**NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE**

Public Board Meeting
held on 19 March 2025 at 2 Redman Place, Stratford and via Zoom

# Unconfirmed

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.

## Board members present

Sharmila Nebhrajani Chairman

Mark Chakravarty Non-Executive Director

Jackie Fielding Non-Executive Director

Gary Ford Non-Executive Director

Alina Lourie Non-Executive Director

Bee Wee Non-Executive Director

Justin Whatling Non-Executive Director

Sam Roberts Chief Executive

Jonathan Benger Deputy Chief Executive, Chief Medical Officer and Interim Director of the Centre for Guidelines

Mark Chapman Director, Medical Technology

Helen Knight Director, Medicines Evaluation

Pete Thomas Director, Finance

## Directors in **attendance**

Nick Crabb Chief Scientific Officer

Clare Morgan Director, Impact and Partnerships

Raghu Vydyanath Chief Information Officer

## In attendance

David Coombs Associate Director, Corporate Office (minutes)

Adam Linney Deputy Chief People Officer

Danielle Mason Associate Director, Strategic Communications and Marketing

Swapna Mistry Chief of Staff for Jonathan Benger (item 7)

Toni Tan Senior Technical Adviser, Surveillance Team (item 7)

Jarin Noronha National Medical Director’s Clinical Fellow (item 7)

Kay Nolan Head of Prioritisation and Surveillance (items 7 and 11)

Louise Edwards Programme Director, Implementation and Insight (item 8)

Nick Baillie Associate Director, Insight and Programmes (item 9)

Helen Lovell Deputy Director, Medicine Regulation and Prescribing, Department of Health and Social Care

## Apologies for absence (item 1)

1. Apologies were received from Helen Williams and Jane Gizbert who were represented by Adam Linney and Danielle Mason respectively.

## Declarations of interest (item 2)

1. The following declarations were made:
	* Jackie Fielding stated that she has been appointed as a non-executive director (NED) at Ossiform (a remunerated role), while her roles as a NED at 3D Lifeprints and an adviser to HealthComms Consulting had ended.
	* Gary Ford stated that he has been appointed as a NED at South Central Ambulance Service NHS Foundation Trust (a remunerated role), with the start date to be confirmed.
	* Sam Roberts stated that she has been appointed as the Chair of the National Council for the AI Centre for Innovation in Regulatory Science (CERSI-AI), which is a non-remunerated role.
2. These, and the previously declared interests recorded in the register of interests, were noted and it was confirmed there were no conflicts of interest relevant to the meeting.

## Minutes of the last meeting (item 3)

1. The minutes of the public Board meeting held on 11 December 2024 were agreed as a correct record.

## Action log (item 4)

1. The Board reviewed progress with the actions arising from the public Board meeting on 11 December 2024 and previous meetings. It was noted that the strategy for income generation is due to be discussed at the September Board seminar, while the publication date for the review of patient safety across the health and care landscape is not known. It was confirmed that the actions marked closed on the log, and also action 24/12, were complete.

## Update from the Department of Health and Social Care (item 5)

1. Helen Lovell provided an update from the Department of Health and Social Care (DHSC) and highlighted the extensive changes in the national health and care system, including the announcement that NHS England (NHSE) will be abolished, with management of the NHS brought back into democratic control within the DHSC. Helen stated that the Secretary of State for Health and Social Care has been clear about his view that there is duplication between NHS England and DHSC, and he has sought to take a ‘one team’ approach across both organisations, working towards the shared mission of building an NHS fit for the future. Work has already begun to strip out duplication and over the next two years NHSE will be brought into DHSC entirely. The Secretary of State has set out his intention to reduce the headcount of the combined NHSE/DHSC by 50% with a similar reduction in headcount at Integrated Care Board (ICB) level. This structural change seeks to ensure the right structures and levers are in place to deliver the 10 Year Health Plan, delivering the three big shifts needed to make the service fit for the future: from hospital to community, analogue to digital, and sickness to prevention.
2. Helen highlighted the Better Regulation Action Plan announced by the Chancellor which seeks to harness the power of regulation to set a firm foundation to support innovation and growth. It is focused on three areas for action: tackling complexity and the burden of regulation; reducing uncertainty across our regulatory system; and challenging and shifting excessive risk aversion in the system, which includes system reform and establishment of the Regulatory Innovation Office to hold regulators to account for enabling innovation. Helen noted NICE’s contribution to the action plan. In addition to NICE’s ongoing work to transform the technology appraisal process to reduce the time taken to complete evaluations, NICE has agreed to work with the MHRA to pilot a joint process to offer concurrent market authorisation and NICE guidance, and also to offer fully integrated NICE and MHRA scientific advice accessed through a single point of entry.
3. The Board noted the update.

## Integrated performance report (item 6)

1. Sam Roberts introduced the update from the executive team and the integrated performance report that outlined progress with the 2024/25 business plan. Sam highlighted NICE’s work in driving access to innovation and new therapies including guidance recommending a revolutionary gene editing technology for sickle cell disease, and a treatment for advanced breast cancer which means NICE has recommended 22 of the 23 breast cancer treatments it has assessed over the last six years. Sam noted the consultation on changes to NICE’s HealthTech programme that could lead to more innovative healthcare technologies being adopted by the NHS and also highlighted the ongoing progress with improving the timeliness and usability of NICE guidance.
2. Executive team members summarised progress with the business plan priorities across the five thematic areas. Key points included:
	* ‘Focusing on what is most relevant’ is rated ‘green’. Highlights include the progress with the refinement of the highly specialised technologies (HST) routing criteria and the ongoing development of the prioritisation board, which now incorporates interventional procedures topic selection.
	* ‘Providing high quality and timely advice’ is rated ‘green’ and progressing well, with NICE on track to incorporate over 170 technology appraisals (TAs) into guidelines by the end of the year, which represents a third of the catalogue with a further third due to be completed in 2025/26. Testing of improvement ideas is underway as part of the guidance timeliness work, and NICE has continued to liaise with colleagues in DHSC and NHSE to seek to include the principles within the HealthTech rules-based pathway in the 10 Year Health Plan.
	* ‘Ensuring our advice is usable’ is rated ‘green’ with the structured recommendations for medicines and HealthTech rolled out and the first topics due to be published in Q1 of 2025/26. Work with Amazon Web Services (AWS) continues on the proof of concept for a semantic data model that will inform next steps with developing a business case for a platform for content creation, management and publication – further information on which will be presented to the Board in May. While there has been a 9% reduction in clicks on guidance products from the NICE corporate website, this has been reviewed and is felt to be due to changes to the website and is not a cause for concern.
	* ‘Demonstrable impact’ is rated ‘green’ with the preparatory work and data definitions for measuring the improvement in uptake of NICE guidance in priority areas completed. Resources to support adoption of maternity and obesity guidance have been delivered, and NICE continues to develop its approach to public involvement using the continuous quality improvement (CQI) methodology.
	* ‘A brilliant organisation’ is rated ‘amber’, which is due to the financial position and the forecast year-end underspend exceeding the target of less than £1m. There has been positive progress with increasing the diversity of the workforce, and the increase in the number of informal resolutions of employee relations issues demonstrates the Just and Restorative approach taking effect.
3. The Board discussed the financial position noting that the year-end forecast is a £1.8m underspend, which has increased since the last Board meeting. Pete Thomas noted that the underspend is primarily driven by above plan TA income alongside a pay underspend arising from vacancies. The forecast however remains uncertain, mainly due to the costs and liabilities arising from the Manchester office move, and the year-end underspend is likely to increase. Looking ahead to 2025/26, Board members highlighted the need to consider the causes of the underspend and how to utilise the available resources to deliver NICE’s ambitions. Board members asked about the impact of the Manchester office move on next year’s financial position and whether the funding from the Office for Life Sciences (OLS) will continue given NICE did not require all of this funding in 2024/25. In response, Pete Thomas confirmed that the costs of the office move can be accounted for 2024/25 where there is reasonable certainty they will be incurred, however there is still significant disagreement with the landlord on the value of the dilapidations which means NICE may incur potentially significant costs in 2025/26. In relation to the pay underspend, Pete explained the vacancy rate was higher than planned due to the impact of the management of change exercises and also a cautious approach to recruitment in the context of the Spending Review and the uncertainty around NICE’s long-term funding. Pete acknowledged the concerns around the underspend and highlighted that increasing NICE’s commercial agility will be one of the priority projects in the 2025/26 business plan. He confirmed the OLS funding stream was due to end in March 2025 and has been replaced by recurrent funding.
4. In response to a question from the Board about the impact of the 10 Year Health Plan on the prioritisation board’s forward view, Jonathan Benger confirmed the forward view is usually reviewed annually, with a smaller mid-year review. However, a light-touch review has been undertaken for the start of 2025/26 so a wider review can take place once the 10 Year Health Plan is published. Jonathan agreed to update the Board on the outcome of this review and whether it led to any changes to the forward view or prioritisation criteria.

Action: Jonathan Benger

1. A question was asked about the priorities for NICE’s collaboration (HEMA) with health technology assessment (HTA) agencies in the USA and Canada and whether this will also look at individualised medicines which fall outside of NICE’s processes. Nick Crabb confirmed that NICE’s HTA Lab is considering the issue of personalised medicines, but he could also raise this as a future topic for HEMA. Nick stated that HEMA’s first project has just been announced and will consider the treatment benefits that should be considered in the HTA process. Nick agreed to update the Board on progress with this work.

Action: Nick Crabb

1. Subject to the actions noted above, the Board noted the report.

## Refinement of the highly specialised technologies (HST) routing criteria (item 7)

1. Jonathan Benger presented the report that outlined the feedback from the consultation on the proposed amendments to the criteria for routing topics to the highly specialised technologies (HST) programme, and NICE’s response to the issues raised. The proposed revisions aim to enhance the predictability and transparency of the application of the routing criteria, while maintaining the intent of the HST vision.
2. Jonathan thanked stakeholders for their feedback which has helped refine the proposals. He highlighted that a retrospective routing decision analysis was undertaken using the refined routing criteria post consultation to consider the impact of applying the criteria to technologies assessed for HST. The retrospective analysis showed the same number of technologies will be routed to the HST programme under the proposals, which gives assurance the proposals support the aim of not introducing more restrictions to accessing the HST programme. Jonathan stated that NICE remains committed to transparency and highlighted that the prioritisation board’s decisions on the routing of each topic will be published.
3. Sharmila Nebhrajani thanked Jonathan Benger and colleagues for the clear report and their diligence in leading this complex and sensitive work that has a significant benefit for patients.
4. The Board:
	* Approved the publication of the refined HST criteria for routing decisions from 1 April 2025.
	* Approved publication of NICE’s thematic responses to stakeholder comments on the proposed refined criteria during the consultation.

## A strategy for improving the uptake and adoption of NICE guidance (item 8)

1. Clare Morgan presented the strategy for improving the uptake and adoption of NICE guidance by the health and care system over the next three years. The strategy focuses on three objectives – establishing a single programme of support for guidance uptake; implementing an effective stakeholder engagement approach; and improving use of uptake insights and system intelligence – to improve the uptake and adoption of NICE guidance in priority areas by 10% by March 2028. The strategy aligns with NICE’s overarching transformation ambition and purpose to deliver high quality, timely guidance that is usable and impactful to ensure NICE helps get the best care to people fast, while ensuring value to the taxpayer. Following Board approval of the strategy, annual deliverables, targets and activities to be taken forward across NICE and in partnership with others in the health and care delivery system, will be developed. Clare highlighted the significant changes and uncertainties in the health and care landscape and stated that the strategy will be reviewed in light of the 10 Year Health Plan and updated if necessary.
2. The Board discussed the strategy and agreed this was a complex issue, with a diverse range of factors affecting the adoption of NICE guidance. It was highlighted that implementation support must be informed by an understanding of the barriers to adoption, and these barriers will vary across different NICE guidance. Board members queried the proposed target to increase the uptake and adoption of NICE guidance by 10% across priority areas and suggested this may not reflect the different stages of adoption of NICE’s recommendations across the priority areas and it may therefore be more appropriate to adopt a more nuanced approach that could potentially seek a more ambitious increase for interventions with limited current uptake, and a less ambitious increase where there is already high uptake. Board members noted the extensive nature of the priority areas, and the volume of NICE guidance within these, and there was encouragement to focus on topics with a high degree of unwarranted variation, learning from areas with higher rates of adoption and focusing where NICE can have greatest impact. The need to avoid duplicating other organisations’ existing activities was also highlighted.
3. The Board supported the proposed areas of focus in the strategy and agreed on the need to prioritise effort but expressed concern about the overarching target to improve the uptake and adoption of NICE guidance in priority areas by 10% by March 2028 for the reasons noted above. The Board therefore supported a more targeted approach and agreed that further work should be undertaken to identify (a) the actions that will be undertaken more widely across the priority areas; and (b) the targeted actions that will have greatest impact on a small number of NICE recommendations within these wider priority areas.

Action: Clare Morgan

1. Board members highlighted the importance of considering the wide range of factors that can affect adoption of NICE’s guidance when developing the work-plan including clinical leadership, access to prescribing data, and the arrangements for funding and procuring new therapies. There was also a suggestion to link in with NHS England’s data analytics team to build the uptake measures into system dashboards and systemise the data collection.

## Guideline collaboration update (item 9)

1. Jonathan Benger presented the overview of current collaboration work in the guidelines programme and planned future activity following the formal closure of the accreditation programme in July 2024.
2. Jonathan stated that while the accreditation programme was successful in many of its initial aims it did not meet NICE’s current needs nor those of users of NICE guidance. He did not feel it was appropriate for NICE to judge other guideline organisations, and it could be confusing if recommendations differ between a NICE guideline and a guideline produced by a NICE-accredited organisation. Therefore, in May 2024 the NICE Executive Team approved a new model for guideline collaboration, which would include utilising externally produced guidance. The new approach should allow NICE to more efficiently maintain and expand its guideline portfolio and better support health and care professionals and the people that use health and care services. Jonathan outlined the six options which range from NICE creating its own guidelines to presenting users with non-NICE guidelines or recommendations, overlaid with an accompanying review or critique by NICE (known as ‘curation’).
3. The Board discussed the new approaches and welcomed the opportunities these present, including producing guidelines in a more efficient way and enabling NICE to maximise its impact and value. Board members highlighted the scope to utilise new ways of working, including data technology and large language models, and there was a suggestion to consider engaging with the collaboration between the Mayo Clinic and the New England Journal of Medicine to see whether NICE could learn from their open evidence collaboration. Jonathan Benger agreed there is scope to utilise this technology, alongside a human element to ensure guidance was of sufficient quality, and confirmed NICE was very willing to collaborate with international colleagues. Sam Roberts highlighted a collaboration funded by the Wellcome Trust looking at a structured way of storing data and components of a guideline, which may be relevant to this work. This is at an early stage but further information could be provided to the Board when available.
4. While the Board supported the aims and benefits of this work, several risks and issues were identified. These include the resources required to ‘curate’ guidelines produced by other organisations, and how to address the scenario whereby NICE does not support part of an external guideline, either because it is produced for another country’s health system, or it has been produced for the UK but does not encompass the full range of issues considered by NICE, including for example, cost effectiveness. Board members noted the importance of being alert to the risk of potential conflicts of interest and ensuring interests have been declared appropriately in the guideline development process. The need to consider how the proposals could impact NICE’s other ambitions, such as incorporation of technology appraisals into guidelines and the use of structured recommendations, was also highlighted. In response, Jonathan Benger confirmed that he did not envisage significant resources would be required to ‘curate’ other organisations’ guidelines. In the scenario whereby an international guideline may be less applicable to the UK, NICE will highlight where this is the case, state the strengths of the guideline, and where it may be less applicable to the UK. He stated that NICE would need to carefully consider where it was appropriate to utilise other guidelines and stated that NICE would remain focused on evidence-based recommendations. Where the evidence is less developed and relies on expert opinion, NICE would refer the issue to an organisation that was better placed to do this work, such as a Royal College.
5. The Board noted the report.

## Standing orders and standing financial instructions (item 10)

1. Pete Thomas presented the updated standing orders (SOs) and standing financial instructions (SFIs) for the Board’s approval following their annual review. Pete highlighted that only minor changes are proposed to the standing orders. As outlined in the covering report, wider changes are proposed to the SFIs, with amendments to the expenditure approval process beneath the Board. The process for approving tender waivers above the public procurement threshold has also been amended to reflect best practice that the Audit and Risk Assurance Committee (ARAC) should not have decision-making powers. The updated documents had been reviewed by the executive team and the ARAC.
2. The Board approved the updated standing orders and standing financial instructions for implementation from 1 April 2025.

## Audit and risk assurance committee (item 11)

1. Alina Lourie presented the unconfirmed minutes of the Audit and Risk Assurance Committee meeting held on 29 January 2025. Alina highlighted the committee’s ongoing close review of cyber security given this remains NICE’s highest rated strategic risk and stated that the committee will review NICE’s business continuity arrangements at its next meeting. The committee also noted the risks around the national policy agenda and system landscape which are anticipated to reduce when the 10 Year Health Plan is published. The committee also reviewed the internal audit report on enquiry handling and were pleased to note the overall positive findings and praise for the enquiry handling team’s work. The committee also discussed the proposed internal audit plan for 2025/26 and agreed the areas to be reviewed.
2. Sharmila Nebhrajani noted the committee discussed the potential reduction in the number of internal audit reviews in 2025/26 to mitigate the increase in audit fees, and highlighted the importance of a sufficiently robust audit programme. Pete Thomas confirmed that since the discussions at the committee it had been agreed to increase the budget for the internal audit service to enable the audit plan to continue to include six audits despite the increased fees.
3. The Board received the minutes.

## Any other business (item 12)

1. Sharmila Nebhrajani highlighted Mark Salmon, Programme Director within the Science Evidence and Analytics Directorate, was retiring at the end of March, after over 20 years working at NICE. On behalf of the Board, Sharmila thanked Mark for his extensive contribution leading a number of high profile and intellectually challenging projects and wished him well for his retirement.
2. There was no further business to discuss.

## Next meeting

1. The next meeting of the Board will be held on 20 May 2025 at 1:30pm.