National Institute for Health and Care Excellence

Health and Social Care Directorate progress report

This report summarises the activities, key issues and developments of the Health and Social Care Directorate for the financial year April 2020 to March 2021.

The Chief Executive’s Report details the delivery of quality standards (QS), endorsement statements and shared learning examples.

Summary of activity

Over the past year, the directorate redirected resources to support NICE's response to the COVID-19 pandemic. The medicines and prescribing team transferred to the Centre for Guidelines to better align functions and 16 members of staff were seconded to work on programmes outside of the directorate, including development of COVID-19 guidance, NICE Connect and to support the work of the Department of Health and Social Care.

The changing external landscape, for example the move towards Integrated Care Systems (ICSs), required us to work differently and reflect on our internal processes to ensure that they are efficient and in line with the new NICE 5-year strategy.

Notable issues and developments

Supporting NICE's response to COVID-19

Throughout the year, we worked flexibly to support NICE’s response to COVID-19 by:

* 1. Developing a rapid endorsement process and prioritising COVID-19 Shared Learning examples to support implementation of NICE’s COVID-19 guidelines.
	2. Updating outputs such as quality standards, social care quick guides and NICE impact reports to ensure that they aligned with newly published rapid guidelines.
	3. Developing stakeholder intelligence reports on the status of the external environment, use of COVID-19 guidelines and the challenges facing the health and care system.
	4. Establishing, with Evidence Resources, the digital marketplace for staff and leading on the development of a cross-organisation COVID-19 SitRep.

Emerging themes from our impact reports

In response to a request from the NICE Board, the 18 previously published NICE impact reports were analysed to identify common themes. Nearly 200 data points relating to the uptake of NICE guidance were extracted. One factor influencing the selection of topics is the availability of published data such as national audits, reports and surveys. As a result, most of the data points (177) relate to uptake of our recommendations in healthcare, with very few data points giving us information about the uptake of our public health or social care recommendations.

We extracted 111 data points showing low uptake, and areas associated with this across multiple reports were identified. We have reported on 36 instances where commissioning of services in line with NICE recommendations showed low uptake, such as vocational rehabilitation for stroke which we found was commissioned by only 27% of CCGs. In 19 instances, recommendations about user involvement in decisions about their own care showed low uptake, such as less than 10% of people receiving end of life care having an advanced care plan agreed before their final hospital admission. We identified 16 instances of low uptake during transition between services, such as just over a third of people with a respiratory condition being followed up for a review within 2 days of being discharged from emergency care.

While almost every report included examples of health inequalities in outcomes, we reported on just 8 examples of variable uptake of our recommendations in different populations. To support NICE's strategic ambition to contribute to reducing inequalities, we are exploring how we can improve reporting in this area and will maintain a focus on inequalities in forthcoming reports. We identified several examples where the reported user experience of care was not in line with NICE guidance, despite organisational audits reporting that our recommendations had been implemented. This will encourage us to continue seeking information on patient or service user experience to inform future reports.

The findings of the analysis will be considered during development of the updated implementation strategy, which includes a workstream exploring how we can use data to drive our implementation offer and measure our impact.

Moving online

During 2020/21, we implemented new ways of working which are expected to bring long term benefits to operational productivity and reduction in costs. Examples of meetings and events that moved online include: Quality Standards and indicator committee meetings; Shared Learning Awards; Evidence Search workshops; 'Learning about NICE' events and Fellows and Scholars events. Other areas which moved to virtual working include:

* 1. Continuing Field team engagements using digital platforms, such as webinars, which have been well attended and positively evaluated. The move to virtual meetings has allowed the team to contribute to more events. However, the absence of informal conversations which are part of face-to-face meetings, can make it harder to develop new relationships and obtain 'softer' intelligence.
	2. Supporting lay members and patient experts at virtual committee meetings and seeking feedback on people’s experiences to enable improvements to be made. Virtual meetings have made it easier for PIP to support patient experts and exit survey data show that 92% of lay members and 88% of patient experts rated their overall experience of being on a NICE committee as good or excellent.
	3. Introducing monthly virtual induction sessions for patient organisations working with us on technology appraisals (TAs). The sessions have replaced individual phone calls and the use of Zoom has allowed for better relationship building.

Streamlining our processes

As a result of the new priorities emerging from the NICE 5-year strategy and external system changes we spent time reviewing our internal processes.

* 1. A streamlined resource impact assessment process manual was published. Changes were made to how the Guideline Resource Implementation Panel (GRIP) works, to bring forward discussions about implementation issues. Our resource impact assessment tools were also updated to look at the impact to the whole system.
	2. NICE impact reports now identify implementation challenges and available support across the healthcare system. A 'what's next?' section identifies priority areas of low or variable uptake and sets out how we will work with partners to help support implementation.
	3. A review of the QS programme looked at local perceptions of QS and the methods used to develop and update them. Changes implemented following the review will ensure that outputs are aligned with stakeholders’ needs and that processes are faster, flexible, and more efficient.
	4. Reviews of our current approaches to strategic engagement, influencing and implementation are underway to support delivery of the new strategy.

Partnership working

We aligned our engagement efforts to reflect the priorities of COVID-19, external system changes and the NICE 5-year strategy. Examples include:

* 1. Maintaining close working relationships with key colleagues from the Care Quality Commission (CQC) to set the direction of joint work in light of both organisations' new strategies. We have updated our Memorandum of Understanding and identified new priority areas of joint work for 2021/22.
	2. Refreshing the relationship management meeting with NHS England and NHS Improvement (NHS E&I) to identify opportunities to work collaboratively within the evolving strategic landscape, for example, on health inequalities and finalising a collaboration agreement.
	3. Continuing to meet regularly with key Royal Colleges to discuss joint priority areas of work and developing collaboration agreements with the Royal College of Obstetricians and Gynaecologists (RCOG), the Royal College of General Practitioners (RCGP) and the Royal College of Physicians (RCP).
	4. Adapting our engagement with key national social care partners such as Skills for Care, Social Care Institute for Excellence (SCIE), and the Association of Directors of Adult Social Services in England (ADASS) to align with the challenges faced by the sector. Key themes have been our new strategic direction, addressing the negative impact of the pandemic on the mental health and wellbeing of the social care workforce and the use of evidence in social work practice.
	5. Aligning strategic ambitions with the AHSN Network and establishing a joint Working Group. A collaboration agreement has also been developed to set out a mutually supportive joint programme of work.
	6. Strengthening local relationships with ICSs following local engagement programme disruption as many senior level contacts were redeployed into pandemic response roles. Despite this, we were able to deliver a significant amount of engagement with ICSs throughout the year and met with 50% of heads of primary care to understand the changing primary care landscape and evolution of primary care networks.

In some instances, the COVID-19 pandemic has made engagement challenging and PIP has worked with the Audience Insight team to consider the impact on voluntary and community sector organisations and their ability to contribute to our work. Findings will allow us to better support these organisations.

Developing products and tools

Despite an uncertain year, the directorate continued to operate a wide range of important functions to support the health and care system.

* 1. NICE in partnership with NHS Digital became responsible for the national library of quality assured indicators, helping position NICE as a system leader in the development and assurance of quality indicators.
	2. Nine new indicators developed by NICE were included in the 2021/22 Quality Outcomes Framework (QOF). The new indicators cover vaccination and immunisation, mental health and cancer and are underpinned by around £131 million of financial incentives.
	3. As recognised experts in the field, PIP was commissioned by NHS E&I to develop a minimum standards framework for patient decision aids (PDAs) to help users and developers understand the essential standards a decision aid should meet. This will publish alongside the NICE shared decision making guideline in June.
	4. Prompted by the widening of health inequalities exposed by the COVID-19 pandemic, we began a comprehensive review of our role in this area with leadership provided by the Health and Social Care Directorate. Consideration is being given to where NICE can best add value to the system’s efforts to tackle health inequalities and projects are underway to explore the usefulness of NICE products in addressing health inequalities at a local level.

Key risks

A lack of stability across the Health and Social Care Directorate has been the key risk during this period, with several senior level posts continuing to be filled temporarily and a number of staff covering vacancies and secondments. Recruitment is currently underway for a permanent System Support and Evaluation Programme Director.

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