the duties of the Responsible Officer are defined by statute and will be quality assessed by the GMC and NHS England.

**How will the Institute measure the effectiveness of this Equality Impact Assessment (EqIA)?**
Any issues raised regarding the application of the policy will lead to a review of both the policy and EqIA.

**STEP 2: CONSIDER THE DATA AND RESEARCH**
Has previous work or research been done on equality issues in the area of the proposed policy? If so what were the results?

The policy complies with appropriate legislation as follows:
The policy will be regularly reviewed to ensure compliance with processes set out by the GMC, the Department of Health and NHS England.

**What research are you aware of that has been done in this area?**
Revalidation processes have been in place from 2012 and are now well embedded. The processes are supported by national audits and guidance from NHS England that have also been assessed for equality impact.

**STEP 3: ANALYSIS OF THE POLICY**
Does the proposed policy have an explicit focus on inequality, human rights and diversity? If so, how?

Does this policy promote equality and help achieve equity?
This change will have no specific impact on equality and equity in the organisation.

Will this policy help eliminate discrimination?
There are no known discrimination issues to eliminate.

**STEP 4: ASSESSE THE LIKELY IMPACT OF THIS POLICY ON EQUALITY**
Does the proposed policy have a potential adverse impact on equality or is it likely to result in unlawful discrimination?

<table>
<thead>
<tr>
<th>Does this policy impact on any particular group?</th>
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<tbody>
<tr>
<td>Age</td>
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<td>Gender</td>
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<td>Race</td>
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<td>Religion/Belief</td>
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<td>Sexual Orientation</td>
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<td>Disability</td>
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Could the way the policy is carried out have an adverse impact on equality of opportunity or good relations between different groups?
No, this has been considered throughout the development of the policy and
reasonable adjustments will be made where practical, for any party involved in the process.

**Does the policy promote equality of opportunity and good relations?**
See step 3.

**STEP 5: CONSIDER THE ALTERNATIVES**
If the assessment shows that the policy is likely to have an adverse impact, you should consider and detail in the following section how you would address this?

**Can changes be made to the policy proposed?**
N/A

**Can the policy be implemented in different ways?**
N/A

**Would a different policy still achieve the aims and objectives of the original proposal, but avoid the adverse impact on equality?**
N/A

**STEP 6: INVOLVE AND CONSULT RELEVANT STAKEHOLDERS**
Detail here which of the relevant stakeholders have been involved in the development of this policy and this EqIA. Note involvement should be proportionate to the policy as applicable to be implemented.

**Who has been involved in the development of this policy?**
Responsible Officer, Deputy Responsible Officer, Human Resources and Non – Executive Director.

**Who has been asked to advise on this impact assessment?**
HR

**STEP 7: MAKING A DECISION ON THE POLICY**
Summarise the findings of this impact assessment and give an overview of whether the policy will promote equality and diversity.

The assessment has demonstrated that the policy does not have any adverse impact in terms of equality and diversity.

**STEP 8: REPORTING RESULTS**
How will you publish the results of this impact assessment? (The Institute has a specific duty to publish the results of its EqIA’s. Publishing results of EqIA’s demonstrates a commitment to promoting equality and shows that the Institute is carrying out its duties of assessing, involving, consulting and monitoring).

This EqIA will be published on the intranet site.

**STEP 9: MONITORING AND REVIEWING**
How will this policy be monitored and reviewed?

The policy will be reviewed every 2 years.

Assessment Undertaken by ..........J Shaw ......

Date: ......09/06/2016
Appendix 2: Definitions used in this policy

**Revalidation**: the process by which doctors will demonstrate to the General Medical Council that they remain up to date and fit to practise.

**Responsible Officer**: a senior licensed doctor, appointed by the organisation in accordance with the Responsible Officer Regulations 2010, to evaluate fitness to practise and to monitor the conduct and performance of the doctors for whom they are responsible and to periodically (usually every 5 years) make a recommendation regarding revalidation to the General Medical Council.

**Appraisal**: the framework to ensure that all doctors have an annual 2-way discussion regarding the performance of their duties and career development.

**Continuing professional development (CPD)**: the means by which people maintain their knowledge and skills related to their professional lives.

**Personal development plan (PDP)**: a document compiled by the employee and their manager listing the employee’s training and development needs and detailing what actions will be taken to support the employee to address these training needs in order to support the achievement of personal and professional objectives.

**Multi source feedback (MSF)**: a system of employee evaluation that involves collecting performance feedback from multiple sources, for example, manager, direct reports, peers, colleagues and service users.

**GMC registration and licensing**: to practise medicine in the UK, a doctor must, by law, be both registered and licensed to practise with the General Medical Council. It is possible for a doctor to be registered with the General Medical Council but not licensed to practise.

**Designated organisation**: an organisation that is recognised as employing or contracting with medical practitioners. This is sometimes also referred to as a prescribed connection.

**Remediation**: the overall process agreed with a doctor to redress identified aspects of underperformance. Remediation strategies will range from informal agreements to more formal supervised programmes.
Appendix 3 - Version Control Sheet

<table>
<thead>
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<th>Author</th>
<th>Replaces</th>
<th>Comment</th>
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<td>2.</td>
<td>13 August 2013</td>
<td>Laurel Tillotson</td>
<td>N/A</td>
<td>Additional paragraphs relating to the support of Non-Executive Members, Chairs and Members. Paragraphs 46-47.</td>
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<td></td>
<td>Sept 2015</td>
<td>Jeremy Shaw</td>
<td>N/A</td>
<td>Minor amends to update GMP statements and revalidation recommendation statements</td>
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<tr>
<td>4</td>
<td>May 2016</td>
<td>Jeremy Shaw</td>
<td>3</td>
<td>Amended to incorporate recommendations following peer review of systems with NHS Professionals</td>
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NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

TRIENNIAL REVIEW: ‘ONE YEAR ON’ PROGRESS REPORT

The Triennial Review of NICE was published in July 2015. The action taken in response to the recommendations has been reported to the Board bi-monthly as part of the consolidated priorities for NICE in the Chief Executive’s report.

NICE’s letter of priorities for 2016-17 from the Department of Health (DH) requires the submission of a ‘one year on’ report that outlines NICE’s response to the review. The proposed report is attached. It includes the action taken in response to the review and the further actions planned.

The Board is asked to note the report and agree any required amendments prior to submission to the Department of Health.

Andrew Dillon
Chief Executive
July 2016
**Triennial review: ‘one year on’ progress report’**

<table>
<thead>
<tr>
<th>Recommendation</th>
<th>Implementation actions</th>
<th>Progress report and further actions planned</th>
<th>Owner</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Recommendation 1:</strong> that the functions of NICE continue.</td>
<td>No action required.</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td><strong>Recommendation 2:</strong> that NICE works with the Department and the Cabinet Office Commercial Models team to i) explore opportunities for greater expansion of NICE International and NICE Scientific Advice and ii) to consider whether these functions could be delivered more effectively through a different model or change of sector and, if this is appropriate, develop an agreed way forward in 2015/16.</td>
<td>1. Review opportunities for the expansion of NICE International and NICE Scientific Advice 2. In light of the above, consider options for the delivery of these functions 3. Agree strategy for implementation of proposed approach</td>
<td>Initial position papers were considered by the Board at its private meeting in November 2015. The future model for the work of NICE has been reviewed by a sub-group of the NICE Board. The review included interviews with all significant interested parties, including the Gates’ Foundation and Government departments. The Board considered the review’s conclusions and agreed a plan for the long term sustainability of the current grant funded activity at its strategy meeting in June. Initial work has been undertaken on commercial models for NICE Scientific Advice including exploration of the advantages and disadvantages of various delivery vehicles. More detailed assessment is planned in 2016/17.</td>
<td>Andrew Dillon</td>
</tr>
<tr>
<td><strong>Recommendation 3:</strong> That NICE retains its status as an NDPB.</td>
<td>No action required</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td><strong>Recommendation 4:</strong> The health and care system is operating in a time of unprecedented financial</td>
<td>1. In conjunction with the Department of Health and NHS England develop and publish a</td>
<td>1. NICE’s balanced scorecard, agreed by the Department of Health as part of NICE’s business plan, sets out a range of key performance indicators across NICE’s activities. In addition, each agreement with NHS England for NICE activity (e.g. the Cancer</td>
<td>Andrew Dillon and Gill Leng</td>
</tr>
<tr>
<td>Recommendation</td>
<td>Implementation actions</td>
<td>Progress report and further actions planned</td>
<td>Owner</td>
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| constraint and NICE should play an integral role in supporting it to achieve its objectives and make best use of resources. It should do this by:  
• Working with the Department and NHS England to develop and publish a set of key performance indicators that reflect strategic objectives and assess the impact of the organisation, and which are supported by appropriate input, output, or other performance targets. [in 2015/16]  
• Working with other health and care leaders; especially NHS England, Public Health England and CQC, to align the approach to implementation of NICE guidance and recommendations in order to support organisations in implementation activity. [by end 2015] | set of key performance indicators that reflect strategic objectives and assess the impact of the organisation  
2. In conjunction with health and care leaders, especially NHS England, Public Health England and CQC, align the approach to implementation of NICE guidance and recommendations in order to support organisations in implementation activity | Drugs Fund) includes specific performance indicators for NICE.  
2. Work on alignment is taking place in a number of ways. NICE and PHE signed a new partnership agreement, underpinned by new principles of engagement that include alignment and avoidance of duplication. This has been communicated across both organisations, and is linked with practical points of engagement. Work to develop something similar for NHS England is underway.  
NICE is a member of the National Quality Board (NQB) and through this forum is engaging with the national group of medical leaders to consider the key levers to drive quality improvement, including the use of NICE guidance and quality standards. This will feed into the new NQB strategy.  
NICE is exploring with NHS England how we can support the new CCG IAF (Clinical Commissioning Group Improvement and Assessment Framework). Currently 8 indicators from the NICE menu are used within the suite of CCGIAF metrics. This builds on the original CCG Outcomes Indicator Set. As noted above, NICE also worked closely with NHS England to develop a new approach to the introduction of new cancer medicines to replace the current Cancer Drugs Fund arrangements. This went live on 1 July 2016. | |

National Institute for Health and Care Excellence  
Triennial Review: 'One Year On' Progress Report  
Date: 20 July 2016  
Ref: 16/065
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<td><strong>Recommendation 5:</strong> DH should consider the clinical and cost effectiveness appraisals currently conducted within the health and care system, including (but not limited to) the Cancer Drugs Fund and the Joint Commission on Vaccinations and Immunisation with a view to establishing whether NICE should be the single expert body with responsibility for such appraisals [by April 2016].</td>
<td>Respond to any request from the Department for Health for a future role in such appraisals.</td>
<td>NICE and NHS England jointly developed consultation proposals for changes to the operation of the Cancer Drugs Fund which have now been implemented. NICE remains ready to work with the Department of Health on any proposals for changes to the current arrangements for the Joint Committee on Vaccination and Immunisation.</td>
<td>Carole Longson</td>
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<td><strong>Recommendation 6:</strong> following the findings of the Accelerated Access Review, the Department of Health and NICE, with input from NHS England, should consider what changes to NICE’s methods and processes are necessary to enable the health and care system to make best use of the resources available [by July 2016].</td>
<td>Following publication of the Accelerated Access Review (AAR) engage with the Department of Health and NICE, with input from NHS England, to consider what changes are required to NICE’s methods and processes</td>
<td>NICE has contributed actively to the AAR and stands ready to engage constructively with its recommendations when they are published. The date of publication of the AAR has extended the timescale for addressing the recommendation beyond that stated in the Triennial Review.</td>
<td>Carole Longson</td>
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<td><strong>Recommendation 7:</strong> In order to work effectively in an evolving health and care system, NICE should increase its profile, work more flexibly and further develop relationships across the system by: analysing awareness of its profile across the stakeholder landscape, including with patients, service users, their families and carers and in social care, and developing actions to increase awareness of its role and functions [by April 2016].</td>
<td>1. Enhance existing arrangements for system engagement</td>
<td>1. NICE’s already considerable profile is being enhanced through its membership of the NHS Five Year Forward View (FYFV) Board and the programmes that the Board is sponsoring. The work of our field team has expanded to include engagement with the devolution communities and the newly emerging GP networks. In social care, as each new guideline published, we are taking the opportunity to expand and deepen our contacts with care providers and commissioners. To formally develop our links with the external system at a regional and local level, we are planning a series of events across the country for the autumn. These will enable us to communicate with our key audiences in health, public health and social care, to help us determine what more we can do to support local practitioners.</td>
<td>Andrew Dillon and Jane Gizbert</td>
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<td>2. Monitor awareness of and impact on the users of our guidance</td>
<td>2. As part of a Cabinet Office government-wide initiative we are working with the Reputation Institute on a project called RepTrak. The surveys are measuring, on a rolling basis, reputation amongst the informed public of 59 UK public sector organisations. The 4th wave of the project has now been completed. NICE is also taking part in a pilot project to explore if the RepTrak model for assessing UK general public perceptions could be extended and used to track perceptions of key stakeholder groups either directly or indirectly.</td>
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<td>Recommendation 8: NICE should continue to work with patient groups to make its approach to supporting patients more transparent, identifying where it can provide more support to those participating in the work of NICE [throughout 2015/16].</td>
<td>1. Review best practice in public and patient engagement  2. Implement any learning from this review to enhance current NICE approach</td>
<td>1. The review of the public engagement is nearing completion. It took longer than expected to develop, as it includes a set of practical recommendations that impact on patient and public input to guidance.  2. The proposals are due to be considered by the Board in July 2016 and will then be subject to formal consultation.</td>
<td>Gill Leng</td>
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<td>Recommendation 9: NICE should continue to improve communications and engagement work with social care stakeholders, including exploring whether alternative approaches to developing products would better fit the audience’s needs [throughout 2015/16].</td>
<td>A social care engagement plan has been developed in conjunction with key partners, including the Social Care Institute for Excellence. The plan is now being rolled out, and meetings with key organisations have been scheduled. We are piloting the development of two new ‘Quick Reference Guide’ products for social care, which draw on guidelines and standards. We will test these with the relevant audiences in the autumn.</td>
<td>Gill Leng</td>
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<td>Recommendation 10: NICE should work with the MHRA to review the partnership agreement and consider publicising</td>
<td>In conjunction with MHRA review the partnership agreement. Publicise both the agreement and the actions taken to implement</td>
<td>The partnership agreement was reviewed in the summer of 2015, confirmed by both organisations and disseminated amongst relevant staff. Quarterly meetings, involving a broad range of staff from both organisations, are held to review strategic and operational issues rising out of the working relationship between the two bodies.</td>
<td>Carole Longson</td>
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<td>both the agreement and steps taken to ensure the principles are put into practice throughout all levels of the organisations [by April 2016].</td>
<td>the agreement within the respective organisations</td>
<td>addition, there are many further interactions to deal with specific issues as they arise. Under the partnership agreement, a detailed log has been established to provide oversight of interactions between the two organisations. Significant progress has been made, including the implementation of arrangements for MHRA and CHM input to NICE clinical guidelines and evidence summaries and initiation of discussions on protocols for data sharing.</td>
<td>Gill Leng</td>
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<td><strong>Recommendation 11:</strong> NICE should work with NHS England to identify systems and processes, with associated metrics where appropriate, to secure the application of commitment in the Partnership Agreement to using NICE guidance in the centralised and devolved commissioning arrangements [by July 2016].</td>
<td>1. Agree support for using NICE guidance with NHS England commissioning team 2. Update NICE/NHSE partnership agreement with associated metrics</td>
<td>Our engagement with NHS England is now being reviewed, beginning with mapping out points of engagement. There is general agreement that links between the National Clinical Directors and the clinical guidelines and standards programme are working very well.</td>
<td>Gill Leng</td>
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<td><strong>Recommendation 12:</strong> NICE should work to further enhance relationships with organisations across health and care, clarifying areas where roles and</td>
<td>1. Engage with key partners at a local level through the NICE field team 2. Establish a clearer process for working</td>
<td>1. Work with the Vanguards continues, and the work of the field team has expanded to include links with the new Sustainability and Transformation Plans footprints, and with devolution areas. 2. The quality standards team and the adoption and impact programme are engaging with stakeholder organisations to review</td>
<td>Gill Leng</td>
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<td>responsibilities could be made clearer to stakeholders.</td>
<td>with quality standard endorsement partners, to ensure they provide effective support for use of relevant standards</td>
<td>their approach to supporting use of quality standards. The approach to endorsing NICE products continues to be developed, and is being very positively received by partner organisations.</td>
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<td><strong>Recommendation 13:</strong> In order to ensure effective governance of the organisation, including its independent advisory committees, NICE should:</td>
<td>1. Undertake assessment of Board effectiveness and implement any arising action plan</td>
<td>1. PwC undertook a Board effectiveness review as an extension of the internal audit plan. The review reported in April 2016 and concluded positively “From the work undertaken we can conclude that the NICE Board is effective in undertaking its role and adopts a forward thinking and strategic viewpoint.” The Board agreed a small number of actions in response to the report regarding communications to Board members, stakeholder management and succession planning.</td>
<td>Andrew Dillon</td>
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<td>• Arrange an independent assessment of the effectiveness of the Board which gives consideration to whether additional expertise is required and how future thinking becomes an integral part of the Board’s activity [by April 2016].</td>
<td>2. Review the arrangements for operating and quality controlling the work of the independent advisory committees to ensure these are robust and transparent</td>
<td>2. and 3. The Board reviewed a paper on the arrangements in place to address the issues outlined in the Triennial Review at its public meeting in March 2016. The paper is available on the NICE website as are minutes from committee meetings which outline how conflicts of interest have been dealt with.</td>
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<td>• Ensure that the arrangements for operating and quality controlling the work of the independent advisory committees are robust and transparent, publishing these arrangements where</td>
<td>3. Ensure the arrangements for the operation of the advisory bodies are displayed on the NICE website</td>
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| **Recommendation 14:** In order to explore opportunities for further efficiencies:  
  • The Accelerated Access Review should consider the advantages and disadvantages arising from charging industry for health technology appraisals and medical devices and diagnostics evaluations.  
  • NICE should investigate the possibility of benchmarking functions with international comparators. [By July 2016]. | 1. Assess the practical, financial and reputational issues associated with charging for technology evaluations  
2. Explore the scope for benchmarking NICE’s functions with international comparators | 1. The Board considered an initial assessment of the financial, operational and reputational issues associated with charging for its technology evaluation programmes in November 2015. In June 2016 it considered a further progress report, which outlined the favoured approach for the charging model.  
2. There are no direct international comparators for the totality of NICE’s work. Independent assessments of the clinical guidelines and technology appraisals programmes were conducted by the World Health Organisation around 10 years ago, and these provided a commentary, comparing the methods and processes of these programmes against similar programmes elsewhere. There are no obvious benchmarking metrics that could be applied to either the sum or the outputs from individual programmes, since the purposes, methods and processes of these internally vary. However, we will undertake a review of the recent literature in which any of NICE’s programmes have been reviewed against related activity in other countries and prepare a report for the Board in November 2016. | Ben Bennett  
Carole Longson |
NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

PROPOSED CHANGES TO PATIENT AND PUBLIC PARTICIPATION IN DEVELOPING NICE GUIDANCE AND STANDARDS

The Board is asked to consider and approve the proposals for consultation.

Professor Gillian Leng
Deputy Chief Executive and Director, Health and Social Care Directorate
July 2016
NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

Proposed changes to patient and public participation in developing NICE guidance and standards - consultation document

1. This paper summarises the changes proposed as a consequence of the review of NICE’s public participation, engagement and involvement activities in guidance and standards development. The proposals are based on the suggestions and recommendations from a combined evidence base of a narrative review of the relevant literature, a public survey, and a multidisciplinary stakeholder meeting.

2. The proposals focus on the participation, engagement and involvement of patients and the public in NICE guidance and standards work, acknowledging the content of our wider engagement activities beyond these programmes, and beyond the current remit of the Public Involvement Programme.

3. The paper suggests some overarching proposals for future ways of working, our aims for patient and public participation, and the principles to which we will work.

4. The summary areas of strategic focus are to:
   - introduce greater standardisation of approaches across the guidance and standards programmes to reduce unnecessary confusion and barriers to engagement and involvement, and to share best practice across the programmes
   - establish direct involvement of patients and the public earlier in the development processes to ensure that relevant issues of concern are addressed in guidance and standards
   - establish a pool of people from which specialist lay committee members can be drawn, supported by a steering group above, and a wider network below
   - to increase transparency in the way we take into account people's experience of care or services, the burden of their condition and the burden of treatment and reflect this in guidance and standards
   - introduce formal feedback mechanisms so that those participating in our guidance and standards development are aware of the influence of their contribution
   - make better use of social media in communicating our messages to our public and patient audience to inform and support their decision making
   - increase internal staff awareness and acknowledgement of their role in patient and public participation, engagement and involvement as a core NICE activity
5. Consideration is also given to ‘phase 2’ of this work - participation, engagement and involvement activities outside of guidance and standards development.

6. The Board is asked to:
   - note the findings of the review (appendix 1)
   - consider the stated overarching aims, and the proposed changes to future involvement approaches to developing guidance and standards
   - make suggestions for improvements and amendments
   - consider the consultation questions (appendix 3)
   - approve the proposals (following amendments) for a 3 month public consultation

Professor Gillian Leng
Director, Health and Social Care Directorate
July 2016
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Background and context

1. A review of NICE's overall approach to public and patient participation was agreed as part of the Public Involvement Programme's 2015-16 objectives. As an evidence-based organisation we want to make sure that our approaches to involvement and engagement are in line with evidence of best practice (as outlined in Appendix 1). We want to provide a useful and effective experience for the patients and the public who work with us, taking a collaborative approach to making recommendations to improve people's experience of care and services.

2. We also to want to be flexible and responsive to changing times and reducing resources, and wish to provide patients and the public with meaningful opportunities to influence and shape our guidance and standards.

3. We want to build on our existing experience and work, and retain the elements of our approach that have given us a strong reputation in this field. This includes the 'person-centred' developments that have been enhanced as a consequence of expanding our portfolio into social care. We also wish to ensure that any apparent gaps in our approach are filled.

4. This paper sets out our proposals for our overall aims, the principles to which we will work, and the overarching recommendations as they directly affect individual NICE work programmes.

5. The proposals focus on the participation, engagement and involvement of patients and the public in NICE guidance and standards work, acknowledging the content of our wider engagement activities beyond these programmes, and beyond the current remit of the Public Involvement Programme.

6. Following consultation on these proposals, and prior to any formal implementation, there may need to be further consultations as part of updates to individual programmes' methodology and process manuals.

Definitions

7. For the purposes of this paper the term ‘patients and the public’ is used to describe the patients, carers, people who use services, experts by experience, survivors, and members of the public who contribute to the development of NICE guidance and quality standards. This includes people with a relevant care or support need, condition or disability, family and friends who provide unpaid care for them, people who work at voluntary and community sector organisations and people who have an advocacy role.
8. Individual work programmes within NICE use different terminology to describe the different types of committees, and committee members. For consistency, the terms adopted here are from Developing NICE Guidelines – The Manual\textsuperscript{1}.

9. Occasionally the term 'lay member' or 'lay person' is used. We acknowledge that this terminology is not universally accepted or recognised, but this term has been adopted as the broadest term that covers the person’s range of skills and experience. In addition, the term 'public participation, engagement and involvement’ is used throughout this guide to describe the input of patients, carers, service users, and members of the public in NICE’s work.

10. Similarly, for the purposes of this document, the term ‘voluntary and community sector organisation’ is used to describe the charities and other third sector stakeholder organisations representing the interests of, and speaking on behalf of, patients, carers, people who use services and members of the public.

Activities that are out of scope

11. We acknowledge that NICE’s public participation, engagement and involvement activities extend beyond guidance and standards development, and include activities such as involvement with citizens through our Citizens Council, and the open scrutiny of holding our Board and committee meetings in public.

12. The Public Involvement Programme also supports patients and the public in NICE programmes and activities outside of guidance and standards development (see Appendix 2). The extensive nature of the guidance and standards work, and the current variety of approaches within these programmes, means that we have had to focus these recommendations in this area of work. A second phase, reviewing our approaches to these other areas of work, will follow in the 2017-18 financial year.

Consultation proposals

13. We are now consulting on proposals and recommendations and are seeking your views. The consultation will run for 13 weeks from 1st August to 31st October 2016. The consultation questions are listed in Appendix 3. Depending on the responses, there may need to be further consultations as part of updates to individual programmes’ methodology and process manuals.

\textsuperscript{1} https://www.nice.org.uk/article/PMG20/chapter/1\%20Introduction\%20and\%20overview
Aims of involvement, participation and engagement with patients and the public

14. NICE seeks to improve the health and wellbeing of the population through our guidance recommendations and quality standards. We recognise that people who use health and social care services are agents of change within the system and therefore we:

- work in a co-productive way so that our guidance and standards:
  - take direct account of the perspectives of people using health and social care services
  - are available for people to make informed choices about the services, interventions, care and treatments open to them.
- take a standardised and evidence-based approach to involvement, and seek to uphold internationally agreed values and standards in relation to participation and engagement.

Principles for involvement, participation and engagement in guidance and standards development

15. The following principles for patient and public participation in guidance and standards development are recommended:

- topics for NICE’s guidance and standards work programmes are informed by the views of patients and the public
- key questions and outcomes (scopes) are informed by the views of patients and the public
- guidance committees take direct account of the perspectives of patients and the public, with minimum of two lay members on each committee
- guidance and standards take formal account of information* relating to people’s experience of care and services
- guidance and standards are written clearly and comprehensibly to inform people about the care available to them
- guidance and standards are disseminated and marketed to the public to raise awareness and support informed decision making
- NICE staff and committee members support patients and the public in participating in our work
- patients and the public are supported to work with NICE
- patients and the public have opportunities to:

* by information we mean a wide range of sources relating to people's experiences of care and services - from formal published research and expert submissions and commentary, through to individual testimony
- obtain feedback from NICE on the impact and value of their contributions, and
- feed back to NICE about their experiences of participation to help us shape continuous quality improvement.

Overarching recommendations for change

16. We are already achieving many of these principles. In order to ensure that both NICE staff and the people who work with us to develop our guidance understand that all of these principles are important, the following are recommended as overarching activities to support involvement, participation and engagement in guidance and standards development. Specific significant implications for individual development programmes are listed below.

Standardised approaches to participation, involvement and engagement in guidance and standards

17. Where possible, standardise approaches to involvement and participation across NICE guidance and standards development programmes to ensure the right input from the right people at the right time, reducing confusion and inefficiency. A current map of the variation between programmes is listed in appendix 5.

Early involvement in guidance and standards

18. To ensure an appropriate focus for the guidance and standards, enable the earliest possible and continued involvement of relevant patients and the public in shaping scopes, outcomes of interest and evidence review questions.

Incorporation of information on people's experience of care and services

19. Take account of information on people's experience of care, burden of condition and treatment. This could range from formal published research and expert submissions and commentary, through to individual testimony.

20. Set expectations from manufacturers' submissions of including information on experience of care and burden of the condition so that the development committees can consider this alongside information from patients and the public.

Two-way feedback

21. Introduce formal feedback mechanisms for the patients and the public we work with to enhance their understanding of the value and impact of their contributions to our guidance and standards, and for them to feed back on their experiences of working with us.

Dissemination and communication channels

22. Make better use of social media as a tool for communicating our messages and as a means of accessing information about people's experiences of care.
Making PPI 'everyone's business'

23. To ensure that involving patients and the public is a core part of everyone's business at NICE, include a session on NICE's approach to participation and engagement as a routine part of induction of new staff. In addition, consider additional training for committee chairs and those staff members, such as coordinators and project managers, with frequent interactions with patients and the public.

24. Consider the balance of activities relating to support for NICE lay members, such as committee inductions, scoping meetings etc. delivered by the PIP and the guidance and standards development teams to promote better integration of patient and public involvement as a core activity.

25. Introduce an oversight group comprising representatives from NICE teams (draft Terms of Reference in Appendix 4) to provide support and insight for the Public Involvement Programme from its key internal links.

A pool of specialists, supported by a wider network

26. Recruit a broad pool of specialist patient/public members, supplemented by additional recruitment where needed, providing each other with peer support. Specialist committee members would then be drawn from this pool rather than recruited each time. This would have the potential to both enhance the skills and experience of the patients and the public who work with us, and to reduce the burden of repeated recruitment activities. The 'pool' would be refreshed on a regular basis. Core committee members would still be recruited on an 'as needed' basis. The niche nature of some topics would still require specialist member recruitment.

27. Engage a wider involvement network of interested lay people and organisations to provide a diverse group of interests on whom we could draw for expertise and act as a sounding board, and who can feed into the 'pool' described above.

An improved name for the support team

28. Rename the support team to better reflect its work and the constituency it serves. 'Public Involvement Programme' implies a focus on citizen involvement which lies outside of the team's current remit, with the potential exception of the citizen engagement as part of our public health work. In addition, the term 'involvement' has passive implications which the terms 'engagement' and 'participation' may not.

Proposed changes - implications for each programme

29. The proposals listed below are those rated as 'red' in the table in Appendix 4, and therefore are those requiring the most significant changes to current processes.
Technology appraisals guidance and highly specialised technologies guidance

30. Some patient experts find the process of giving testimony to committee satisfactory, while others report that their role is confusing and sometimes frustrating. For example some patient experts are not given the opportunity to contribute to the committee discussion in a way that they think would better explore the issues that concern them. Some also report frustrations at not being able to give a final summing up. In addition the process of nominating is confusing because it differs from the approaches in other programmes.

31. As a consequence we either need to change the patient expert process to ensure that those helping us feel they are making a meaningful contribution to the committee discussion, or we need to take a different approach to how we integrate patient views. Our stakeholder survey (see Appendix 1) indicated that people directly affected by the condition under consideration should be involved in the decision making, which could be achieved by using a model that involves a combination of core lay members and specialist contributions.

- Proposed options:
  - In order to reduce variability and improve people's ability to contribute, ensure a standardised approach to how committees interact with and seek contributions from the patient experts during the meetings
  - To increase efficiency and reduce confusion about the process for choosing patient experts, select patient experts from a pool of specialists rather than seeking nominations for each new appraisal/HST,

OR

- allow self-nomination of patient experts e.g. via the NICE website - a model closer to the recruitment process for committee members

32. We currently routinely ask VCS organisations to make formal submissions of evidence about people's experience of care, the burden of their condition, and the burden of the treatment they experience. As a supplement to this, and in order to encourage technology manufacturers to be explicit about the unmet need and the improvements in a patient's quality of life their product is addressing, any submission to NICE should address this issue.

- Proposal - set expectations from manufacturers' submissions of including information on experience of care and burden of the condition so that the development committees can consider this alongside information from patients and the public.

Diagnostics

33. We routinely ask VCS organisations to make formal submissions of evidence about people's experience of care, the burden of their condition, and the burden of the treatment they experience. As a supplement to this, and in order to encourage technology manufacturers to be explicit about the unmet need and
the improvements in a patient's quality of life their product is addressing, any submission to NICE should address this issue.

- Proposal - Set expectations from manufacturers' submissions of including information on experience of care and burden of the condition so that the development committees can consider this alongside information from patients and the public.

**Medical technologies**

34. On occasion the medical technologies programme considers products that are used or operated by a patient or carers. In such circumstances an equivalent to the TA 'patient expert' model is currently used. For the reasons given above this can lead to frustration on the part of the experts who are not able to take part in committee decision making. Our stakeholder survey (see Appendix 1) clearly stated that people directly affected should be involved in the decision making. Ideally we should be looking to identify a model that involves a combination of core lay members and specialist contributions.

- Proposed options:
  - In order to reduce variability and improve people's ability to contribute, ensure a standardised approach to how committees interact with and seek contributions from the patient experts during the meetings
  - To increase efficiency and reduce confusion about the process for choosing patient experts, select patient experts from a pool of specialists rather than seeking nominations for each new appraisal/HST,

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- Proposal - set expectations from manufacturers' submissions of including information on experience of care and burden of the condition so that the development committees can consider this alongside information from patients and the public.

**Interventional procedures**

36. At the moment we do not ask for evidence submissions from relevant stakeholder organisations as part of developing IP guidance. As a consequence we are potentially missing helpful patient-focused evidence.
• Proposal - encourage written submissions, using a standard template, from voluntary and community sector organisations as a routine part of evidence gathering, alongside evidence from individual patients acquired (currently) through questionnaires

**Clinical guidelines**

37. On a topic specific basis we should be considering people’s experience of care, burden of condition, burden of treatment etc, where such a consideration would add value e.g. in contextualising the effectiveness evidence, and/or where interventions are complex. Such questions help in making recommendations about interventions or actions that could improve people’s experiences and quality of life.

• Proposal - identify evidence questions where a sub-question on people’s experience of care or services would add value in relation to the topic under consideration

38. At the moment we do not ask for evidence submissions from relevant stakeholder organisations as part of developing clinical guidelines. As a consequence we are potentially missing helpful patient-focused evidence.

• Proposal - encourage written submissions, using a standard template, from key voluntary, community and social enterprise organisations as a routine part of evidence gathering and not just in relation to evidence gaps

**Public health guidelines**

39. On a topic specific basis we should be considering people’s experience of care, burden of condition, burden of treatment etc, where such a consideration would add value e.g. in contextualising the effectiveness evidence, and/or where interventions are complex. Such questions help in making recommendations about interventions or actions that could improve people’s experiences and quality of life.

• Proposal - where relevant identify evidence questions where a sub-question on people’s experience of care or services, or the acceptability of interventions, would add value in relation to the topic under consideration

40. At the moment we do not ask for evidence submissions from relevant stakeholder organisations as part of developing public health guidelines. As a consequence we are potentially missing helpful community-focused evidence.

• Proposal - encourage written submissions, using a standard template, from key voluntary, community and social enterprise organisations as a routine part of evidence gathering and not just in relation to evidence gaps

**Social care guidelines**

41. At the moment we do not ask for evidence submissions from relevant stakeholder organisations as part of developing social care guidelines. As a consequence we are potentially missing helpful community-focused evidence.

• Proposal - encourage broad written submissions, using a standard template, from key voluntary, community and social enterprise
organisations as a routine part of evidence gathering and not just in relation to evidence gaps

Quality standards
42. No significant changes proposed in relation to specific methods and processes, although any changes to the guidelines programme will affect QS indirectly - future specialist committee members to be drawn from the proposed 'pool' and the balance of core to specialist members will be reconsidered.

Implications for the Public Involvement Programme and other NICE teams
43. These recommendations should introduce efficiencies to both the public involvement team and to the guidance and standards developer teams in the longer term. There may be 'teething' issues during transition but steps will be taken to mitigate these.

44. A different approach to identifying, recruiting and supporting our lay members may well necessitate a reconfiguration of the current workload distribution within the public involvement team. Changes to processes and methods may also mean that the current approach of specialisation according to NICE work programme may need to be reconsidered.

45. However these changes are likely to reduce the burden on the team in relation to the 'translation role' we currently perform, describing the different methodologies and processes of NICE's various work programmes to our lay participants - more standardised approaches should facilitate this. Similarly a reduction in the number of 'as needed' recruitments should free up capacity in the team to be able to innovate, develop long-term strategic projects and be creative and pioneering about future approaches to involvement.

46. A re-stating of the aims of patient and public involvement at NICE should also provide the team (and our other NICE colleagues) with clarity of purpose about the team's responsibilities, and just as importantly, what lies outside of our remit.

Exclusions
47. As indicated a number of programmes and activities outside of guidance and standards development involve the participation of patients and the public (listed in appendix 2). Some of these are currently supported by the PIP and some lie outside of our remit. We will consider, and present to the Board, recommendations for changes within these activities as a 'phase 2' of this project.

Next steps
48. Following feedback from the Board, the above proposals will be subject to a public consultation exercise. The consultation will run from 1st August 2016 to 31 October 2016 (13 weeks in total).

49. Comments from the public consultation will be summarised and considered and thematic responses will be prepared.
50. A summary of the comments, any changes to the proposals, and a draft implementation plan will be submitted to the January 2017 Board report, with a view to initiating the implementation plan from 1st April 2017, subject to any further consultations needed on individual programmes' methodology and process manuals.

Gillian Leng, Health and Social Care Director
Victoria Thomas, Head of Public Involvement
June 2016
Appendix 1 - A review of NICE's public involvement activities - summary of evidence and findings

Introduction
1. As part of the Public Involvement Programme's 2015-16 objectives, we agreed to review NICE's overall approach to public and patient participation. The findings of the review are presented here.

Background
2. A review of NICE's public involvement activities has been triggered by three key prompts.
   - The findings of a recent literature review on best practice in public involvement in the development of clinical guidance and quality standards. It is critical for an evidence based organisation such as NICE to ensure that its public involvement activities are aligned with theoretical and research-based best practice
   - NICE’s recent Triennial Review included a recommendation of direct relevance to NICE’s public involvement activities:
     - “Recommendation 8: NICE should continue to work with patient groups to make its approach to supporting patients more transparent and identifying where it can provide more support to those participating in the work of NICE.”
   - Approaches from NICE’s Board members about the Public Involvement Programme’s (PIP) capacity to continue to deliver a ‘gold standard’ service given increasing demands and limited capacity

Purpose
3. The purpose of the review is to refocus on key high value activities leading to a motivated and enthusiastic workforce. Given the ongoing financial constraints we also sought to consider the reduction or termination of low value activities with a view to building or freeing up capacity within the team, within the organisation, and among the lay members.
4. We wish to ensure enthusiasm and motivation within the public involvement team for future ways of working.

Governance
5. The project has been led by the Head of Public Involvement reporting to a Project Oversight Group which has met three times to date. The Oversight Group is Chaired by the Health and Social Care Director and comprises members from the Public Involvement Programme, the guidance and standards
Appendix 1 - A review of NICE's public involvement activities - summary of evidence and findings

development teams, an academic specialising in public involvement, and two of NICE's lay committee members.

6. Ongoing progress has also been noted at the Public Involvement Programme's weekly team meetings, and bimonthly strategy meetings. Initial findings were presented to the Board at its strategy meeting in December 2015 and at a public stakeholder meeting in January 2016.

Assumptions

7. The review has assumed no increase in funding for public involvement activities at NICE. The review has also assumed no change in governance arrangements for the Citizens Council and the Meetings in Public work programmes. These two programmes sit outwith the scope of the Public Involvement Programme. Their function as part of NICE's direct engagement with the public is acknowledged however the boundaries of this review concentrate for the main part on the involvement of patients and the public in the development of NICE's guidance and standards.

Literature review

8. A narrative literature review examined the key themes in the international public involvement literature. It identified a concurrent rise in importance of evidence based medicine and public involvement in health policy as the backdrop to the evolution of PPI in healthcare guidance around the world. It also identified a number of themes for consideration including:

- Integration of experiential and scientific knowledge – fundamental and chair is vital
- Recruitment – diversity and representation required, and patient vs citizen
- Models of involvement – routine vs specific, and role of social media
- Stages of involvement – throughout vs pockets
- Rationale and evaluation – little evaluation, but increases legitimacy

9. The review also suggested a number of practical issues such as:

- the potential barrier of medical and scientific terminology and the need for more accessible and informative glossaries and the use of ‘jargon-buster’ type sessions in critical appraisal training sessions.
- the role of a facilitative guidance group chair as a critical factor in group dynamics
- whether individual or broad societal perspectives are beneficial
- the need to widen search strategies in evidence reviews to include patient preference literature
Appendix 1 - A review of NICE's public involvement activities - summary of evidence and findings

- highlighting the relative uncertainty of recommendations and linking to decision support tools
- improving the route and support for VCS organisations to submit data and information as part of evidence gathering

Public survey

10. The survey, which ran in January 2016 for 2 weeks aimed to explore with a wide stakeholder community how NICE can continue to deliver high quality, meaningful public involvement in a rapidly-changing environment. The survey ran online using software called SNAP. The participants were recruited via a number of communication channels such as NICE website, email invitation, Twitter, staff newsletter & intranet.

11. Twelve questions (a mix of qualitative and quantitative) were posed to a targeted sample of people:

- External population: individuals & organisations potentially involved in NICE work
- Committee members and Board
- NICE staff

Findings

12. We received a total of 684 responses (see Table 1). 553 of these responses were from people external to NICE. 51 NICE staff responded, along with 80 members of the Board and our advisory committees. Of the external respondents, 298 people identified themselves as patients, carers or members of the public; 81 were from our stakeholder organisations; 128 from health and social care professionals. 46 respondents identified themselves as public involvement experts.
Summary responses

13. When asked to prioritise the involvement of patients and the public in a variety of guidance development stages, our respondents were largely aligned in terms of their priority areas (see table 2).

14. The views on with whom NICE should engage was quite mixed. Respondents generally felt that decisions about funding of treatments on the NHS and recommendations about individual treatment or care decisions should incorporate the views of people directly affected by the topic of the guidance. However when making recommendations about population-based public health interventions it was felt that NICE should incorporate the views of the general public/citizens.

15. 311 participants identified gaps in NICE’s current patient and public involvement activities including:

- the need for greater communication to raise awareness of:
  - how patient and the public can be involved in NICE’s work
  - how their involvement impacts on NICE’s work
  - the value of their involvement
- education and training for lay people, staff and committee chairs:
  - “Providing feedback on the impact of stakeholder involvement. Giving examples of impact of patient and public involvement. Increased
Appendix 1 - A review of NICE's public involvement activities - summary of evidence and findings

training committee chairs, committee members and NICE staff on the value of patient and public involvement.” NICE staff

- More outreach engagement
  - “There could be more training and recruitment type events. Often I see vacancies advertised but I imagine only quite specific audiences apply. Maybe doing more outreach work to encourage more applications around minority areas, how to apply, what to expect etc. could be useful.” NICE lay committee member

Table 2 - top 3 priority stages for involvement

<table>
<thead>
<tr>
<th>All responses</th>
<th>External target population</th>
<th>Committee members and Board</th>
<th>NICE staff</th>
</tr>
</thead>
<tbody>
<tr>
<td>defining the outcomes the guidance should consider</td>
<td>defining the outcomes the guidance should consider</td>
<td>defining the outcomes the guidance should consider</td>
<td>commenting on draft guidance</td>
</tr>
<tr>
<td>setting key questions for reviewing the evidence</td>
<td>setting key questions for reviewing the evidence</td>
<td>patients and the public as members of NICE’s committee</td>
<td>defining the outcomes the guidance should consider</td>
</tr>
<tr>
<td>commenting on draft guidance</td>
<td>helping to produce plain language versions of the guidance</td>
<td>setting key questions for reviewing the evidence</td>
<td>setting key questions for reviewing the evidence</td>
</tr>
</tbody>
</table>

16. 180 respondents suggested additional mechanisms that NICE should consider in identifying people’s experience of care. These included:

- provide people with a clearer and more structured approach to feedback their experience of care, e.g.
  - focus groups, workshops, interviews, (online) surveys
  - use of online communities, panels and forums
  - use of social media, e.g. Facebook, Twitter, blogs
- provide appropriate support mechanisms, e.g. signer, interpreter, written documents in multiple languages, physical assistance
- review and incorporated research data on people’s experience of care in line with academic evidence
- work in partnership with voluntary, community and social enterprise organisations to ensure we are making the best use of their data

17. 325 participants provided their feedback on key suggestions for additional public involvement work:
Appendix 1 - A review of NICE's public involvement activities - summary of evidence and findings

- Communication about the work of NICE as a whole, but more specifically about the opportunities to get involved and how patient evidence is used
  - “Perhaps doing more to raise awareness about how NICE operates, and how decisions are reached, and how guidelines are put together.” NICE lay committee member
  - “At the moment I think patient/public involvement is a well-kept secret - I only found out about it in a roundabout way, but I think that there are a lot of people who could be very useful and interested who don't know about the opportunities offered by NICE.” Patient
- Local engagement, e.g. patient participation sessions in GP surgery, local engagement events
- Provide education/training to NICE staff and patients and the public
- Implementation and dissemination of NICE guidance
  - “Patients and public should become more involved in guidance dissemination and should be able to try and influence commissioners to implement guidance.” Primary Care Project Officer

Stakeholder meeting - 26th January 2016
18. The findings from the literature review and the survey were discussed with a multidisciplinary group of stakeholders at a meeting held on 26th January 2016. The views expressed at that meeting are reflected in the proposals that follow.

Recommendations
19. The recommendations for change are set out in the consultation document above and in Appendix 4, but the key thematic issues arising concentrate on standardising approaches and ensuring involvement can occur as early as possible in the development process to ensure the correct outcomes are considered, and the appropriate evidence reviews are commissioned.

Victoria Thomas, Head of Public Involvement
June 2016
## Appendix 2 - Patient and public involvement outside of guidance and standards development

### Supported by Public Involvement Programme
- Accreditation
- Bursary Scheme for the NICE conference
- Commissioning support documents
- Endorsement
- Fellow and Scholars
- Implementation support
- Indicators
- Insight community
- Medtech Information Briefings
- Office for Market Access
- Patient Access Scheme Liaison Unit
- Patients Involved in NICE (PIN)
- Scientific advice
- Shared Decision Making Collaborative
- Student Champions

### Not supported by PIP
- Citizens Council
- Meetings in public
Appendix 3 - Consultation questions

1. What are your views on the stated aims for participation? (paragraph 14)
2. What are views on the principles for participation? (paragraph 15)
3. Given the options outlined in paragraphs 16-41, what are your suggestions for improving patient and public involvement, engagement and participation in NICE’s evaluation of drugs, technologies, guidelines and standards?
4. Do you have suggestions for a new name for the Public Involvement Programme?
5. Is there anything else we should consider?
Public Involvement Oversight Group Terms of Reference

Background
1. The Steering Group is managed by the Public Involvement Programme at NICE.
2. The Public Involvement Steering Group (PISG) has been established to provide guidance and support to the work of the Public Involvement Programme from internal teams and, on occasion, external stakeholders.
3. The Group was established in April 2017 and will be reviewed on annual basis.

Terms of Reference
4. PISC provides oversight and support for the work of the Public Involvement Programme. It has the following terms of reference:
   • to promote a culture of patient and public involvement within NICE
   • to discuss issues of mutual interest regarding PPI at NICE and to advise on developments in the evidence base for public involvement
   • to consider updates to NICE’s PPI policy and other support documents such as its payments for lay contributions
   • to review and comment on the PIP’s annual report to the Board.

Membership
5. The group is chaired by the Head of Public Involvement.
6. Membership of the group comprises representatives from teams across NICE with whom the PIP has key working relationships.
7. Members represent their directorate or team are expected to co-ordinate input into activities that fall under the remit of PISG.
8. Depending on the topic under discussion, the Steering Group members may be joined by additional external experts such as, the Patients Involved in NICE (PIN) group, the core lay members of NICE’s committees, and members of the ‘pool’ of specialist lay members to engage on specific issues.
9. Re-imbursement for any external experts will be in line with NICE’s travel and subsistence policy.
Appendix 4 – Public Involvement Oversight Group Terms of Reference

Meetings
10. The group will normally meet twice a year.

Submitted: July 2016

To be reviewed: July 2017
The Board is asked to receive the update on the Office for Market Access (OMA) safe harbour service.

Professor Carole Longson
Director, Centre for Health Technology Evaluation
July 2016
NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

Update on the NICE Office for Market Access (OMA) safe harbour service

Background

1. Safe harbour meetings are being developed as a first of their kind service from Health Technology Assessment bodies. The meetings enable complex multi-stakeholder discussions to take place in a protective and facilitative environment. Safe harbours aim to include participation from a wide range of stakeholders including the relevant life science company, patients, clinical experts, NHS England, the Medicines and Healthcare Regulatory Agency (MHRA), the Department of Health as well as representatives from relevant NICE teams (for example NICE Scientific Advice, PASLU, PIP and guidance producing teams). OMA will charge for safe harbour meetings on a cost recovery basis.

2. Safe harbour meetings form part of our support to life science companies. The intent of the safe harbour process is to work with companies during their passage through clinical development and market access, with a view to deliver timely patient and NHS access to medicines and technologies.

Creating safe harbours

3. The concept for safe harbour meetings was generated from a similar style of meeting held at a European level through the European Medicines Agency (EMA) Adaptive Pathways, see: http://www.ema.europa.eu/ema/index.jsp?curl=pages/regulation/general/general_content_000601.jsp. These meetings aim to improve timely access for patients to new medicines.

4. There was a clear demand for a similar style of meeting to be held at a national level and OMA put themselves forward as the vehicle for creating the safe harbour process ahead of an anticipated recommendation from the Accelerated Access Review about the development of this type of engagement opportunity for the life sciences industry.

5. OMA initiated and held preliminary discussions with key stakeholders in the autumn of 2015 and subsequently developed a plan to run a pilot safe harbour. NICE had already been in discussions with two pharmaceutical companies that had suitable products going through the EMA’s Adaptive Pathways and these were selected as pilots for the process. The pilots have not incurred charges for the companies as they helped us gain the necessary experience and knowledge to develop a robust process that can be delivered as a cost recovery service.
Safe harbour concept, definition and rules of engagement

6. A safe harbour meeting is a multi-stakeholder discussion supported by rules of engagement designed to ensure a broad, open and free discussion within a confidential framework. They provide a safe environment to share ideas, allowing participants to think beyond their own area of interest. This collaborative approach helps companies deliver a market access plan that is patient and healthcare system focussed. Holding safe harbour discussions at an early stage provides the greatest opportunity for the company to understand what is feasible and desirable for the healthcare system. The discussions are intended to help the company prepare for the processes they will need to follow as they move toward product launch. For example, the discussion can help the company consider what questions the healthcare system would ask about their product and what the practical considerations for the system are.

7. Companies, wishing to discuss plans for their product development and launch, are encouraged to request a safe harbour meeting, via NICE OMA, at an early stage in the development of their product (for pharmaceuticals around the start of Phase II trials and for a MedTech product at the point trials are being designed or value propositions are being developed). The discussions are non-binding and they cannot be interpreted as official or binding advice from participating stakeholders, or as a commitment to action following the discussions.

8. In order to stimulate an open and free discussion, all participants are reassured that any information shared is subject to the confidentiality agreements which individuals participating have already signed. Any relevant declarations of interests for each individual engaging in safe harbour discussions are shared with all attendees.

9. There are no written outputs produced from a safe harbour and papers prepared by attendees would be exempt from release through a Freedom of Information request, as release would prejudice commercial interests.

10. This approach is designed to reassure those taking part that a safe harbour discussion is a safe space in which to discuss issues. The aim is to facilitate an open and honest discussion and a broad exploration of possibilities through the help of an expert facilitator who chairs the discussion.
The first Safe harbour pilot

11. The first pilot took place on 5 April 2016 in the NICE London office. It had over
30 attendees in person, some travelling internationally to attend, and a further
18 joining by teleconference. The meeting lasted for three hours. Networking
time was allowed before and after the meeting.

12. The meeting began with NICE outlining the concept of safe harbour and was
followed by a description of the product from the company. The main body of
the meeting covered whether there was a high unmet need in the treatment
area - clinicians and patient expert played a significant role in these
discussions. The agenda then reviewed feedback received at the Adaptive
Pathway EMA/HTAs stage II meeting and feedback from the MHRA - NICE
Scientific Advice and MHRA staff played the significant role in this part of the
meeting. Discussions also covered potential payment scenarios at a conceptual
level - NHS England and NICE colleagues played a substantial role in the
conversation.

13. As far as we are aware, this was the first meeting of its kind to be held in the
context of the NHS in England. Having all relevant key stakeholders in the
English healthcare landscape in one meeting provided a unique opportunity for
all views to be heard and discussed with the company.

Feedback

14. OMA sought feedback following the first safe harbour pilot. This has provided
valuable feedback for developing plans for the second pilot and for considering
the feasibility of developing a standardised, chargeable safe harbour service.

15. Appendix A contains key feedback statistics received from the attendees from
the first safe harbour pilot meeting. The feedback was very positive; suggesting
that the first safe harbour meeting was a success. A few areas have been
highlighted for improvement.

16. The key aspects being amended prior to the next pilot include :

- Ensuring we set clear deadlines to receive final materials by, so that they
can be shared with all attendees.

- Ensuring that we have all relevant individuals at the meeting – for example relevant expertise from NHS England.

- Briefing participants to ensure that they understand what they will be expected to contribute to the meeting – especially the patient experts.
Next steps

17. OMA is now in the process of organising the second pilot with a company whose product has also been subject of the EMA Adaptive Pathways.

18. Estimates made from the time taken to plan and deliver the first safe harbour pilot show the charge to companies for a safe harbour event in the future would be in the region of £15 - £18k.

19. It is proposed that, following the pilot, and taking into account the evaluative feedback received, the safe harbour service will be offered on a cost recovery basis from September 2016.

Professor Carole Longson
Director, Centre for Health Technology Evaluation
July 2016
APPENDIX A – Safe harbour feedback

Introduction

Following the meeting, the OMA requested responses from all participants via a specially designed feedback survey. This included those who joined the meeting via teleconference as well as those who attended in person. Full results can be found on page 8.

The feedback survey focussed on three areas:

1. Preparation – the build up to the meeting.
2. Meeting content – including feedback on things such as the type of content, interaction and outcomes.
3. Logistics – including the materials, agenda order and venue.

14 responses were received from attendees – including those from the company, the MHRA, patient experts, clinicians and NICE staff.

The responses indicated the pilot was successful and well received by attendees. In the feedback there was not a single ‘strongly disagree’ response – a significant achievement for a pilot meeting.

1. Preparation

This was overall very positive – in response to the overall question ‘I felt that the preparation ahead of the meeting was well handled, relevant and suitably thorough’, all those who responded selected strongly agree or agree.

There were a few areas to note where we received some negative feedback – these included two attendees who were not clear on what type of input they were expected to give at the meeting.

2. Meeting Content

This section was again predominantly positive with the responses to the question: ‘Overall the session delivered what I expected and required’ being largely agree and strongly agree.
This section also contained more critical feedback, which centred on feedback to the question of whether the correct people were present. This reflected that physical presence from NHS England was preferred (NHS England joined the meeting via teleconference).

This is something we are setting in motion for the second pilot. Early indications suggest there will be appropriate NHS England representation in person.

3. Logistics

This section looked at whether the session itself was run effectively. This included questions on timing, agenda, materials and more. The feedback was again mostly positive though there were some clear areas for improvement.

Responses to the question: ‘Overall the session was run effectively’ were all responded to with agree and strongly agree.

The areas that were identified where improvement could be made were on the provision of materials, the venue, time for networking and the way introductions were carried out. We are working on developing a more structured and systematic approach including a timeline and checklist which will improve these areas in the future.
<table>
<thead>
<tr>
<th><strong>Table of Results</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Overall I felt that the preparation ahead of the meeting was well handled, relevant and suitably thorough</strong></td>
</tr>
<tr>
<td>I felt that the process of setting up the meeting was efficient and well organised</td>
</tr>
<tr>
<td>I felt that the choice of venue was suitable for the meeting</td>
</tr>
<tr>
<td>I thought that the pre-meets, deciding the content were sufficient to establish the basis for an effective meeting</td>
</tr>
<tr>
<td>I felt that the communication from the OMA ahead of the meeting was consistent and clear</td>
</tr>
<tr>
<td>It was clear what was expected of me in terms of providing materials for the meeting</td>
</tr>
<tr>
<td>I was clear on the type of input I was expected to give at the meeting</td>
</tr>
<tr>
<td><strong>Overall the session delivered what I expected and required</strong></td>
</tr>
<tr>
<td>The session had clear objectives</td>
</tr>
<tr>
<td>The session met its objectives</td>
</tr>
<tr>
<td>The topics covered were relevant and useful</td>
</tr>
<tr>
<td>The session increased my knowledge and understanding</td>
</tr>
<tr>
<td>I was able to participate fully in the meeting</td>
</tr>
<tr>
<td>I had sufficient opportunity to ask questions in the meeting</td>
</tr>
<tr>
<td>The meeting was chaired effectively</td>
</tr>
<tr>
<td>I felt able to speak freely and honestly</td>
</tr>
<tr>
<td>I felt all the people I needed to speak to were present</td>
</tr>
<tr>
<td>I felt clear about what the next steps for all parties were following the meeting</td>
</tr>
<tr>
<td><strong>Overall the session was run effectively</strong></td>
</tr>
<tr>
<td>There were the right number of breaks</td>
</tr>
<tr>
<td>The time devoted to each item was suitable</td>
</tr>
<tr>
<td>The introductions were clear and necessary</td>
</tr>
<tr>
<td>All the materials needed were included and easy to identify</td>
</tr>
<tr>
<td>The order of discussion was suitable</td>
</tr>
<tr>
<td>The layout of the room was suitable for the discussion</td>
</tr>
<tr>
<td>There was enough time for networking</td>
</tr>
<tr>
<td>The refreshments were adequate</td>
</tr>
</tbody>
</table>
The terms of reference of the Audit and Risk Committee state that the committee shall be appointed by the Board and will comprise five non-executive directors (NEDs) of NICE. There is currently a vacancy on the committee following Rona McCandlish retiring from the Board on 31 March 2016. The Board is asked to appoint Tim Irish to this position on the committee.

The committee composition will then be:
- Jonathan Tross (committee chair)
- David Hunter
- Tim Irish
- Bill Mumford
- Linda Seymour

Bill Mumford’s tenure as a NED ends on 31 July 2016, whilst those of David Hunter and Linda Seymour end on 31 October 2016. Recruitment for these non-executive roles is currently underway and the Board will be asked to fill the arising vacancies on the committee later in 2016 when there is greater clarity on the outcome of this recruitment.

Jonathan Tross’ term of office as a NED ends on 31 December 2016. A NED is specifically recruited to chair the Audit and Risk Committee, and this recruitment is also underway.

The Board is asked to confirm the appointment of Tim Irish to the Audit and Risk Committee.

David Haslam
Chair
July 2016
The Centre for Clinical Practice was renamed on the 1 July 2016 to the Centre for Guidelines (CfG) when the Centre for Public Health and Social Care Programmes joined with the Centre for Clinical Practice to make one guidance producing centre.

The Centre for Guidelines develops and maintains a portfolio of high quality, timely, evidence based and cost effective guidelines that are easily accessible to a range of users on the prevention, treatment and care of people with specific diseases and conditions and service delivery within the NHS. These guidelines form the principal source for Quality Standards. From the 1 July 2016, the Centre for Guidelines will publish guidelines relevant to public health and social care.

The Centre for Clinical Practice also included the NICE Medicines and Prescribing Programme, which provides advice to prescribers and organisations responsible for medicines optimisation together with Evidence Summaries on new medicines and unlicensed and off-label medicines and guidance and advice on medicines optimisation. From the 1 July 2016, the Medicines and Prescribing Programme moved to the Health and Social Care Directorate.

The Centre for Guidelines retained the management of the contract for the BNF, within its commissioning function.

The Centre for Guidelines also hosts the Institute-wide review of methods and processes for the clinical, medicines practice, public health and social care guidelines and is now leading the development of digital strategies to improve the efficiency of processes and the effectiveness of presentation.

The Board is asked to review the progress report.

Professor Mark Baker
Director, Centre for Guidelines
July 2016
Centre for Guidelines 2016/17

1. This report provides the Board with a summary of the progress the Centre for Guidelines made against the business plan objectives for 2016/17.

Clinical Guidelines

2. The purpose of the clinical guidelines programme is to develop and maintain high quality, timely, evidence based and cost effective clinical guidelines that are easily accessible to a range of users on the treatment and care of people with specific diseases and conditions and service delivery within the NHS. The Centre for Guidelines business plan objectives for 2016/17 and delivery of the progress to date is as follows:

3. To publish 25 clinical guidelines including updates. Of the 25 planned topics, 5 have been published up to the end of June 2016. The 5 publications are listed in Appendix A.

Public Health and Social Care

4. The Public Health and Social Care programmes moved to the Centre for Guidelines on 1 July 2016.

5. The overall objective of this programme is to publish guidelines relevant to public health and social care. Progress to date is as follows:

6. To publish 5 Public health guidelines. Of the 5 planned topics, 0 have been published up to the end of June 2016.

7. To publish 1 Social care guidelines. Of the 1 planned topics, 0 have been published up to the end of June 2016.

Surveillance Reviews

8. Surveillance reviews, undertaken at intervals during the life of a published clinical guideline, enable decisions to be taken on whether or not to update existing clinical guidelines.

9. To publish 40 surveillance reviews and 5 exceptional reviews. Of the 45 planned reviews, 3 have been completed and published up to the end of June 2016. The 3 publications are listed in Appendix A.

10. We are developing sustainable processes and methods for reviewing guidelines. Progress to date is as follows:
• We have set up a series of senior strategic meetings to discuss the way surveillance reviews are carried out and are putting plans in place to develop sustainable methods and processes for the future. This includes changes to the frequency of standard reviewing, identifying topics that could go straight to scoping, and, the introduction of continuous searching for live guideline pilots and trial tracking.

11. We are developing new methods and processes to update clinical guidelines to contribute to agreed efficiencies. Progress to date is as follows:

• Work is underway and plans are being developed on a pilot project for scoping medium sized topics in-house as part of the surveillance process. This includes the development of methods and processes which have been recently discussed as part of the CfG teams strategy meetings.

• The process for the validation of accelerated guideline updates is being developed. An options appraisal is being prepared to share with the senior management team in CfG, which identifies the risks and benefits of each option.

External contracts

12. We are required to operate the Centre within budget and put in place plans to meet the agreed efficiency savings. The progress to date is as follows:

• 2 external contractors are operational (31 capacity slots) developing guidelines following new contract agreements that commenced on 1st April 2016.

13. We have removed one guideline slot in the Internal Clinical Guideline Programme during quarter 1.

14. A fourth standing update committee will not be imminently established.

15. Put in place plans to ensure that contractors (including the BNF) and developers embed new processes and methods that will, maintain and improve the quality of work and contribute to efficiencies. Progress to date is as follows:

   Development Centres

16. A ‘Development Programme Dashboard' has been implemented for developers to use when reporting quarterly. This will provide more detailed information to enable greater accountability.

17. We are currently developing a ‘Guideline Development Tool’ for developers to capture contemporaneous and detailed information when reporting on each
guideline. We are piloting this new tool with the Internal Clinical Guideline Programme.

18. The intellectual property rights (IPR) of all full guidelines publications from 1 April 2016 are owned by NICE. We have developed a minimum dataset of documents required to update guidelines, which will be submitted to NICE upon each guideline's publication.

19. We continue to operationalise the new processes developed by the Guidance Development Project, with guideline developers.

BNF Print and Distribution

20. The stickers issued by the BNF Publisher which correct errors in the September 2015 print editions have now been distributed nationally. Some organisations had already implemented corrective measures.

BNF Online

21. A steering group comprising representatives from NICE, the BNF Publisher, NHS Digital, NHS Business Services Authority, Department of Health Pharmaceutical Advisors Group and the Devolved Administrations has been established to develop an NHS owned information standard to replace the legacy BNF hierarchy, and is now meeting quarterly. Work between the BNF, NHS Digital and NHSBSA to develop a mapping between the old and new hierarchies is progressing well.

22. Development of the new BNF platforms on NICE Evidence continues. An alpha platform was delivered in May 2016 for feedback by NICE MPP staff and Associates.

BNF Apps

23. A prototype of the BNF Publisher's new app was delivered for NICE assessment in May 2016. Feedback has been provided and a next iteration is expected July/August 2016. Transition planning is already underway via liaison with the BNF Publisher, NICE Communications and IM&T.

BNF Accreditation

24. The BNF Publisher submitted an Accreditation application on 27 May 2016, which is being reviewed by analysts in the Accreditation team for consideration at the September 2016 Accreditation Committee meeting.

25. We are developing the methods of clinical guideline development to maintain and enhance the Centre’s reputation for methodological quality and efficiency. Progress to date is as follows:
26. The Centre is continuing to support the implementation of the new guidelines manual for those clinical guidelines in development from 1 January 2015. The Centre is also supporting the implementation of revised considerations as to how resource impact is considered during guideline development for those guidelines in development from 1 April 2016.

27. The service guidance, acute medical emergencies, is helping to populate six quality standards, namely; urgent and emergency care, out of hours care, seven day working, consultant review within 12 hours, medical admissions in the first 48 hours and readmissions. This work continues to be challenging in terms of the complex health economic approach required to model the acute medical emergencies services and their influence on other hospital services.

28. Following the NIHR Health Service & Delivery Research (HS&DR) Programme expert seminar in February 2016 that prioritised their future programme of research, we have initiated engagement with NIHR to ensure that the research recommendations developed through the service guidance for acute medical emergencies fits with their agenda.

29. In May 2016, the Centre participated in a DH Quality Research Workshop to discuss with policymakers the merits of a project on the valuation of quality within health and social care ahead of its consideration for funding by DH’s R&D committee. Discussions centred around the proposed approaches and applicability of the outputs to stakeholders such as NICE, NHS England, NHS Improvement and Care Quality Commission.

30. We continue to contract the Technical Support Unit (TSU) to provide specialist technical and methodological advice for guideline-specific issues and on-going training and development sessions for staff in the Centre, Guideline Development Centres and members of Guideline committees.

31. We have maintained involvement with the international Grading of Recommendations Assessment Development and Evaluation (GRADE) working group. Two members of staff attended the annual GRADE working group meeting in May 2016. We have also maintained involvement with the Prediction Model Studies Risk Of Bias Assessment Tool (PROBAST) project, the Quality Assessment Tool for Diagnostic Accuracy Studies (QUADAS-2) project, and the Core Outcome Set Standards for Reporting (COS-STAR) project. A member of staff is a member of the Delphi panel for all three projects.

32. In May, 2016, the Centre hosted the launch meeting of the UK GRADE Network which was attended by members representing all partner organisations: University College London, the Scottish Intercollegiate Guideline Network (SIGN), Cochrane UK and BMJ Evidence.
33. We continue to attract interest from students and researchers seeking short-term placements to gain experience in clinical guideline development. We are a partner organisation of the EU-funded project ‘Methods in Research on Research (MIROR)’ as part of which we will be hosting two PhD students for short term placements in 2018. A member of staff joined interview panels in May 2016 for two studentship awards under this scheme. We have also agreed with the European Respiratory Society to host, with the Cochrane Collaboration, 2 research fellows for 3 month placements in 2016. They will pursue a guideline-related research project of their choosing while being exposed to as many NICE activities as possible.

34. We continue to co-lead the Manchester Evidence Synthesis Network in collaboration with the University of Manchester. The network organises regular educational workshops on topical subjects with high profile speakers.

35. We continue to promote the advance of methodological and process innovation in guideline development. Our approach to updating guidelines will form a plenary session at the 2016 Guidelines International Network (GIN) conference in Philadelphia in September. A further 14 abstracts submitted by 10 members of CCP staff were accepted for presentation at the 2016 Guidelines International Network conference. Three members of staff have been approved to attend GIN and will be presenting the work of the Surveillance and Clinical Guidelines Updates teams.

Guidance Development Project

36. The Guidance Development Project supports the Implementation of the guidelines manual and the NICE content strategy and oversees the transforming guidance development programme. The business plan object for the guidance development project was as follows.

37. To support the Implementation of the guidelines manual and the NICE content strategy; oversee the transforming guidance development programme.

Progress to date is as follows:

38. Work with the resource impact team is ongoing to embed consideration of resource impact earlier in the guideline development process, following changes to the guidelines manual in April 2016. Consideration is currently being given to how the identification of preference sensitive decision points in guidelines by Committees can be formalised, and how data can best be presented to patients.

- Two significant transformation projects have delivered in the current reporting period:
In line with our vision to manage our content as smaller pieces of information and the relationships between them, NICE quality statements have been labelled by population, setting and condition. A discovery tool is available on the NICE web site that enables users to query the collection and retrieve quality statements relevant to their needs. This is the first time that NICE content has been made available to users in this way.

The guidelines and IP programmes are now using EPPI-Reviewer to manage evidence in the systematic review process. Collaborative development of the system continues with EPPI-Centre to provide efficient document supply functionality and improve other features.

Recent developments

Standing Committee Updates

39. Three update standing committees (Committee A, B and C) are now operating fully. Three topics have published to date in 2016/17. A further 11 topics are currently in development, seven of which are due to be published in 2016/17.

International Contextualisation Work

40. Following a meeting in Dublin in March 2016, the Centre is engaged in further discussions with the Ireland Government’s National Clinical Effectiveness Committee to explore how we might contextualise NICE guidelines for the Irish health care context.

41. The Centre continues to work with Best Practice Advocacy Centre New Zealand (BPACnz) to contextualise NICE guidelines for the New Zealand health care context. Two clinical guidelines have now been contextualised - Respiratory Tract Infections and Urinary Incontinence and have been consulted on and published in New Zealand. We are in discussion with BPACnz about future topics. NICE receives an income from BPACnz.

Expert Advisor Panel

42. The expert adviser panel initiated last year has recruited nearly 500 former GDG members from approximately 900 invites sent out to date. The first of the adverts to recruit to expert advisers to fill gaps in the panel went out in May 2016.
Key indicators

CfG Activity Summary
Clinical Guidelines Activity Summary

Published Clinical Guidelines

Cumulative Clinical Guideline Publications 2016/17

- Planned
- Actual
- Variance

Published Surveillance Reviews of Clinical Guidelines

Cumulative Surveillance Review Publications 2016/17

- Planned
- Actual
- Variance
Published Public Health and Social Care Guidelines

Cumulative Public Health and Social Care Publications 2016/17

- **Planned**
- **Actual**
- **Variance**

![Cumulative Graph](image-url)
Appendix A


- Routine preoperative tests for elective surgery (update) (NG45)
- Jaundice in newborn babies under 28 days (standing committee update) (CG98)
- Crohn's disease: management (standing committee update) (CG152)
- Psychosis and schizophrenia in children and young people: recognition and management (standing committee update) (CG155)
- Haematological cancers: improving outcomes (NG47)


Four year reviews:
- CG126 Stable angina: management

Six year review:
- CG101 Chronic obstructive pulmonary disease in over 16s: diagnosis and management

Exceptional reviews
- CG100 Alcohol use disorders: diagnosis and management of physical complications
The Centre for Health Technology Evaluation develops guidance on the use of new and existing medicines, including highly specialised technologies, treatments, medical technologies, diagnostics and surgical procedures within the NHS. In addition to its guidance producing activities, the Centre is responsible for the Patient Access Scheme Liaison Unit, the Science Policy & Research (SP&R) Programme, NICE Scientific Advice, the Office for Market Access and the NICE Topic Selection Programme.

The Board is asked to note the report.

Professor Carole Longson
Director, Centre for Health Technology Evaluation
July 2016
Centre for Health Technology Evaluation

1. This report provides the Board with a narrative progress report on the main business plan objectives for the Centre for Health Technology Evaluation for 2016/17, and highlights recent developments for the months of April 2016 to June 2016.

Business Plan Objectives 2016/17

2. Based on the latest information on the regulatory status of relevant medicines, technology appraisals currently anticipate publishing 50 pieces of final guidance (including 11 CDF reconsiderations) and the patient access scheme liaison unit expect to advise Ministers on 12 patient access schemes.

3. The Medical Technologies Evaluation Programme has published 1 piece of guidance, of a planned 7 based on the selection and routing decisions of the Medical Technologies Advisory Committee. The programme is also forecast to publish 36 medtech innovation briefings following agreement of publication targets with NHS England through the MoU (publication target finalised after the Business Plan published).

4. The interventional procedures programme is expected to publish 10 pieces of guidance.

5. The diagnostics assessment programme has published 2 pieces of guidance in the business year to date out of a planned total of 6.

6. The highly specialised technologies programme expects to publish 3 pieces of guidance.

7. Based on the current schedule and projections for incoming requests, NICE Scientific Advice anticipates recovery of all programme costs and to fully contribute to the Institute’s overhead costs. Since April, the team has worked on 19 advice projects, hosted 3 educational seminars and participated in 8 external events, with a further 12 projects scheduled to start later in 2016/17. NICE Scientific Advice continues to work closely with NICE Digital Services in the development of the Medtech Early Technical Assessment (META) Tool and will be initiating the next phase of testing in July and August.

Other developments

The Office for Market Access (OMA)

8. Over 300 enquiries have been received since OMA launched in October 2015. OMA have also held their first cost recovery Early Access to Medicines Scheme (EAMS) meeting and have further EAMS meetings scheduled. Preparations are proceeding for the second pilot multi-stakeholder safe harbour meeting, which will take place in August 2016.
Science Policy and Research Programme

9. NICE is a partner on two IMI (Innovative Medicines Initiative) research project funding submissions and one IMI Call and Support Action funding submission. NICE was chosen over other comparable agencies to lead & coordinate the regulatory/HTA/payer engagement activities in these projects: suggesting that the external community holds NICE in high regard in the delivery of HTA policy and research activities. The aim of our activities will be to ensure that the projects deliver outputs that are useful for regulatory and HTA agencies as well as being of high scientific quality. There is an indicative budget for SP&R of around £1.04m which will enable recruitment of a project team to deliver this activity over the coming years. The IMI office has confirmed that these projects will continue on a “business as usual basis” following the UK EU membership referendum outcome.

10. Myeloma UK and NICE are partnering in a 2-year research project to explore how patient preferences can be captured quantitatively which, in principle, would facilitate incorporation into decision models or be used alongside other evidence as part of the decision making process. This is a highly innovative project that seeks to translate methodology that is already used in other disciplines into existing HTA methods. SP&R is recruiting a fully-funded 2yr fixed term Scientific Adviser role to work on the project full time. It is hoped that this work will lead to significant future funding. Patient groups are key stakeholders in NICE guidance production and it is therefore important that activities funded by patient groups do not directly impact guidance on specific topics. Appropriate governance arrangements related to patient groups funding research from NICE were carefully considered. The research will be undertaken as part of the SP&R programme which has no direct input to individual guidance topics. Research outcomes will be considered for implementation through standard processes for updating methods and processes guides.
Key indicators

11. Figure 1 highlights programme activity for guidance producing teams for the months of April 2016 to June 2016.
The Communications Directorate is responsible for ensuring NICE’s stakeholders know about how NICE’s work can help to improve quality and change practice in health and social care. We help to protect and enhance the reputation of NICE through daily contact with the public, media, parliamentarians and other key groups. And we contribute to ensuring NICE content meets users’ needs and is easily accessible through our website and other channels.

The Board is asked to review the progress report.

Jane Gizbert
Director, Communications Directorate
July 2016
Our plans for 2016-17

1. The 2016-17 Communications Directorate business objectives are closely aligned to the NICE strategic objectives which are:

   **Content:** Producing guidance, standards and evidence services to enable high quality, sustainable care and support the efficient use of resources;

   **Engagement:** Working effectively with organisations, inside and beyond the public sector, to shape and drive the use of our guidance, standards and evidence services;

   **Adoption and impact:** Providing practical tools and other support to help users make the most of our work and to measure its uptake;

   **Productivity:** Using our staff and our other resources efficiently and effectively, acting sustainably and building future resilience to climate change where needed.

2. This report covers the Communications Directorate’s work in May and June to meet our 2016-17 business plan objectives which are outlined below.

**Objective 1:**

Curate and facilitate high quality content in the outputs from the communication directorate and across NICE

**NICE website and pathways**

3. In June there were over 1.3 million visits to the NICE website with 80% resulting in a meaningful interaction, for example accessing recommendations or completing a stakeholder registration form. For Pathways, there were over 209,000 visits with 58% meaningful interactions.
4. During May and June, we have been taking a more in-depth look at how our audiences are accessing guidance through different routes on the website. For example the graph below shows the number of people accessing guidance through topic pages. Our topic pages give users links to all the guidance, quality standards and other products on a subject in one place. However the graph below shows that less than half the people visiting a topic page actually click through to guidance or other documents. We are investigating this further to see if we need to make improvements to our topic pages.
5. Last month we refreshed and updated our content on quality standards. As part of our move to identify the best way to present complex information using different media formats, we have introduced a new timeline graphic. The timeline provides a visual overview of the development process and gives our audiences the key milestones at a glance. See it here:


Editorial

6. During this reporting period we prepared 61 documents for digital publication. We published 1 new guideline, 17 pieces of CHTE guidance, and 3 Quality Standards

7. There has been a lot of editorial activity to support the changes in technology appraisals, including the appraisals of the cancer drug fund topics and the consultation on the abbreviated technology appraisal process. We have finalised shorter ACD and FAD templates and discussed ways to make the discussion sections of ACDs and FADs shorter and easier to write and read.

8. Road testing of the new guideline template is complete and we are working with the guidelines team to schedule its introduction for forthcoming topics.

9. Training for other teams is one of our activities to help teams across NICE to produce quality content. In May, two of the editors joined the public health team’s workshop on recommendations, and ran sessions on writing recommendations and reporting the committee discussions. The topics covered included writing information that meets our users’ needs and writing with digital publication in mind. We have also discussed the training needs and induction plans for new analysts in technology appraisals.

10. As part of other work to support colleagues writing NICE content, we have updated the NICE glossary to include new NICE terms. We will be promoting it to everyone in NICE, via NICE Space and Writing for NICE training, as the place they should go for NICE definitions to ensure consistency in everything we publish.

11. We have been providing editorial support for the development of a website for the GetReal Project (an EU public-private consortium) investigating new ways of integrating data from real life settings into drug development. As well as editing summaries of the work carried out by GetReal, we have advised on structure and formatting of text appropriate for the web format.
Internal Communications

12. We have engaged staff on a wide range of topics during May and June. We promoted the annual staff survey and secured a 78% completion rate, just beating last year’s 77%. We also introduced a weekly vacancies email to support the 2020 programme which is being read by 78% of staff.

13. We sent text and email updates to staff during the London office closure. Following the incident we asked staff via a NICE Space poll how they wanted to receive information in an emergency situation. 96% said they wanted to receive updates by text.

14. Staff engagement through NICE Space continues to grow. 20 teams now have active blogs and we are seeing an increasing number of staff commenting on articles and taking part in the weekly homepage poll. Interactions with NICE Space rose 16% between May and June. Our most popular article ‘A right royal affair’ was read by 300 staff.

15. During May and June we refreshed the design of our employee magazine NICE times and moved to a more interactive format. The new edition has just been published with lots of positive feedback from staff.
Objective 2: Create a structured and coordinated approach for working with and listening to stakeholders

This objective reflects our ambition to develop systems and strategies to reach stakeholders, keep track of our stakeholders, make it easier for them to register for our various activities, and to monitor and analyse their views and concerns. Cross-Institute collaboration will be particularly crucial in meeting this objective.

**Audience insights**

16. During May and June we conducted a series of in-depth interviews to find out how our savings and productivity resources are being used by healthcare professionals, and to identify areas for improvement. We will be carrying out further interviews in July but interim findings show that our users would like the resources to be easier to find on the website and to be grouped differently to more closely reflect how they are used in practice.

17. To support engagement work with local authorities we have provided advice on a survey to chief executives which is being conducted through SOLACE. The survey aims to find out how chief executives want us to communicate with them, and what their perceptions are of NICE and our work. The results will feed into the wider stakeholder research we are planning with the Reputation Institute.

18. The 4th wave of the Reptrak survey of informed public, (also manged by the Reputation Institute for the Cabinet Office Government Communication Service), was reported to us this month.

19. NICE’s reputation amongst the informed public was calculated by measuring the organisation’s strength in 7 dimensions:

- **Product/Services**: consistently offers an efficient and reliable service that meets the needs of users / customers

- **Development**: develops new ideas and initiatives that improves the quality of users’ / customers’ lives

- **Workplace**: is a positive, attractive and interesting place to work with employees committed to public service

- **Governance**: is a responsibly run organisation that is open and transparent, offering clear accountability

- **Citizenship**: is a fair organisation that has a positive impact on society

- **Leadership**: is an organisation that is well led with clear goals and targets for the future
Performance: is a high performing organisation that delivers good value-for-money

20. The survey found that NICE has a strong reputation (70.4), which is significantly above that of the UK Public Sector average (62.7). Across the 64 ALBs and government departments that were ranked in this wave, NICE is within the top 15.

21. During June we asked our 1500-member Insight Community for feedback on the content of our guidance. We asked them a range of questions to identify the most important sections, and to find out what influenced them most to put recommendations into practice. We also asked them to compare recommendations written in different ways and select their preference. We received 99 responses and some key points emerging are:

- Most people said they read fewer than 10 recommendations

- The strongest factors influencing the respondents to follow NICE recommendations and change their practice are that recommendations are up to date and the evidence and reasoning behind the recommendations are clear.

- The most common elements stopping the respondents from implementing recommendations in guidelines are that the evidence seems out of date, recommendations are not practical to implement, they don’t have the resources to implement the recommendations, or the actions aren’t clear.

- The majority of respondents said they preferred recommendations to be written to be in plain English with shorter sentences.

Enquiries

22. During May and June we responded to 1,872 enquiries. The origin of enquiries remained broadly the same with the NHS accounting for 30% and members of the public accounting for 36%. International enquiries were up slightly at 7%.

23. We responded to 27 requests made under the Freedom of Information (FOI) Act. These covered a wide range of subjects including a request for all information held relating to the relationship between NICE and the National Obesity Forum, a request for information held on NICE activity relating to the 2014 PPRS, and a request for strategy papers relating to NICE International and Scientific Advice.
24. Seventeen parliamentary questions were answered during May and June. These included questions on the cost assessment made for hepatitis C treatments, the implementation of the cancer drugs fund, and any guidance issued by NICE on the use of gastric balloons for people with diabetes.

25. We responded to 23 MP letters. Many of these expressed disappointment in our recommendation not to offer lumacaftor–ivacaftor (Orkambi) for treating cystic fibrosis homozygous for the F508del mutation.

26. We have also started to receive correspondence from patients unhappy with our guidance on CFS/ME, in anticipation of a review next year.

External relations

We have developed a microsite to present the 2016-17 NICE business plan in a user friendly format. The microsite is due to be launched this month and will be promoted to key stakeholders, highlighting our key priorities for the year ahead and explaining how NICE will work in partnership with the health and social care system to deliver our business objectives. See the business plan here: http://businessplan2016-2017.nice.org.uk

27. Together with NHS England we organised two stakeholder engagement events to discuss plans for the new Cancer Drugs Fund arrangements with industry. The events were an opportunity to engage further with stakeholders on plans for the CDF and the finer detail of the operating procedure.

28. In May and June we worked with the RCGP to place an interview with Rosie Benneyworth in their members' bulletin, Clinical News. We also featured the consultation on multimorbidity in the bulletin and in the Chair’s weekly message to all RCGP members.

29. We disseminated information on the TA for sacubitril heart charities, cardiovascular professional associations and royal colleges. We also promoted the Home Care QS in SOLACE’s monthly newsletter.
Objective 3: Promote NICE's work and help users make the most of our products by providing practical tools and support, using innovative and targeted marketing techniques. Contribute to demonstration of impact through regular evaluation

30. In June we were invited to showcase our work on evaluating communications activities at an 2016 conference of the Association for the Measurement and Evaluation of Communications. The international conference was sponsored by the Cabinet Office Government Communications Service (GCS). NICE is one of the GCS Evaluation Champions. We highlighted our menopause guideline, demonstrating how we evaluated the multi-channel activities we used to launch and promote the guideline.

31. The Media team hosted our first Twitter chat on May 12 with Professor Alan Maryon-Davis to talk about the new draft guidance for managing severe mental illness and substance misuse. It made more than 126,000 impressions during the hour (more than a hundred thousand people saw our tweets) compared with an average of 21,000 daily impressions. We also produced an online summary of the chat (#NICEChat) using Storify.

32. The second Twitter #NICEChat ran on July 1st discussing draft guidance for the end of life care for children. A summary of this will be in the next Board report.

33. Our follower numbers on Twitter continue to grow. We now have over 106,000 people following the account, up by 3% since the last report. We made 1.6m Twitter impressions (number of people who saw our tweets) in May – June, up from 1.4m in the previous two months. May was our most
successful month with over 880,000 impressions (number of people who saw our tweets) and 12,500 visits to our profile page. This was largely driven by the Twitter chat we hosted. We have a strategy in place to reply and respond more and increase engagement.

34. The News pages on the NICE website attracted 69,068 new visitors and 42,313 returning (within one month) visitors in May/June, slight drops on the previous two month period. NICE new stories received a total of 20,048 views with the new treatments for type 2 diabetes receiving the most, 1,795 views.

35. The tone of media coverage received during the reporting period was mainly positive or neutral with low levels of negative coverage. In May the coverage was 62% positive, 35% neutral and 3% negative; In June positive coverage was 56%, 38% neutral and 6% negative.

36. We facilitated a NICE exhibition stand at 3 major events in May and June where NICE staff spoke directly to our guidance users to promote new and forthcoming guidance: Community Care Live attended by more than 3,000 social care professionals, the Healthwatch Annual Conference, and the RCN Annual Conference. At the Healthwatch event, Annie Coppel from the Field Team presented a new guide showing how local Healthwatch organisations can get the most out of NICE guidance, titled ‘Giving Healthwatch NICE teeth.’

37. NICE staff and committee members spoke at 39 events and conferences in May and June, engaging with a wide variety of audiences on diverse topics including: NICE’s return on investment tools for local authorities; using NICE quality standards to commission dementia care; and what NICE is doing to tackle antimicrobial resistance.

38. External Communications provided briefings for two Royal College visits for the Chair of NICE to the RCP and RCGP in May and June. The briefings offered a snapshot of their priorities and highlighted key NICE/guidance issues to be aware of.

Objective 4: Be effective and efficient to work better for less

To achieve this objective we will look at how we can work differently to provide high quality communications expertise efficiently and within a reducing budget.

39. The examples below illustrate how we are using software packages and planning systems to work more efficiently.

40. The Media Team purchased new publishing software, Shorthand, which allows us to show off our multimedia content to its best. We first used the
Shorthand software to tell the story of our new draft guidance on end of life care for children.

41. We are now using weekly planning meetings and management tools such as Basecamp to work more closely and seamlessly. The aim is to get the most out of the content we produce. Part of this involves training all team members in using their smart phones to be able to record interviews, create infographics and take great pictures to share across NICE’s communications functions and to illustrate NICE’s work.

42. Work is underway to help us achieve the first phase of the Communication Directorate efficiencies and cost savings programme. Saving are expected to be found through a combination of attrition, cost recovery and a Management of Change exercise which will begin in the autumn of 2016. We are working with staff to develop a plan that will support the communication need of the organisation in 2016-17 and beyond.
The Evidence Resources directorate comprises two teams which provide a range of functions to NICE:

- The Digital Services team delivers NICE’s digital transformation programme and maintains all NICE’s digital services.
- The Information Resources team provides access to high quality evidence and information to support guidance development and other NICE programmes. It also supports the provision of evidence content to NICE Evidence Services and it commissions key items of content made available to the NHS via the NICE Evidence Services.

The directorate manages the NICE Evidence Services, a suite of evidence services including a search portal (Evidence Search), the Clinical Knowledge Summary service (CKS), access to journals and bibliographic databases via a federated search (HDAS), and medicine awareness products.

The Board is asked to review the progress report.

Alexia Tonnel
Director Evidence Resources
July 2016
Performance against business plan objectives for 2016/17

1. This section of the report introduces the directorate objectives for 2016/17 and summarises the directorate’s performance in the first quarter of this financial year.

**Evidence Information Services and Commissioned Content and Access Management teams**

2. A key objective of the team is to ‘deliver and continue to improve the suite of digital evidence services that constitute NICE Evidence Services’, and to do so within a reduced funding envelope. During Quarter 1, the team:

   - Prepared to phase out the Eyes on Evidence and the Public Health Awareness bulletins. The last issue of Eyes on Evidence will be in July 2016;
   - Worked with the Digital Services team to prepare the beta launch of the improved federated search (HDAS) and the BNF service; and
   - Is updating the tagging of content to launch a new ‘type of information’ filter on Evidence Search which has been developed in collaboration with Public Health England.

3. Another key objective of the team is to ‘put in place arrangements to collaborate with key stakeholder organisations on the provision of evidence services to their users’. This includes developing partnerships with other ALBs to improve sharing and interoperability of content, including work to syndicate NICE content. This also includes commissioning work to support Health Education England (HEE) deliver its information assets to the system. During Quarter 1, particular activities of the team included:

   - Release of the Invitation to Tender for the national Access and Identity Management Service (AIMS) for purchased content for use in England. Nine expressions of interest have been received;
   - Preparation of the procurement documentation for the National Link Resolver and Knowledge Base service; and
   - Release of the Invitation to Tender for the national Framework Agreement for the purchasing of print and electronic content, and scoring of the bids. The process is now in the Alcatel period.

**Guidance Information Services team:**

4. The objective to ‘develop Information Services (IS) capacity and support for new programmes of work’ was carried over from the previous year. In 2016/17, this will include supporting work on the cancer drugs fund (CDF), rapid evidence summaries and commissioning support documents, and any change to requirements for
information services support as a result of the Accelerated Access Review. In Quarter 1, support was provided for a number of CDF topics and for rapid evidence summaries.

5. The team is also maintaining the objective to ‘explore new methods and approaches, and where suitable deliver service improvement in the provision of information services across NICE’. In Quarter 1, the team continued to monitor savings from using the Royal Society of Medicine’s document delivery service and from requesting copyright cleared journal articles under the new NHS copyright licence.

**Digital Services team:**

6. A primary objective of the team is to ‘deliver digital service projects in line with the agreed investment priorities for 2016/17 and NICE’s business plan objectives’. This will cover project work across 3 of 5 Strands of the NICE Digital Strategy. In Quarter 1, notable project work included:

- **Strand 1: Web Services**
  - **Return on Investment (ROI) Tools:** these tools, which help commissioners and policy makers in local authorities and the NHS make better investment decisions, have now completed development. Each tool enables the user to evaluate a portfolio of interventions in their geographical area and models the economic returns that can be expected in different payback timescales. The RoI tools will go live on our website later in July, following a Digital Standards Service Assessment by the Department of Health.
  - **META and Light Scientific Advice:** this project is delivering toolkits for developers of medical technologies and diagnostics, to help them analyse the data they have gathered in supporting their value proposition and, if/when gaps are identified, direct them to relevant resources and services. All development work has been completed and the toolkit is about to go into BETA testing. The META and Light Scientific Advice toolkits are targeted at medical technology SMEs and larger companies respectively and will provide a revenue stream for NICE as NICE will charge for these services.

- **Strand 2: Pathways; Strand 3: Syndication**
  - No further investment in new project work this financial year; however continuous improvement of existing services is ongoing.

- **Strand 4: Evidence Services**
  - **Healthcare Databases Advanced Search (HDAS):** by using HDAS, users are able to search bibliographic databases and access nationally and locally procured content in a single location rather than having to learn how to navigate and search a number of different places. The majority of development work has completed on this project which is undergoing final testing before going live later in July.
- **British National Formulary (BNF) Feed**: an enhanced feed of BNF content is enabling NICE to develop an improved digital service that will provide the right information on medicines, in the right format, in the right place, at the time right to its users. The majority of work is now complete on this project and the new BNF service is due to go into a BETA release later in July, and subsequently live following a Digital Service Standards Assessment by the Department of Health.

- **AIMS**: this system uses Eduserv’s OpenAthens to control users’ access to all of locally and nationally procured content. The contract is due to expire and the digital team are supporting the re-procurement of the service.

- **Link Resolver**: this is a link redirections service to enable users to link to full text documents. The contract is due to expire and the digital team are supporting the re-procurement of the service.

- **Strand 4: Guidance Services**
  - **EPPI-Reviewer**: the team have completed the first phase of work in partnership with the EPPI-Centre at University College London (UCL) to deliver the EPPI-Reviewer which manages systematic reviews of guidance. Work is now ongoing with UCL to migrate data from the pilot systematic review system (STAR) into EPPI-Reviewer. Additional functionality is also being developed or integrated to further EPPI reviewer to meet NICE’s needs - for example, a ‘Screening only’ interface and a ‘Cite While You Write’ which automates citation and bibliography generation.

  - **Document Supply system**: early investigation work (Discovery) has concluded there is nothing available on the market that fully meets NICE’s needs therefore it is the intention that this service will be built by the in-house team. This project aims to deliver a system which looks at NICE’s published guidance, identifies related documents and submits orders to the British Library via their API for these documents. At the moment staff do this work manually for approx. 20,000 articles p.a. and efficiency savings of approx. £75,000 p.a. are forecast as a result of implementing this.

  - **External Consultation & Identity Management**: Early investigation work (Discovery) has commenced on the need for an automated tool to handle external consultations with stakeholders. This project will also investigate how NICE handles identity management for external consultations to ensure that the right people undertake consultations and use NICE services. Identity Management will also enable NICE to track who is interested in what on the NICE website and build up a rounded view of groups of external stakeholders and their interests.

  - **Knowledge Base – Quality Standards**: Follow-up continuous improvement work is in progress to add on a feature that will allow updated content to be published without breaking existing links, this will enable the development of:
• a "what has changed" feature in the discovery tool, which was requested following demonstration at the NICE conference; and

• a feature that allows updates to Quality Standards to be modelled properly where statements are moved between Quality Standards and where statement numbers are reused when statements are reused.

7. Another key objective of the team is to ‘maintain operational service delivery and implement service improvements based on user insights and service performance against key performance indicators’. In Quarter 1, the team delivered the following maintenance and improvement activities:

• Continuous Improvement:

<table>
<thead>
<tr>
<th>Change Control Request (CCRs)</th>
<th>% of Allocation</th>
<th>16/17 Allocation of Days</th>
<th>Q1 Consumption</th>
<th>% Total Usage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strand 1: Website</td>
<td>35%</td>
<td>385</td>
<td>159</td>
<td>41%</td>
</tr>
<tr>
<td>Strand 2: Pathways</td>
<td>5%</td>
<td>55</td>
<td>23</td>
<td>42%</td>
</tr>
<tr>
<td>Strand 3: Syndication</td>
<td>5%</td>
<td>55</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Strand 4: Evidence</td>
<td>35%</td>
<td>385</td>
<td>93</td>
<td>24%</td>
</tr>
<tr>
<td>Strand 5: Guidance Development</td>
<td>20%</td>
<td>220</td>
<td>84</td>
<td>38%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>1,100</td>
<td>359</td>
</tr>
</tbody>
</table>

Overall, consumption of the CCR budget is higher than anticipated for this quarter.

Web and Guidance Services have had higher consumption due to less developer and Business Analyst resource being required on projects which has enabled them to focus on CI initiatives. As more projects move out of Discovery, the balance of activity will become more focused on project delivery rather than CCRs.

Pathways Service Group had a large number of CCRs queued from last year therefore consumption has been high for Q1; it is anticipated that now this backlog is cleared, consumption will level out for this strand.

• Defect Resolution:

<table>
<thead>
<tr>
<th>Maintenance (Defects)</th>
<th>% of Allocation</th>
<th>16/17 Allocation of Days</th>
<th>Q1 Consumption</th>
<th>% Total Usage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strand 1: Website</td>
<td>35%</td>
<td>525</td>
<td>80</td>
<td>15%</td>
</tr>
<tr>
<td>Strand 2: Pathways</td>
<td>5%</td>
<td>75</td>
<td>6.5</td>
<td>9%</td>
</tr>
<tr>
<td>Strand 3: Syndication</td>
<td>5%</td>
<td>75</td>
<td>3</td>
<td>4%</td>
</tr>
<tr>
<td>Strand 4: Evidence</td>
<td>35%</td>
<td>525</td>
<td>78</td>
<td>15%</td>
</tr>
<tr>
<td>Strand 5: Guidance Development</td>
<td>20%</td>
<td>300</td>
<td>20.5</td>
<td>7%</td>
</tr>
<tr>
<td></td>
<td></td>
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<td>1,500</td>
<td>188</td>
</tr>
</tbody>
</table>

Consumption of maintenance budget is lower than forecast which is positive, and supports the overall trend for reduction in defects being raised; this is the
expected outcome from ongoing investment in continuous improvement of systems and services.

<table>
<thead>
<tr>
<th>Q1 16/17</th>
<th>Defects Open</th>
<th>Defects Closed</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>P1 - Critical Incident</td>
<td>0</td>
<td>10</td>
<td>10</td>
</tr>
<tr>
<td>P2 - High Priority Defect</td>
<td>3</td>
<td>44</td>
<td>47</td>
</tr>
<tr>
<td>P3 - Medium Priority Defect</td>
<td>11</td>
<td>88</td>
<td>99</td>
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<tr>
<td>P4 - Low Priority Defect</td>
<td>11</td>
<td>32</td>
<td>43</td>
</tr>
<tr>
<td>P5 - Very Low Priority Defect</td>
<td>0</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td><strong>25</strong></td>
<td><strong>179</strong></td>
<td><strong>204</strong></td>
</tr>
</tbody>
</table>

Only 3 defects remained open from Q4 15/16. During Q1 16/17 a further 201 defects have been raised of which 88% have been resolved.

- **Hosting Migration Project**: The team have now implemented a new ‘virtual’ hosting service for NICE’s digital services and applications. This uses Amazon Web Services (AWS), a cloud service which reduces the need to invest in expensive hardware assets and allows high flexibility in usage. The team are now progressing moving all services onto AWS. Significant savings are expected from this project over the next 2 years.

8. The team has a further objective to ‘continue to build capacity and capability across the Digital Services teams’. This will cover user experience (UX) testing, semantic development, content modelling, agile methodology management tools, and disaster recovery resilience. In Quarter 1, the following improvements to capabilities were under way:

- Three new staff were recruited into the UX/Design team re-building depleted capacity during 2015/16;
- As part of the Hosting Migration Project a new approach is being taken to disaster recovery through the implementation of resilient services in different zones of availability within AWS. This enables automated fail-over in the event of a serious issue within a particular availability zone. This will be tested as part of the Hosting Migration Project;
- Plans are being put in place to further develop security policies for NICE Digital Services and subsequently put in place further risk management measures; and
- Within the Information Architecture and Search team a 6 month fixed term post has been filled (starting 1st June) to cover data modelling needs in short term. A consultation is in progress on a management of change to establish two new roles: Data architect and Healthcare terminologies analyst.

9. A related objective of the team is to ‘continue to improve the productivity and effectiveness of the NICE Digital Services teams’. Targets include further improvement in the end to end delivery time of small changes, improving scheduling of suitable resource across the project portfolio and more closely monitoring project ‘burn
charts’ against plan, recruit permanent staff in line with budget assumptions, improve retention and develop talents. In quarter 1, the following activity was under way:

- 15 new staff started with the NICE Digital Services team or were successfully appointed to team since the start of the financial year. The successful campaign was underpinned the team building their presence and visibility in the North-West digital community to attract new talent;

- Recruitment of a permanent Portfolio Manager has enabled creation of a Portfolio Management Office (PMO). This function has commenced resource management and provided the first round of resource forecasting against Digital Projects, enabling a realistic view of what is feasible to deliver in 16/17 against available resource capacity;

- Work is in progress to further standardise how teams deliver agile projects; this will be aligned with Government Digital Services standards and approach and will enable NICE Digital Services to pass the Digital Service Assessments required by DH/Cabinet Office Spending Controls to release project delivery funds.

10. The final objective of the team is to ‘promote collaboration on digital initiatives and content strategy across ALBs and with academic establishments and other external stakeholders’. Notable developments and events in Quarter 1 were:

- Continued collaboration and communication with Cochrane regarding digital transformation projects;

- Acceptance of two workshop abstracts exploring digital systems to support systematic reviews and guideline development for both the GIN conference and Cochrane Colloquium – co-authored with GIN Tech working group;

- Support to research projects including:
  - HENCE – A project to improve the management of evidence using a human and artificial intelligence driven ecosystem built on the principles of linked data.
  - The Wearable Clinic: Connecting Health, Self and Care – A project to investigate the novel interoperation of patient-driven signals of everyday functioning from wearable sensors, clinical knowledge representable from electronic health records and networks of actions around shared care plans.

**IP and Content Business Management**

11. Subject to completion of a proposed management of change exercise, a new team focused on developing business opportunities associated with the use and re-use of NICE content is being put in place within the NICE Evidence Resources directorate. There are three objectives associated with the work on this team:

- ‘to actively pursue revenue generation opportunities associated with the use and re-use of NICE content and quality assurance’;
‘to continue to encourage the use of NICE content through the use of the NICE Syndication service’; and
‘to contribute to the development of a strategic plan to grow NICE’s commercial activity over the next 10 years’.

12. Notable developments and events related to these objectives in Quarter 1 were:

- A paper submitted to and agreed by SMT to set up a new IP and content business management team;
- Letters sent to NICE’s top 50 ‘content’ customers to introduce them to the new process for permission to use NICE content;
- Presentation delivered at Evidence Live on how syndicated NICE content supports Evidence in to practice;
- £23,316 of content related income generated.

**Directorate-wide objectives**

13. There are 2 further objectives held at directorate level:

14. The first is: ‘Subject to the release of budget for this programme of work, support the implementation of the National Information Board (NIB) ‘Framework for Action’ and specifically contribute to the development of a framework for the assessment of digital applications.’ Notable developments and events related to this objective in Quarter 1 were:

- A bid for funds has been submitted to the Health and Social Care Information Centre (HSCIC) to support NICE’s resource costs for the next quarter in continuing to support the work of the NIB.
- NICE staff are developing the overall framework for the assessment of digital applications with colleagues from Public Health England (PHE), HSCIC, and NHS England, with a particular focus on developing:
  - methods of characterising and classifying digital applications for the purposes of evaluation;
  - a topic selection process relevant to digital applications, aligned to national and local processes;
  - a new NICE evidence evaluation product for digital applications;
  - an evidence guide, setting out and explaining different types of studies relevant to the evaluation of digital applications. The guide would be aimed at manufacturers and NHS and Social Care organisations involved in identifying and adopting digital applications,
- This work complements work being undertaken by HSCIC and PHE on the more technical aspects of the assessment of digital apps and the development of a digital
platform to support the assessment.

15. The second is ‘to implement the first year of a three year strategy to manage the reduction in the Department of Health’s Grant-In-Aid funding and plan for a balanced budget in 2017-18’. Notable developments related to this objective in Quarter 1 were:

- A Management of Change consultation was initiated on Tuesday 21st June to propose changes to the Evidence Information Services, Commissioned Content and Access Management and the Information Architecture and Search teams in the Directorate. The consultation will close on 19th July.
- Negotiations with providers of content are underway to deliver the targeted cost reductions.
- Recruitment into the Digital Services team is progressing well, in line with savings plans for the year.

Key statistics and activity indicators from the Directorate

NICE Evidence Services: statistics

16. The performance of NICE Evidence Services is reported in this section, following the same format as performance reporting on the NICE Website and NICE Pathway service by the Communications Directorate. Each sub-service of the NICE Evidence Services has been separated to allow the reader to focus on three key metrics:

- The first metric is ‘sessions’ to the site, which is the number of visits to a website within a date range
- The second metric is ‘meaningful interactions’, which, as the name suggests, is a percentage of visits that completed one or more meaningful interactions for that digital service. These ‘meaningful’ interactions are agreed by the Service Group and are the basis for any continual improvement to the digital service. For example, for Evidence Search, a meaningful interaction is a user clicking on a search result following a search or scrolling down the page to assess results.
- Lastly the ‘% of returns within 10 days’ is provided, which again is a percentage of visits and is a metric used by the Service Group to monitor engagement in the digital service and user loyalty.

These dashboards and similar dashboards including online versions provide a consistent framework for recording digital services performance.
17. Key developments in the last quarter include:

- Evidence Search: sessions have decreased gradually from April to June (seasonal, same trend than last year). 9% increase in meaningful interactions year on year.
- HDAS: sessions have also decreased gradually month on month (seasonal too). Meaningful interactions have increased 53% year on year.

**NICE Apps: statistics**

18. The reporting for NICE Apps follows the same new performance reporting model. Downloads are now omitted from this report.
Information Services: activity levels

19. The number of searches undertaken by guidance Information Services (gIS) in the last quarter is summarised in the graph below.
Risk register update

20. The assessment of the risks associated with delivering the Evidence Resources directorate responsibilities has not changed since it was presented to the Audit Committee in June 2016.

- Risk levels were not changed.
- No new risks were added to the Evidence Resource register
- Key progress on actions to mitigate risks included progress with the governance arrangements associated with the NIB App Assessment work reported in paragraph 14 and progress with hosting migration reported in paragraph 7 (last bullet).
The Health and Social Care directorate covers a range of work: quality standards, indicators, accreditation, the Public Involvement Programme (PIP), external engagement, support for the adoption of NICE guidance and standards and guidance and support for safe and efficient use of medicines.

Quality standards are developed for healthcare, public health and social care, alongside associated indicators to inform routine measurement across the health and care system.

This report provides the Board with an overview of the Health and Social Care directorate’s achievement against its main objectives for 2016/17. The report also highlights notable developments alongside key programme indicators.

The Board is asked to review the progress report.

Professor Gillian Leng
Director, Health and Social Care Directorate
July 2016
Progress against business plan objectives for 2016/17

1. The following sections, by programme, provide the Board with an overview of achievement against the business plan objectives from April 2016 to June 2016.

Leadership & Engagement Programme

2. This programme is central to supporting NICE’s strategic engagement with external organisations, and coordinating cross-Institute functions for the Health and Social Care directorate. Progress against deliverables during the first quarter of 2015/16 include:

- Engaging with 12 Local Authority social care commissioners against an annual target of 120 (80% of commissioners).
- Identifying two examples of NICE public health related guidelines or quality standards being used to inform Local Authority health and wellbeing policies or commissioning arrangements (annual target 40).
- Engaging with 3 local social care provider networks (annual target 10 networks). From the networks visited, 2 practice examples have been identified that outline how the networks are taking forward recommendations from the NICE guideline on transition between inpatient hospital settings and community or care homes settings for adults with social care needs.
- Planning a campaign of engagement targeting 30 GP Federations to report on use or planned use of NICE guidance, quality standards or indicators.
- Engaging with 7 acute and specialist trusts (annual target 120 or 80% of trusts.
- Hosting 2 student champion training events, reaching 13% of the predicted target of 15 events for the year.

Public Involvement Programme

3. The overall objective of this programme is to support opportunities for public involvement across all of NICE’s work programmes, and to encourage lay stakeholder organisations to support implementation. Overall progress against deliverables includes:

- Delivering three training sessions for guideline and public health committee lay members.
• Receiving 274 applications for 28 vacancies across 19 guideline and standing committees. Of these:
  – 31 full places were offered on committees.
  – 5 lay people were invited to join the Quality Standards, Public Health, Diagnostics and Guidelines Update Committees as specialist members.
  – 27 people gave testimony to the Technology Appraisals and Highly Specialised Technologies Committees as patient experts.

Quality Programme

4. The overall objective of this programme is to develop and publish quality standards and indicators, and manage the accreditation and quality assurance programmes. Overall progress against deliverables includes:

• Publishing 6 quality standards. Two additional publications will not publish as originally planned (obesity in adults: clinical assessment and management and obesity in children and young people: clinical assessment and management). This is due to additional work with specialist committee members. A new way of finding the quality statements and associated information has been launched on the NICE website. It is now possible to filter by population, setting and condition in order to find the statements that are most relevant.

• Producing two final accreditation decision reports and 9 endorsement decisions.

• Supporting NICE’s work on disinvestment by publishing 2 quality and productivity case studies, and 1 Cochrane review highlighting ineffective interventions. Also see the update on page 7.

• Delivering a further Evidence Based Treatment Pathway package to NHS England on Urgent and emergency psychiatric liaison mental health services.

Adoption and Impact

5. The objective of the programme is to support the adoption and use of NICE guidance and quality standards. This includes providing implementation support, resource impact tools and having responsibility for tracking the uptake of NICE guidance. Overall progress against the deliverables includes:
Completing 19 ‘first adoption engagements’ with health and social care organisations to understand how they have implemented a specific piece of medical technology or diagnostic equipment into their practice.

Producing 5 adoption scoping reports for guidance teams to advise them of the likely barriers to adoption.

Initiating the development of five adoption support products.

Progressing the asthma feasibility project. All 7 primary care sites submitted data for month 1. A successful project update meeting was held with 7 key national stakeholder organisations who commented on the draft guideline recommendations.

Publishing 17 Resource Impact Assessment products. This included working with the education team to complete one multi agency guideline support project to stimulate action on improving knowledge and competency across health and social care to deliver QS116 (statement 2) on domestic violence and abuse.

**Medicines and Prescribing Programme**

6. The purpose of the Medicines and Prescribing Programme is to provide a comprehensive suite of advice and support for delivering quality, safety and efficiency in the use of medicines. Progress against the deliverables includes:

- Publishing six Evidence summaries: new medicines or unlicensed/off-label medicines, out of a planned annual total of 20:
  
  - ESNM 72: Chronic obstructive pulmonary disease: tiotropium/olodaterol (Spiolto Respimat)
  
  - ESNM 73: Reversal of the anticoagulant effect of dabigatran: idarucizumab
  
  - ESNM 74: Complicated urinary tract infections: ceftolozane/tazobactam
  
  - ESNM 75: Complicated intra-abdominal infections: ceftolozane/tazobactam
  
  - ESNM 76: Visual impairment due to myopic choroidal neovascularisation: aflibercept
  
  - ESNM 77: Moderate to severe acute post-operative pain: fentanyl transdermal system
- Publishing one of two planned Medicines Practice Guidelines on Controlled drugs: safe use and management.

- Holding the second of five education and dissemination contact days for medicines and prescribing associates on 21 June, with the medicines optimisation leads from RightCare and CQC also in attendance.

- Publishing Medicines evidence commentaries (MECs) as part of the weekly medicines awareness service. Medicines evidence commentaries help to contextualise important new evidence on medicines and prescribing, highlighting areas that could signal a change in clinical practice. Of the 25 MECs planned for 2016/17, 11 have been published up to the end of June 2016. The MECs are also published on NICE Evidence search.

**Notable recent developments**

**Stakeholder engagement**

**Five Year Forward View**

7. NICE has contributed to the ‘Quick Guides’ that support the Sustainability and Transformation Plans (STPs). The guides were published in May and provide a two page briefing about specific topic areas, with the guides about prevention, mental health and dementia and cancer containing direct links through to NICE guidance.

8. NICE supported a Library of resources on care and quality, health and wellbeing for the STPs. This document contains links to NICE guidance, quality standards, NICE pathways, indicators where relevant as well as having a specific section on key NICE standards across 9 priority themes.

**Healthcare partner organisations**

9. Following a recent meeting with NHS England, an exercise is now underway to map points of engagement between NICE and NHS England. This will help inform the future mechanism for engagement and oversight between the two organisations.

10. A workshop was held with NHS RightCare (RC). Outcomes from the workshop included embedding guidance and pathways in RC’s most recent focus packs. The focus packs consider the highest spend areas in NHS care, with the packs published in this wave focussing on musculo-skeletal/trauma, cancer, mental health and dementia and maternity/early years.
11. A workshop between NICE and the Care Quality Commission (CQC) is planned for 28 July. The workshop will consider how best to enhance collaboration and will determine what can be achieved in the short-term, establish a framework for how to collaborate longer-term, and feed into the next phase of work for the CQC 2016 strategy to be implemented from April 2017.

Social Care

12. NICE and Ofsted continue to develop their agreement for closer working. A meeting was held in June and a draft set of principles for engagement has been agreed. The principles will be incorporated in a partnership agreement.

13. A partnership agreement is being developed between NICE and Skills for Care (SfC) and is expected to be completed during Quarter 2. The Chair of NICE is scheduled to meet with the Chair of SfC in August.

14. The internal Social Care Forum continues to provide oversight of the action plan for social care engagement. Progress from the plan includes development of a ‘Quick reference guide’ to better support those working in social care. This output will be based on relevant Quality Standards and guidance and will be produced with the Social Care Institute for Excellence (SCIE). A product specification is in the final stages of development and a project group is being established to oversee delivery.

15. NICE gathered 21 regulatory, professional, training and commissioning organisations to an event aimed at improving knowledge and competency across health and social care to deliver the quality standard (statement 2) on domestic violence and abuse. Participants said they valued: knowledge that free quality training exists; gathering of different colleges to ‘make links’, ‘discuss collaboration’ and to ‘stop working in isolation – essential to solve the problem’; considering the links between training needs in health and commissioning to ensure effective pathways; greater awareness of role of health sector(s) in respect of DV – often missing part of the jigsaw for PCCs in terms of partnership working. A draft evaluation report will be available in August 2016.

Public Health

16. Representatives from NICE attended Public Health England’s (PHE) Senior Leadership Forum in May. The meeting agenda included discussion on NICE and PHE working together. The recently refreshed partnership agreement was welcomed as was the proposal for greater PHE involvement in guidance development. The first NICE/PHE jointly badged scope has now been published.
17. NICE is also a regular contributor to the Public Health Systems Group and the Prevention Board, groups that represent the main platforms for providing a system overview in public health.

**Indicators**

18. NICE has been undertaking some exploratory work with the Cheshire and Merseyside Public Health Collaborative to investigate how NICE indicators can support the use of the NICE quality standard for hypertension.

19. A recent review investigating how NICE indicators are being used shows they are being used across a wide range of national frameworks including the CCG Improvement and Assessment Framework (CCG IAF).

**Shared decision making**

20. NICE hosted the third Shared Decision Making Collaborative on 23 June, which explored national-level policy developments in relation to shared decision making. This included how these concepts can achieve greater traction in the system through education, culture change and initiatives such as Choosing Wisely, in the context of the consensus statement developed by the Collaborative in 2015.

**Supporting disinvestment**

21. A meeting was held on 18 February chaired by the Department of Health to explore the support from NICE around decommissioning inappropriate interventions. There was broad support for the direction of NICE’s activities in this area and a recognition that there are synergies with other initiatives. Clinical behaviour, awareness and availability of data were seen as potential barriers to change.

22. NICE has engaged with the DH National Director of Clinical Productivity, the director of Strategy, System Oversight and Performance, and Medicines and Pharmacy. The intention is to prepare an aligned narrative and strategic context to support the optimal use of treatments. Other stakeholders, including the NHS England Chief Pharmaceutical Officer, RPS, RCGP and Health Education England, will also be involved.

23. The NICE digital services team is undertaking a research project to better understand audience needs in relation to savings and productivity, in order to further improve NICE’s product offer. In addition to this, we are exploring the syndication of Savings and Productivity Collection content to improve visibility.
and awareness of these resources through external platforms beyond the NICE website.

24. New functions have been added to the Savings and Productivity Collection enabling users to calculate how much the implementation of Quality and Productivity case studies could save organisations locally. A function to browse Do Not Do recommendations by condition and disease has also been added.

25. The Medicines and Prescribing team has estimated indicative savings if potentially inappropriate medicines were not used in older patients in England. The assumptions are being evaluated and potential benefits validated by the NHS Business Services Authority Change and Commercial Delivery Directorate. The team is also working closely with NHS England RightCare to help develop its medicines optimisation offering for CCGs. This includes mapping resources and services to the RightCare model, developing a narrative for commissioners and clinicians, and exploring collaboration between RightCare delivery partners, the NICE field team and medicines and prescribing associates to support CCGs. The CQC medicines optimisation lead is also involved in this collaboration.

**New publications**

26. The adoption and impact team have developed a new audit publications planner, which details current and future national audits measuring the uptake of NICE guidance. The planner can be used by organisations to help with reporting progress in relation to NICE guidance and Quality Standards and to assist with evidence gathering for inspections. The planner has received positive feedback from clinical audit networks and from field team visits.

27. The adoption and impact team have also developed 3 new monthly digests, which have links to the resource planner and resource impact tools. These are being circulated to all CCG Chief Financial Officers, and over 750 people in total. Positive feedback has been received.
Key programme indicators

28. The following charts provide a visual depiction of progress towards key objectives for each of the programmes. In some cases progress is expected to be linear, whereas in other cases it might be affected by variable factors.

Leadership and Engagement Programme
Public Involvement Programme

Lay member recruitment summary - April 2016-June 2016

<table>
<thead>
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<th></th>
<th>Guideline committees</th>
<th>Specialist members</th>
<th>Standing committees</th>
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<tr>
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<td>3</td>
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<td>No. of successful applicants</td>
<td>8</td>
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<td>No. of applications</td>
<td>29</td>
<td>154</td>
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Quality Programme

Quality Standards

Accreditation reports

Cumulative published
Cumulative plan

Date: 20 July 2016
Ref: 16/073
Adoption and Impact Programme
Resource impact assessment products

Implementation support projects and activities
Medicines Prescribing Programme

Cumulative evidence summaries planned and published 2016-17

[Graph showing cumulative evidence summaries planned and published from April to March 2016-17, with no significant changes through the months.]
NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE
AUDIT and RISK COMMITTEE

Unconfirmed minutes of the meeting held on 20 June 2016 in London and VC to Manchester

Present
Jonathan Tross, Non Executive Director (Chair)
Linda Seymour, Non Executive Director
Bill Mumford, Non Executive Director

In attendance
Andrew Dillon, Chief Executive
David Coombs, Associate Director Corporate Office
Natalie Sargent, Head of Financial Accounting, Finance
Barney Wilkinson, Associate Director Procurement & IT
Catherine Wilkinson, Associate Director Finance & Estates
Julian Lewis, Governance Manager
Felicia Wright, NAO
Paul Holland, NAO
Jeremy Nolan, DH
Wajid Shafiq, DH
Tim Irish, Non Executive Director (observer)

APOLOGIES FOR ABSENCE
David Hunter, Non Executive Director, Ben Bennett, Business Planning and Resources Director, Larraine Howard-Jones, Associate Director HR

DECLARATIONS OF INTEREST
1. Tim Irish was introduced to the Committee as a possible future committee member.
2. There were no declarations of interest.

MINUTES OF THE LAST MEETING
3. The minutes were agreed as a correct record with the exception of Felicia Wright’s name being incorrectly stated on page 4.
4. Action log: The progress detailed in the action log was noted. The Committee asked that owners of action points should in future provide updates and completion dates prior to each meeting.

Action: NS
RISK MANAGEMENT

Strategic Risk Register
5. The Chair explained that the Committee reviews the High Level Risk Register alongside the Strategic Risk Register at every meeting. In addition once a year the Committee receives the full Directorates’ registers, not to review in detail, but to provide assurance that risk management is consistently applied at the various levels of the organisation.

6. Andrew Dillon confirmed that the ‘old’ risks were still relevant and that the register had been formulated after discussions with the Board and related to the Board’s strategic view on where it would like NICE to be in 2020.

7. The Committee discussed the Strategic Risks and noted in particular the following risk areas:
   - Governance continuity - due to the high turnover of board members. Reference to the NEDs are to be included in the Strategic Risk Register.
   - Financing – risk in recovering Technology Appraisal costs on which the planned balancing of the budget depended. Should that not happen the risk applied across the organisation.
   - Quality reducing as a result of a reduced budget increasing pressure on staff.
   - Reduction in morale during the Management of Change programme.
   - The challenge to balance two competing themes; to promote innovation/excellence and to recognise the real affordability pressures on the NHS.

High Level Risk Register
8. The Committee considered the refreshed register, well articulated. The Committee suggested that NICE consider:
   - In relation to high risk 22 (Technology Appraisal income), what the broader impact on the business would be should the income not be received.
   - Disinvestment – whether we can do more to help providers cope with reduced funding. This also links to stakeholder engagement to ensure that our products meet their needs.
   - What measures/tests can be introduced to ensure the controls are working and early warning signs if things are deteriorating.

Action: JL
9. The Committee had recommended in its Annual Report that the High Level risks should be discussed at Board level more regularly to provide more Board level engagement. The Chair of the Committee would discuss the timing further with the NICE Chair and Secretariat.

**Action: JT/DC**

**INTERNAL AUDIT**

**Audit Plan**

10. Jeremy Nolan gave an oral update on the plan. Three audit areas have been agreed – Strategic Financial Management, Key Financial Controls and Risk Management & Assurance. Three further areas have been suggested - Payroll (to include external assurance), Contract Management/General Procurement Controls, and the final audit area to be in a business area such as Appeals, CDF or Scoping. For the latter business audit the auditors would like a NICE staff member attached to the audit team to assist in the audit. This staff member would not be from the audit area itself but from a similar team. Jeremy noted there may also be a health group wide cross-cutting audit on Cyber Security.

11. The committee agreed the addition of Payroll and Contract Management/General Procurement Controls audits. In subsequent discussion with auditors, the Committee confirmed that they would favour an audit in a service business area and suggested one in the Technology directorate as this had received less attention in recent years than other directorates.

12. Jeremy Nolan raised the issue of a fraud audit. The Committee suggested this might better be considered as part of the scoping of the procurement audit. It was agreed that Internal Audit and management should discuss further with management to agree a programme to be provided to the Committee by the end of July.

**Action: BB/JT**

13. Jeremy Nolan provided feedback on the review of DH’s external quality assessment of their service, which found that DH was generally compliant, and slightly above standard.

**Follow-up of Recommendations**

14. Jeremy Nolan had suggested that arrangements be put in place for NICE management to maintain a register of the action taken in response to audit recommendations. The Chair had shared with Jeremy and colleagues his view that this would be helpful, which the Committee endorsed. He suggested that in the first instance it should be for the secretariat to the committee to assure that action had been taken, to be reviewed by internal audit as appropriate. The Chair confirmed that an example from the Police Complaints Commission had been shared with David Coombs for him to consider and propose a more structured approach.

**Action: DC**
DH Audit team

15. Jeremy Nolan advised that the DH audit team are moving to an agency structure, where government audit will be centralised. He reassured the Committee that NICE will not see any changes in the service during the current year. The Committee was not surprised by the news as a unified government wide audit service had been proposed at various times over the years. They wished to record the excellent work done by Bronwyn Baker in managing the move of audit services for the ALB family to a centrally managed DH resource.

ANNUAL REPORT AND ACCOUNTS

16. Natalie Sargent presented a briefing paper which highlights NICE’s duties and the outturn for 15/16.

17. Paul Holland presented the NAO Completion Report, adding that no significant risks were identified, and there were no unadjusted errors. The NAO thanked the NICE finance team for a smooth audit.

18. The Committee welcomed the clear explanation of the key points in the cover paper, and noted the more detailed pensions disclosure note. The Committee further noted the higher redundancy costs in 2015/16 and the provision for Management of Change costs relating to future years. It also noted that NICE is not required to return to DH the cash balance held at year end.

19. Following their review of the contents of the report from auditors and the draft letters of representation and audit certificates the Committee formally adopted the Annual Report and Accounts on behalf of the Board.

20. The Committee thanked the NAO and the NICE finance team for their hard work on delivering high quality annual accounts.

CONTRACT WAIVERS

Waivers report

21. Barney Wilkinson presented the report, which was noted.

IT SECURITY REPORT

22. Barney Wilkinson presented the report, which is in response to the Disaster Recovery audit.

23. The Committee noted the report and that the high volume of breach attempts that NICE has received was standard for such organisations rather than suggesting specific targeting of NICE. It welcomed that NICE is considering engaging with a third party to penetration test the NICE internal system during this year. This is in addition to the network vulnerability scans (machine penetration testing) which are routinely undertaken by NICE IT. The Committee suggested that thought be given to whether it was worth joining the health group cross-cutting audit review of Cyber Security.
USE OF SEAL
24. The seal was not used.

COMPLAINTS REPORT
25. David Coombs presented the report. The Committee noted the report and that the process is well managed. It was also pleased that the process for NEDs to get involved is working well.

INCIDENT REPORTS
Manchester
26. Catherine Wilkinson updated the Committee on two incidents in the Manchester office. The first was a power outage when the electrical system had its 6 month check. The Bypass switch developed a fault during checking, and it is scheduled to be repaired.

27. The second incident was a flooding caused by the expansion tank of the boiler filling with water, which then became too heavy for its retaining wall screws. It caused some flooding in the office but also flooded two shops below NICE. The potential liability is £20k but NICE are expecting the contractors, Gilks Ltd, to foot the bill. Gilks believe it is a manufacturing/design fault and not negligence on their part.

London
28. Barney Wilkinson updated the Committee on the power outage in the London office, which was caused due to damage to a power cable leading to Spring Gardens. A new cable was fitted by the electricity company and power was restored within 2.5 days. London staff were able to log onto the Manchester network during this time.

29. The Committee noted that NICE’s resilience had been tested, with remote working established quickly. However the lessons learned were that staff communications can be quicker, and that the information going out can be improved. New staff and those staff members who did not share their mobile numbers were not able to be notified. The Committee further noted that the NICE Disaster Recovery Policy was to be discussed at SMT the following day.
ANY OTHER BUSINESS

30. The Committee recorded that this was Bill Mumford’s last meeting as member, due to the government’s current approach not to reappoint NEDs. The Committee thanked him for his contribution, adding that his departure means the loss of a calm, wise and supportive colleague.

31. There was no other business.

PRIVATE DISCUSSION

32. As normal the Committee briefly reviewed progress with auditors without officers present. Aspects of this discussion are recorded in the section on audit above.

Future meeting dates

- 13 October 2016  2pm
- 25 January 2017  10:30am
- 26 April 2017  2pm
- 21 June 2017  2pm
- 25 October 2017  2pm