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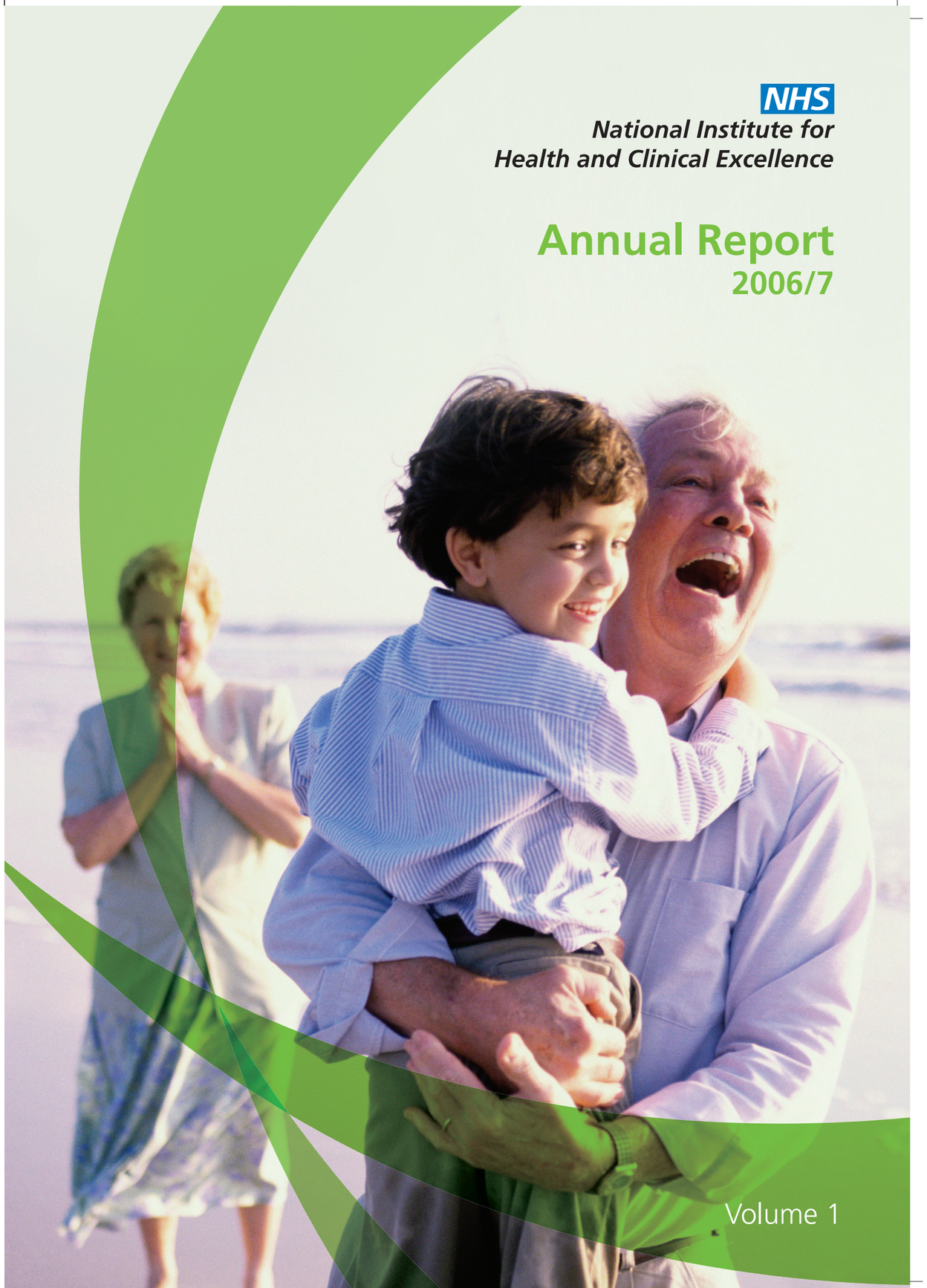
NHS
National Institute for
Health and Clinical Excellence

Annual Report
2006/7



Volume 1

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National Institute for Health and Clinical Excellence (Special Health Authority)

Annual Report and Accounts 2006/7

Presented to Parliament pursuant to Paragraph 6 (3), Section 232, Schedule 15 of the National Health Service Act 2006

Volume 1

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Contents

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Financial overview

How the funding was used

Figure 2 shows what the money was spent on in 2006/7. The main areas of expenditure are external contracts and salaries. External contracts include the expenditure on the National Collaborating Centres which help us to produce clinical and public health guidance.

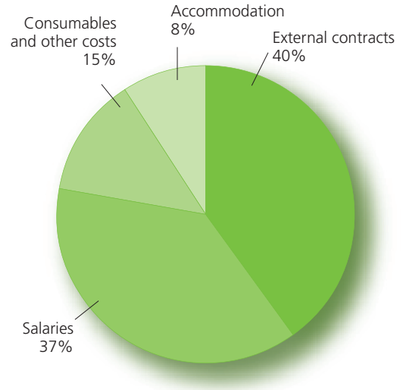

Figure 2

Programme costs

Figure 3 shows how the spending was split between the Institute's work programmes and the support functions.

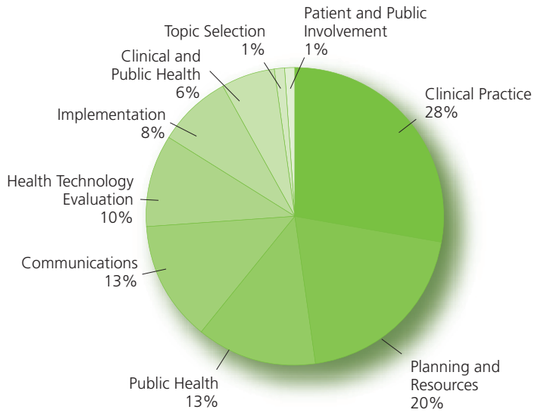

Figure 3

Financial overview

This section provides an overview of the Institute's financial accounts. The full statutory accounts have been published as a supplement and accompany this document. The full annual accounts are available on our website (www.nice.org.uk), or by writing to Natalie Sargent, Finance Controller, NICE, MidCity Place, 71 High Holborn, London WC1V 6NA or by contacting NICE on 020 7067 5800

Overall position

The Institute instigated a number of new programmes and activities during the year including topic selection, short guidelines, single technology appraisals and set up a field team of implementation consultants. The funding for these developments was made available from within existing resources through cost saving measures that the Institute initiated in the previous financial year. The Institute had a target as part of the Department of Health's arms length bodies review to make cost efficiency savings of £2.6m by the end of 2008. This target was achieved in 2006. New activity relating to optimal practice guidance for the NHS was also funded from within its existing resources.

During the year the Institute identified three key areas where it would not be able to apply the resources it had allocated during 2006/7. The Department of Health therefore agreed that the £2.7m resource allocation relating to these could be carried forward into 2007/08. They were:

- slippage in the establishment of a permanent Manchester office
- optimal practice guidance not commencing until last quarter
- delay in referral of public health topics

After the transfer of this £2.7m out of the 2006/7 budget into the 2007/8 budget the Institute ended the year with an overall under spend of £29,000.

How is the Institute funded?

Most of the Institute's funding comes from the Department of Health. This year it received £27.7m as shown in figure 1. It also received £0.6m from the Welsh Assembly Government and £0.4m from other sources.

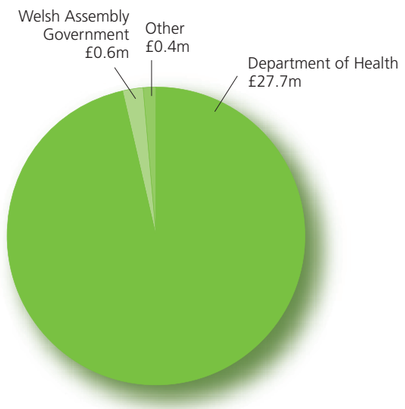

Figure 1

Chairman's and Chief Executive's Foreword 2006/7

The increasing expectations of those who use our guidance and those who depend on it for their care, together with sometimes intense media coverage of our recommendations, characterised a year in which we maintained a flow of diverse, high quality clinical and public health advice

Our clinical guideline on obesity encouraged the NHS and local authorities, schools and early year's providers, employers and town planners to tackle a growing threat to the health of our nation. This was the first time that evidence-base recommendations, integrating advice on prevention and treatment, had been issued at a national level. Our public health advisory bodies have continued their ground-breaking work in developing clear, concise recommendations using the best available evidence and in their use of economic analysis. We also issued guidance on preventing sexually transmitted infections and reducing under-18 conceptions, together with advice for those working with young people who are vulnerable to drug misuse.

We are constantly checking to make sure that the way we go about our work produces the best advice. In 2006, the way in which we develop clinical guidelines was the subject of an independent review by international experts from the World Health Organization (WHO). The WHO panel identified a number of strengths including the close links between our guidelines programme and the Royal Colleges, the use of a respected methodology, and our excellent work on involving patients and other stakeholders in developing guidelines. They also made recommendations about how we can improve – for example, by helping to better explain the relative importance of individual recommendations in a guideline. This was the second such review by the WHO and we intend to continue international scrutiny of our work in our other guidance programmes.

Because drugs often arrive with so much promise, it's perhaps not surprising that our advice on the use of new drugs and other treatments being made available to the NHS attracts so much attention. Patients and health professionals want our advice as quickly as possible. Last year, we introduced a new process (the single technology appraisal) to develop guidance on new drugs in half the time of our standard process. If new drugs are referred to us at the right time, we can issue draft guidance within weeks of them coming onto the market. New drugs and new indications for existing drugs to treat early breast cancer were among the first to take advantage of this innovative approach.

Of course, we have a responsibility to provide guidance across the range of diseases and conditions for which we expect the NHS to offer treatment. So, last year, we produced advice on topics ranging from postnatal care through to renal cancers. In total, we produced 21 technology appraisals, 50 interventional procedure reviews, 13 clinical guidelines and 2 sets of public health advice.

None of these activities would have been possible without the dedication and hard work of the Institute's staff, and the wonderful support we receive from our growing community of external experts: the healthcare professionals, public health experts, academics and patients and carer representatives, who work with us on our independent advisory bodies and help develop guidance on our behalf. With around 230 staff and well over 2000 external advisors, we have one of the largest networks of its kind in the world. We are very grateful to them all for giving their time and expertise to improve the quality and consistency of healthcare in the United Kingdom.

Professor Sir Michael Rawlins, Chairman
Andrew Dillon CBE, Chief Executive

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NICE overview

The National Institute for Health and Clinical Excellence

The National Institute for Health and Clinical Excellence (NICE) is the national organisation responsible for providing guidance on both the promotion of good health and the prevention and treatment of ill health. Professor Sir Michael Rawlins is Chairman and Andrew Dillon CBE is Chief Executive.

The roles and responsibilities of NICE

NICE produces guidance in three areas:

Public health – the promotion of good health and the prevention of ill health for those working in the NHS, local authorities and the wider public and voluntary sector

Health technologies – the use of new and existing medicines, treatments and procedures within the NHS

Clinical practice – the appropriate treatment and care of people with specific diseases and conditions within the NHS.

NICE has a remit to support the implementation of its guidance, which it does through the effective engagement of stakeholders, patients and the public in the selection of topics and the guidance development process. In addition, NICE has developed a programme of work with key partners to provide a supportive environment in which practitioners can implement guidance effectively with a range of implementation tools.

NICE technology appraisal guidance and clinical guidelines cover the NHS in England and Wales. The Institute's guidance on interventional procedures covers England, Scotland and Wales, while its public health guidance is for England only.

New relationship between NICE and Northern Ireland

In 2006, the Northern Ireland Health Minister Paul Goggins announced that the Northern Ireland Executive would formalise its relationship with NICE. This would allow local review of the applicability of all NICE guidance to Northern Ireland. The new arrangements became operational from 1 July 2006.

Andrew Dillon, Chief Executive of NICE, said, 'We are delighted to welcome the new relationship between NICE and Northern Ireland. This is a tremendous vote of confidence in the work of the Institute and will ensure that patients in Northern Ireland have access to quality health services underpinned by NICE guidance.'

NICE centres of excellence

Centre for Public Health Excellence

The Centre for Public Health Excellence was established in April 2005 to develop guidance on the promotion of good health and the prevention of ill health. It produces two types of guidance – public health programme and public health intervention guidance.

Public health programme guidance deals with broad action for the promotion of good health and the prevention of ill health. It may focus on a topic, such as smoking, or on a particular population, such as young people, or on a particular setting, for example, the workplace.

Public health intervention guidance provides specific recommendations on types of activity that help to reduce people's risk of developing a disease or condition or help to promote or maintain a healthy lifestyle.

Examples of interventions are:

- **giving advice** (for example, in GP practices to encourage exercise)
- **providing services** (for example, a needle exchange scheme for injecting drug users)
- **providing support** (for example, for new mothers to enable the uptake and continuation of breastfeeding).

Centre for Health Technology Evaluation

The Centre for Health Technology Evaluation develops technology appraisal and interventional procedure guidance.

Technology appraisals are recommendations on the use of new and existing medicines and treatments within the NHS, such as medicines, medical devices (for example, hearing aids or inhalers), diagnostic techniques (tests used to identify diseases), surgical procedures (such as repairing hernias) and health promotion activities (for example, ways of helping people with diabetes manage their condition). Recommendations are based on a review of the clinical and economic evidence.

This year NICE used its single technology appraisal process for the first time. This new, rapid way of assessing drugs and other treatments has proved especially useful as a way of assessing newly licensed products.

Staff profiles

Steve Sparks is the NICE implementation consultant for London and the South East. It's a new role for NICE and for Steve, who was previously a PCT commissioner.

His role is to support NHS organisations and local authorities providing social services as they implement NICE guidance. It's not a desk job – most days he is out and about talking to people about how they find working with the guidance.

'We are the face of NICE,' he says. 'We provide the personal contact. In my previous job as deputy director of the Sussex Commissioning Service I had worked on implementing NICE guidance. I had always thought how good it would be to have more support from NICE, so when these jobs came up I applied and started in July 2006.'

The work is enjoyable and challenging. 'We make the organisation much more accessible,' he says. 'We can introduce people to the huge range of tools that NICE produces to support implementation, we can get people along to talk to them and get them involved in suggesting topics.

We are gathering an enormous amount of intelligence and I think an important role for the future will be fostering networking between people with similar issues.'

Steve likes working for NICE. 'It's a great organisation. There are some very clever people around and that keeps you on your toes. There's also a really positive attitude which is refreshing.'

Helen Chung left her job as a doctor in the NHS to work in the City in 1999. She was drawn back to the NHS in 2005 by a job at NICE.

She is now a technical adviser on the Technology Appraisals programme, working from NICE's Manchester office.

'My role is to provide advice to members of the team, our stakeholders, committee members and other NICE directorates,' she says. 'Ultimately, I aim to ensure we produce high quality guidance.'

With her background, she feels very grounded, not just in medical science but also in the value of what the team is doing. 'NICE was one of my inspirations for coming back to the NHS,' she says. 'I feel very secure and motivated by what we are doing to spread good practice by using available knowledge and funds as sensibly as we can.'

Caroline Coulter is an IT trainer at NICE. She has a long history with the Institute's predecessors having started out as a secretary at the Health Education Council. This became the Health Education Authority and then the Health Development Agency, which merged with NICE in 2005.

Much of her day-to-day job involves training new and existing staff to use the IT systems at NICE such as MS Office and web packages.

'Most of them are pretty computer literate already so I am usually teaching at intermediate or advanced level,' she says. 'Whether it's word processing or the sophisticated editing programmes that allow NICE staff to work collaboratively on documents, it's all about increasing their efficiency and effectiveness.'

'NICE is a good employer,' adds Caroline. 'There's a good working atmosphere and as a mother of a child under two I am able to work flexibly. I work from home one day a week which is really important for me.'

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Partners Council

The Partners Council provides a forum for the exchange of ideas and future plans between NICE and its stakeholders.

Members are drawn from organisations with special interests in NICE's work. They include patient groups, health professionals, NHS management, quality organisations, industry and trade unions.

Organisation	Name
Academy of Medical Royal Colleges	Professor Tim Coates
Arthritis & Musculoskeletal Alliance	Bill Freeman
Association of Ambulance Services	Paul Grant
Association of British Healthcare Industries	Colin S Morgan
Association of British Insurers	Dr Natalie-Jane Macdonald
Association of Directors of Social Services	Mr Ted Unsworth
Association of the British Pharmaceutical Industry	Mr David J Fisher
Association of Welsh Community Health Councils	Professor David Owens
British Dental Association	Susie Sanderson
British Dietetic Association	Lee Hooper
British Medical Association	Dr David Lewis
British Psychological Society	Stephen Pilling
Carers UK	Malcolm Blanch
Chartered Institute of Environmental Health	Mr Graham Jukes
Chartered Society of Physiotherapy	Kate McCoy
College of Occupational Therapists	Dr Elizabeth White
Equalities National Council BME Disabled People/Carers	Julie-Jaye Charles
Community Practitioners and Health Visitors Association	Ms Lesley Young-Murphy
Faculty of Dental Surgery	Professor Fraser McDonald
Faculty of Pharmaceutical Medicine	Dr David Galloway
Faculty of Public Health Medicine	Professor Rod Griffiths
Independent Healthcare Forum	Dr Andrew Vallance-Owen
Institute for Quality Assurance	To be appointed
Local Government Association	Cllr David Rogers OBE
National Consumer Council	Saranjit Sihota
National Federation of Womens' Institutes	Margaret Simons
NHS Confederation	Bryan Stoten
Black Health Agency	Mr Nik Barstow
Royal College of Anaesthetists	Dr Anne May
Royal College of General Practitioners	Dr Mayer Lakhani
Royal College of Midwives	Julie Wray
Royal College of Nursing	Clare Morrell
Royal College of Obstetricians and Gynaecologists	Professor Allan Templeton
Royal College of Ophthalmologists	Professor Usha Chakravarthy
Royal College of Paediatrics and Child Health	Dr Edward Wozniak
Royal College of Pathologists	Dr Peter Cowling
Royal College of Physicians	Professor Ian Gilmore
Royal College of Psychiatrists	Dr Paul Lelliott
Royal College of Radiologists	Rodney Reznek
Royal College of Speech and Language Therapists	Diane Payne
Royal College of Surgeons of England	Dr Mark Emberton
Royal Institute of Public Health	Awaiting to be advised
Royal Pharmaceutical Society of Great Britain	Mr John Patrick Farrell
The Princess Royal Trust	Alison Ryan
UNISON	Bob Abberley
United Kingdom Public Health Association	Professor David Hunter
Wales Council for Voluntary Action	David Smith
Ex-Citizens Council	Sylvia Brown
Ex-Citizens Council	Audrey Pestell

Membership during 2006/7

Interventional procedure guidance evaluates the safety and efficacy of procedures where they are used for diagnosis or treatment. These procedures can involve making a cut or a hole to gain access to the inside of a patient's body, or gaining access to a body cavity without cutting into the body, or using electromagnetic radiation (including X-rays, lasers, gamma rays and ultraviolet light).

Health Minister Andy Burnham has agreed that from 1 April 2007 responsibility for running the Advisory Committee on Borderline Substances (ACBS) will transfer from NICE to the NHS Purchasing and Supply Agency (NHS PASA).

The ACBS was set up in 1971 to advise GPs on the prescription of products that are not drugs or medical devices. The committee is an advisory Non-Departmental Public Body, non-statutory and UK wide. NHS PASA has significant procurement expertise and currently facilitates contracts for ACBS-approved enteral feeds and other nutritional products.

Centre for Clinical Practice

The Centre for Clinical Practice at NICE develops clinical guidelines. These are recommendations, based on the best available evidence, on the appropriate treatment and care of people with specific diseases and conditions within the NHS.

Good clinical guidelines aim to improve the quality of healthcare. They can:

- provide recommendations for treatment and care
- help patients make informed decisions and improve communications between patients and health professionals
- provide the basis for developing standards to assess the clinical practice of individual health professionals
- contribute to the education and training of health professionals.

In January 2007 NICE launched a consultation on a new short clinical guideline process that would allow the Institute to produce clinical guidelines covering a small number of specific clinical issues in 9–11 months, as opposed to full guidance which takes 24 months to produce and covers an entire patient pathway. Short clinical guidelines will be developed using the same rigorous methods as existing clinical guidelines. The first short guideline topic is being developed and is due to be published in July 2007.

NICE role in topic selection extended

In September 2006 the Department of Health announced a bigger role for NICE in the topic selection process. Topics are the specific treatments, drugs, or ways of caring for people with specific conditions or diseases about which NICE provides guidance for the NHS and the wider public health community, with the aim of preventing ill health or promoting good health.

Previously, healthcare and public health professionals, patients, carers and the general public could suggest topics for NICE via the NICE website. This information then went to the Department of Health, which was responsible for selecting the topics that would become part of the NICE technology appraisal and clinical guideline programmes.

Under the new arrangements, NICE is responsible for the administration of the early stages of topic selection and is the principal point of contact for individuals and organisations who want to suggest topics. It is also responsible for performing an initial 'sift' of suggestions (for example, to check that the topic isn't already part of NICE's existing work programme).

The Department of Health also asked NICE to organise seven new independent consideration panels. The panels make recommendations to the Department about the topics on which NICE should produce guidance. They are made up of individuals who:

- have expertise in one of seven subject areas: cancer; children, adolescents and maternity; vascular conditions; long-term conditions; general and acute conditions; mental health; and public health, or
- have a broad understanding of the health service and NICE's work, or
- are lay people with an understanding of wider patient, carer and community perspectives.

Ministers will continue to make the final decision on which topics are referred to NICE.

Andrea Sutcliffe, Deputy Chief Executive of NICE, said, 'We welcome these changes to the topic selection process. NICE's increased role should help the process operate more efficiently, allowing us to start working on topics suggested more quickly and so produce guidance on selected topics earlier.'

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Staff at NICE

NICE has established an office in Manchester and most vacant and new posts are being recruited there. The Institute has around 234 staff of whom about 50 are currently based in Manchester. The majority of the rest are in London with a small number of home workers. Our plan is to have equal numbers of staff in the Manchester and London offices by 2012.

Equal opportunities

The Institute is committed to promoting equality and eliminating unlawful discrimination. We aim to comply fully with all legal obligations to:

- promote equality and equality of opportunity between men and women, regardless of race or disability
- eliminate unlawful discrimination on grounds of race, disability, age, sex and gender, sexual orientation, and religion or belief in the way we carry out our functions and in our employment policies and practices.

NICE produces an equal opportunities report each year for the Secretary of State for Health, the most recent of which shows:

- 18% of the workforce belong to a minority ethnic group
- 75% of employees are female
- 23% of the workforce are aged under 30; 52% are aged between 30 and 44, and 25% are aged 45 and over.

Case study 11

NICE's role in research and development

Professor Tony Culyer became chair of the NICE Research and Development Advisory Committee in February 2007.

He said, 'NICE has always recognised that it has a role to play in identifying and stimulating research which supports its guidance programmes. A key role of the research and development programme is to promote research in areas where better evidence has the potential to radically improve care for patients.

The Programme aims to increase the uptake of research recommendations made by NICE by developing a system to prioritise recommendations and effectively communicating recommendations to the research and development community. All NICE guidance is reviewed and updated on a regular basis which means that the results of new research are used to inform updated NICE guidance.

My main task is to help NICE identify and stimulate research which benefits patients and the public and shapes health research policy across the NHS. I also look forward to strengthening our links with potential research partners through regular networks and seminars.'

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National Collaborating Centres

The National Collaborating Centres harness the expertise of the royal medical and nursing colleges, professional bodies and patient carer organisations in developing clinical guidelines.

- NCC for Acute Care based at the Royal College of Surgeons
- NCC for Cancer based at the Velindre NHS Trust
- NCC for Chronic Conditions based at the Royal College of Physicians
- NCC for Mental Health run jointly by the Royal College of Psychiatrists and the British Psychological Society
- NCC for Nursing and Supportive Care based at the Royal College of Nursing
- NCC for Primary Care run by the Royal College of General Practitioners
- NCC for Women's and Children's Health based at the Royal College of Obstetricians and Gynaecologists and Royal College of Paediatrics and Child Health

Review body for interventional procedures

NICE commissions an independent review body to carry out a systematic review when more information is needed before guidance can be developed on an interventional procedure. The review body consists of a consortium of the following organisations:

- School of Health and Related Research, University of Sheffield
- Institute of Applied Health Sciences, University of Aberdeen
- Sheffield Teaching Hospitals NHS Trust

Public health

NICE set up the Centre for Public Health Excellence in April 2005 to produce guidance and supporting evidence on topics in public health for practitioners and policy makers in the NHS, local authorities and the wider public and voluntary sector. This year the Centre published two new pieces of intervention guidance and developed work on a list of topics referred by the Department of Health

New intervention guidance published

In 2006/7 NICE published two new pieces of public health intervention guidance.

Preventing sexually transmitted infections and reducing under 18 conceptions presented recommendations on one-to-one interventions to prevent the transmission of sexually transmitted infections (STIs) including HIV and to reduce the rate of under 18 conceptions, especially among vulnerable and at risk groups.

The NICE guidance on community-based interventions to reduce **substance misuse** among vulnerable and disadvantaged children and young people called for anyone working with young people to identify those who are vulnerable to drug problems and intervene at the earliest opportunity.

Programme development groups established

Work continued on public health topics that had been referred to NICE by the Secretary of State for Health in 2005/6 with the establishment of independent programme development groups for each topic.

Group members include people working directly in public health, managers in the health service and other organisations, researchers, statisticians and representatives from lay groups such as charities or patient/carer organisations.

The programme development groups look at the evidence available and consider comments made on draft versions of the guidance issued for consultation before making final recommendations.

In 2006/7 programme development groups were established for:

- behaviour change
- community engagement
- maternal and child nutrition
- physical activity and the environment
- smoking cessation.

New topics announced

In August 2006, the Secretary of State for Health referred eight further public health topics to NICE. This was in line with the Institute's remit for developing guidance on promoting good health and preventing and treating ill health. New public health topics referred to NICE were:

- strategies for reducing the harm from smoking
- information for schools on sensible drinking
- workplace health promotion
- promotion of mental health
- strategies for reducing health inequalities in the short, medium and longer terms
- promotion of physical activity in children
- health promotion in schools and colleges of further education
- management of long-term sickness and incapacity.

Case study 1

Joined-up thinking on obesity

It was 12 days before Christmas and it wasn't just the goose that was getting fat when NICE produced the first ever national clinical guideline addressing both the prevention and treatment of obesity in adults and children.

As Professor Peter Littlejohns, Clinical and Public Health Director at NICE, put it, 'Obesity is the most serious threat to the future health of our nation. Its risks are as serious as smoking and urgent action is needed to tackle this problem now.'

The guideline contained wide-ranging recommendations, not just for the NHS but also for schools and early years' providers, local authorities, employers and town planners. It was the first clinical guideline to cover a health issue from both a public health and clinical point of view.

Liz Biggs is Hertfordshire's Healthy Schools Co-coordinator and provided input from the schools' perspective to the NICE obesity guideline. She said, 'I'm responsible for supporting the schools in my area to take a "whole school approach" to health issues – meaning that there are consistent messages about being healthy in the classroom, in the dining room and in the playground. The NICE guidance helps to reinforce the messages in a "whole schools" way.

Schools probably wouldn't describe themselves as working within public health, but they have an important role in improving the health of their pupils. Those working in education won't be used to getting advice and information from NICE, but now that NICE has a remit to produce public health guidance, I look forward to seeing other NICE recommendations that can help support the work that schools are doing.'

Case study 2

Stepping in on substance misuse

With 70,000 people aged 15–24 classed as problematic drug users, substance misuse is an issue for everyone who works with young people. In March 2007 NICE made recommendations calling for anyone working with young people to identify those who are vulnerable to drug problems and intervene at the earliest opportunity, before they start using drugs at all, or before they get into more difficulties if they are already misusing drugs.

The guidance, which was based on the best available evidence, gave advice on how to step in and help young people access the right support and services, as well as outlining just what those services might be.

Professor Peter Littlejohns, Clinical and Public Health Director at NICE and Executive Lead for this guidance, said, 'This guidance will help practitioners working with young people to understand which interventions are effective and how they should be used with those at high risk of substance misuse.'

Dr Catherine Law, Institute of Child Health, University College London and chair of the Public Health Interventions Advisory Committee at NICE, added, 'The good thing about these recommendations is that they can be implemented by any individual whose role involves interacting with young people in their daily work.'

Independent advisory committees

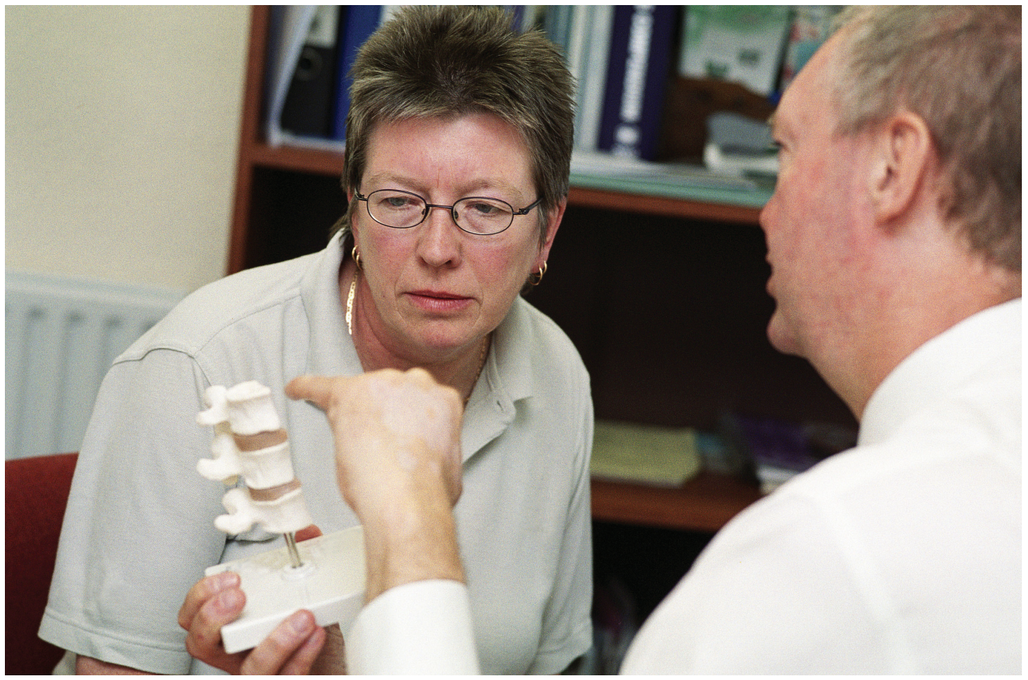
Membership of these committees includes health professionals working in the NHS and people who are familiar with the issues affecting patients and carers. While they may seek the views of organisations that represent healthcare professionals, patients and carers, manufacturers and government, their advice is independent of any vested interest. They are:

- **Interventional Procedures Advisory Committee** chaired by Professor Bruce Campbell
- **Public Health Interventions Advisory Committee** chaired by Dr Catherine Law OBE
- **Research and Development Advisory Committee** chaired by Professor Tony Culyer
- **Technology Appraisal Committee** chaired by Professor David Barnett CBE and Professor Andrew Stevens

Independent academic centres

NICE commissions an independent academic centre to review the published evidence on the relevant technology when developing technology appraisals guidance. NICE currently works with the following organisations:

- Health Economics Research Unit and Health Services Research Unit, University of Aberdeen
- Liverpool Reviews and Implementation Group, University of Liverpool
- Centre for Health Economics, University of York and the Regional Drug and Therapeutics Centre, Newcastle (main contact for single technology appraisals)
- Centre for Reviews and Dissemination and Centre for Health Economics, University of York (main contact for multiple technology appraisals)
- Peninsula Technology Assessment Group, Peninsula Medical School, Universities of Exeter and Plymouth
- School of Health and Related Research, University of Sheffield
- Southampton Health Technology Assessment Centre, University of Southampton
- West Midlands HTA Collaboration Department of Public Health and Epidemiology, University of Birmingham



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Board Sub-committees

Audit Committee

The Audit Committee provides an independent and objective review of arrangements for internal control within the Institute, including risk management. The members of the Audit Committee are:

- **Mr Roy Luff OBE**
  Non-Executive Director (until December 2006)*
- **Jonathan Tross CB**
  Non-Executive Director (from January 2007)*
- **Professor Leon Fine**
  Non-Executive Director (until February 2007)
- **Frederick George**
  Non-Executive Director
- **Ms Jenny Griffiths OBE**
  Non-Executive Director (from March 2007)
- **Mark Taylor**
  Non-Executive Director

*Chair of the committee

The Remuneration and Terms of Service Committee

The Remuneration and Terms of Service Committee sets remuneration levels and terms of service for senior staff at the Institute, in line with NHS practice. The members of the Remuneration and Terms of Service Committee are:

- **Professor Sir Michael Rawlins**
  Chairman*
- **Mark Taylor**
  Vice Chair (from January 2007)
- **Dr Susannah Lawrence OBE**
  Vice Chair (until December 2006)
- **Jonathan Tross CB**
  Non-Executive Director (from January 2007)
- **Mr Roy Luff OBE**
  Non-Executive Director (until December 2006)
- **Mr Frederick George**
  Non-Executive Director

*Chair of the Committee

Senior Management Team

The members of the Institute's Senior Management Team are:

- **Andrew Dillon CBE**, Chief Executive
- **Andrea Sutcliffe**, Deputy Chief Executive and Planning and Resources Director
- **Professor Peter Littlejohns**, Clinical and Public Health Director
- **Dr Gillian Leng**, Implementation Director
- **Dr Carole Longson**, Health Technology Evaluation Centre Director
- **Dr Mercia Page**, Clinical Practice Centre Director
- **Professor Mike Kelly**, Public Health Excellence Centre Director
- Louise Fish, Communications Director

Citizens Council Committee

The Citizens Council Committee, in consultation with the rest of NICE, decides the questions to be put to the Citizens Council. The members of the Citizens Council Committee are:

- **Professor Sir Michael Rawlins**
  Chairman*
- **Mercy Jeyasingham**
  Non-Executive Director
- **Professor Peter Littlejohns**
  Clinical and Public Health Director
- **Professor Helen Roberts**
  Non-Executive Director
- **Andrea Sutcliffe**
  Deputy Chief Executive and Planning and Resources Director.

*Chair of the Committee

Public health intervention guidance published in 2006/7

Title	Publication date
Prevention of sexually transmitted infections and under 18 conceptions (PHI 003)	February 2007
Interventions to reduce substance misuse among vulnerable young people (PHI 004)	March 2007

Public health intervention guidance in development

Title	Publication date*
Workplace interventions to promote smoking cessation	April 2007
Alcohol and schools intervention	November 2007
Mental wellbeing of children in primary education	February 2008
Mental health and older people	March 2008
Proactive case finding and retention and improving access to services in disadvantaged areas	April 2008
Workplace physical activity	May 2008
Prevention of smoking by children and young people	June 2008
Workplace mental health	August 2008

Public health programme guidance in development

Title	Publication date*
Behaviour change	October 2007
Smoking cessation services	November 2007
Physical activity and the environment	January 2008
Community engagement	February 2008
Maternal and child nutrition	February 2008
Management of long-term sickness and incapacity	December 2008
Promotion of physical activity in children	December 2008
Health promotion in schools and colleges of further education	July 2009

* at time of going to press

Health Development Agency publications produced in 2006/7

NICE took over the functions of the Health Development Agency in April 2005, taking on a wider role in public health and inheriting a publications programme. The last of the inherited publications were issued this year.

Title	Publication date
Health and social inequalities in English adolescents: exploring the importance of school, family and neighbourhood	April 2006
Healthier planning: spatial strategies and beyond	April 2006
Review of grey literature on drug prevention among young people	May 2006
The NHS and local transport planning: a briefing	May 2006
Promotion of breastfeeding initiation and duration: evidence into practice briefing	July 2006
Food-support programmes for low-income and socially disadvantaged childbearing women in developed countries: systematic review of the evidence	July 2006
Interventions to prevent accidental injury to young people aged 15–24: evidence briefing	July 2006
Transport interventions promoting safe cycling and walking: evidence briefing	July 2006
Interventions that use the environment to encourage physical activity: evidence review	September 2006
Smoking and public health: a compendium of smoking behaviour initiatives that address socially disadvantaged populations: evidence review	January 2007
Public health interventions to promote positive mental health and prevent mental health disorders among adults: evidence briefing	January 2007

About us

NICE has a robust corporate governance structure ensuring that the Institute has a clear direction and a strong focus on delivery

The Board

The Board's membership in 2006/7 was as follows:

Professor Sir Michael Rawlins
Chairman

Mark Taylor
Vice Chair (from January 2007)

Dr Susannah Lawrence OBE
Vice Chair (until December 2006)

Professor Shah Ebrahim
Non-Executive Director

Professor Leon Fine
Non-Executive Director (until February 2007)

Frederick George
Non-Executive Director

Ms Jenny Griffiths
Non-Executive Director

Dr Margaret Helliwell
Non-Executive Director (from January 2007)

Mercy Jeyasingham
Non-Executive Director

Mr Roy Luff OBE
Non-Executive Director (until December 2006)

Mary McClarey
Non-Executive Director

Professor Helen Roberts
Non-Executive Director

Jonathan Tross CB
Non-Executive Director (from January 2007)

Andrew Dillon CBE
Chief Executive

Dr Gillian Leng
Implementation Director

Professor Peter Littlejohns
Clinical and Public Health Director

Andrea Sutcliffe
Deputy Chief Executive and Planning and Resources Director

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Technology appraisals

Technology appraisals make recommendations on the use of new and existing medicines and treatments within the NHS. This year NICE produced its first rapid appraisal under the new single technology appraisal process. In total, 21 technology appraisals were published on topics ranging from Alzheimer's disease and anti-cancer drugs to the management of children with conduct disorders

First single technology appraisals delivered on schedule

In August 2006 NICE published a technology appraisal on the use of trastuzumab (Herceptin) in treating early breast cancer, just as promised a year earlier. This was the first technology appraisal to be developed using the new single technology appraisal (STA) process launched with the Department of Health in 2005. Others on breast cancer drugs docetaxel (Taxotere) and paclitaxel (Taxol) came just a month later.

The new STA process was designed to sit alongside NICE's existing processes to produce faster guidance on life-saving drugs that have already been licensed and on new medicines close to when they first become available. NICE consulted with organisations representing patients, healthcare professionals and healthcare industries on details of the new process.

In 2006/7 NICE recruited new members to its independent Appraisal Committees to support this work. Andrew Dillon, Chief Executive of NICE, welcomed them saying, 'Last year we announced our new rapid appraisal process which will allow us to issue guidance to the NHS on new drugs and treatments more quickly. In order to deliver this new programme of work we needed to increase the capacity of our Appraisal Committees. We looked to recruit individuals who have the experience and commitment to help the Institute take some of the most difficult decisions in public life, and in doing so contribute to improving the quality and consistency of care provided by the NHS.'

In August 2006 the Department of Health asked NICE to transfer a range of existing topics to the STA process. These were:

- erlotinib (Tarceva) for non-small-cell lung cancer
- irinotecan (Campto) for adjuvant treatment of advanced colorectal cancer (subject to licensing)
- pemetrexed (Alimta) for non-small-cell lung cancer
- cetuximab (Erbitux) for locally advanced recurrent metastatic head and neck cancer (subject to licensing)
- atrasentan (Xinlay) for hormone refractory prostate cancer (subject to licensing)
- omalizumab (Xolair) for asthma
- lerdelimumab (CAT-152) for glaucoma
- carmustine implants (Gliadel implants) for recurrent glioma
- nesiritide (Natrecor) for acute heart failure
- natalizumab (Tysabri) for multiple sclerosis
- infliximab (Remicade) for psoriasis.

New appraisal topics referred to NICE

In August 2006 the Secretary of State for Health referred a range of new topics for technology appraisal. They were:

- idraparinux sodium for the prevention of stroke in patients with atrial fibrillation
- idraparinux sodium for the prevention of recurrent venous thromboembolism
- varenicline for smoking cessation
- alteplase for acute ischaemic stroke
- drugs for refractory rheumatoid arthritis
- adalimumab and leflunomide for the treatment of psoriatic arthritis
- ruboxistaurin for the treatment of diabetic eye disease
- drugs for the treatment of sleep apnoea
- neuro-imaging in identification of first episode psychosis
- cochlear implants.

In February 2007 a further five topics were referred under the STA programme, namely:

- bevacizumab for non-small-cell lung cancer
- certolizumab pegol for rheumatoid arthritis
- infliximab for ulcerative colitis
- lapatinib for advanced or metastatic breast cancer
- rimonabant for the treatment of obese and overweight patients.

Three more were added to NICE's multiple technology appraisal programme. They were:

- endovascular stents for abdominal aortic aneurysms
- machine versus cold (static) storage of donated kidneys
- spinal cord stimulation for chronic pain.

In addition, NICE was asked to appraise adalimumab for moderate to severely active Crohn's disease. This will be appraised as part of the multiple technology appraisal (MTA) programme, along with infliximab (review of existing guidance), certolizumab pegol and natalizumab.

Case study 3

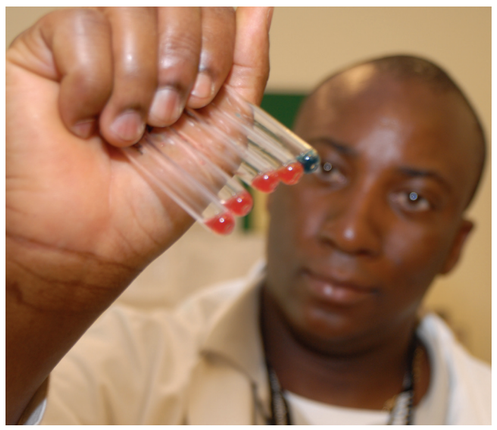
Why cost effective doesn't always mean cheaper

Professor David Barnett co-chairs the Institute's three appraisal committees which help develop technology appraisals. One aspect of the committees' role is to look at cost effectiveness.

'The treatments provided by the NHS are normally designed to improve quality of life or to extend life and sometimes both. They all have a cost, of course, and it's part of our job to decide whether new treatments offer enough benefit to patients, compared to current standard treatments, to justify what the NHS is being asked to pay for them. To help us do this, we use a measurement called a "quality adjusted life year", or QALY. QALYs allow us to take account of the extent to which new treatments offer improvements in quality of life as well as extending life. Using QALYs in all our assessments means that we avoid regarding one disease or condition as more important than another.

Making sure new treatments offer real benefits for patients and provide good value for money for the NHS is important because we have a fixed amount of money to spend on the NHS and it's not possible to buy everything that might have even the smallest benefit for everyone. Put simply, we can't afford to buy treatments that don't work well enough. Spending money on treatments with little or no value for one group of patients means that money can't be spent on treatments that are effective for another group.

It's not just about price, though. A very expensive treatment might well be cost effective if it offers sufficient benefits for patients. Conversely, a treatment that might not cost very much could still be poor value for money if it doesn't offer enough improvement in quality or length of life.'



NICE continued its popular fringe events at the main political party conferences in 2006. The health spokespersons for the Liberal Democrats and Conservatives and the chair of the Health Select Committee (at the Labour Party fringe meeting) introduced the event and responded to the views of the NICE chairman and chief executive. The ensuing audience discussion stimulated many novel ideas about how NICE guidance can reach its target.

NICE e-newsletters

NICE News

In February 2007 NICE launched its new-look e-newsletter, NICE News. Published on the fourth Wednesday of each month, NICE News provides access to information on newly published guidance documents, important diary dates, forthcoming events and guidance topics plus features, stories and press releases. Now with a massive 35,000 subscribers, NICE News is a quick way for NHS professionals, patients and interested members of the public to keep up to date with the latest developments at NICE. Subscription to NICE News is free and open to all.

To subscribe to NICE News, visit www.nice.org.uk/alerts

Into Practice

Into Practice is the new free electronic bulletin aimed at people implementing NICE guidance. Launched in March 2007 and published on the second Wednesday of each month, Into Practice includes details of the latest implementation tools, shared learning entries and reports added to the Evaluation and review of NICE implementation (ERNIE) database. Complete with reports from the NICE implementation team, including updates from NICE implementation consultants working around the UK, Into Practice is set to become an invaluable source of information for all those responsible for implementing NICE guidance.

To subscribe to Into Practice, visit www.nice.org.uk/alerts

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Website a hit

Use of NICE's website continued to grow in 2006/7 aided by the addition of new tools described in the implementation section of this report and continuous improvement to its accessibility and user-friendliness.

The website now features an online glossary defining the terms and acronyms used on the site. Users can also search guidance by date. The website's first collection of online content (www. nice.org.uk/guidance) makes it easier for users to find the guidance within the website.

Growth in web traffic

Hits for March 2005:	4,086,882
Hits for March 2006:	5,298,503
Hits for March 2007:	7,819,621

Exhibitions and conferences

NICE staff attended a wide range of exhibitions and conferences as delegates, speakers and exhibitors throughout 2006/7.

The Health Technology Assessment conference and the International Society for Quality in Healthcare each provided international platforms for NICE to discuss best practice with colleagues from around the world.

Other events attended included:

- Patient Information Forum
- UK Public Health Association
- Royal College of Nursing Annual Congress
- Primary Care
- Faculty of Public Health
- NHS Confederation
- National Obesity Forum
- Community Practitioners and Health Visitors Association annual conference
- National Association of Primary Care
- Royal National Institute for the Blind/Department of Health Delivering the Vision
- Diabetes UK Annual Professional conference
- MIND annual conference.

Case study 4

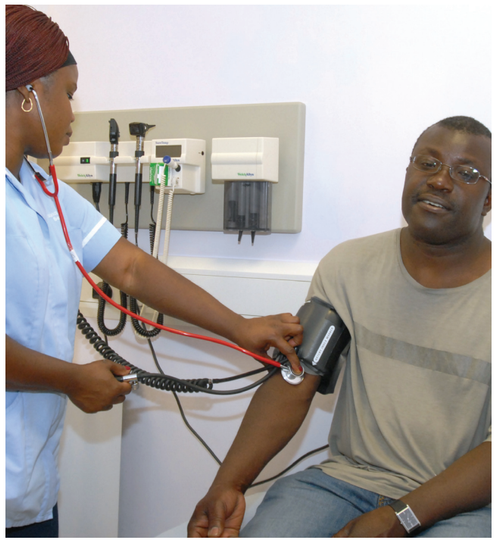
Bringing technology appraisals and guidelines together

Technology appraisals assess individual treatments, like drugs, used in the NHS. In 2006/7 NICE worked in partnership with its counterpart in social care, the Social Care Institute for Excellence, to incorporate a technology appraisal into a guideline for both health and social care staff.

The topic was dementia and the joint NICE/SCIE guidance covered the treatment and care of people with dementia in health and social care. It not only incorporated the latest technology appraisal of drugs for Alzheimer's disease but also called for a coordinated and integrated approach from health and social care staff to provide treatment and care for patients with dementia and support for their carers. The guideline emphasised that memory assessment centres should be the single point of referral for all people with a possible diagnosis of dementia. People diagnosed with dementia should not be excluded from other services.

Andrew Dillon, NICE Chief Executive, said, 'This is a very important guideline not only for people with dementia but also their carers. This is the first time that a clinical guideline has been produced in conjunction with SCIE, demonstrating the real importance of health and social care professionals working together closely to drive forward improved standards of care for people with dementia.

The clinical guideline incorporates our appraisal guidance on the use of drugs for people with Alzheimer's disease, but it also sets wider standards for the care of people with all types of dementia which clinicians and commissioners alike in the NHS are expected to implement.'



Technology appraisals published in 2006/7

Title	Publication date
Renal transplantation – immunosuppressive regimens for children and adolescents (TA99)	April 2006
Colon cancer (adjuvant) – capecitabine and oxaliplatin (TA100)	April 2006
Prostate cancer (hormone-refractory) – docetaxel (TA101)	June 2006
Conduct disorder in children – parent-training/education programmes (TA102)	July 2006
Psoriasis – efalizumab and etanercept (TA103)	July 2006
Psoriatic arthritis – etanercept and infliximab (TA104)	July 2006
Colorectal cancer – laparoscopic surgery (review) (TA105)	August 2006
Hepatitis C – peginterferon alfa and ribavirin (TA106)	August 2006
Breast cancer (early) – trastuzumab (TA107)	August 2006
Breast cancer (early) – paclitaxel (TA108)	September 2006
Breast cancer (early) – docetaxel (TA109)	September 2006
Follicular lymphoma – rituximab (TA110)	September 2006
Alzheimer's disease – donepezil, galantamine, rivastigmine (review) and memantine (TA111)	November 2006
Breast cancer (early) – hormonal treatments (TA112)	November 2006
Diabetes (type 1 and 2) – inhaled insulin (TA113)	December 2006
Drug misuse – methadone and buprenorphine (TA114)	January 2007
Drug misuse – naltrexone (TA115)	January 2007
Breast cancer – gemcitabine (TA116)	January 2007
Hyperparathyroidism – cinacalcet (TA117)	January 2007
Colorectal cancer (metastatic) – bevacizumab and cetuximab (TA118)	January 2007
Leukaemia (lymphocytic) – fludarabine (TA119)	February 2007

Technology appraisal guidance under development

Title	Publication date*
Glioma (newly diagnosed and high grade) – carmustine implants and temozolomide	June 2007
Ischaemic stroke (acute) – alteplase (STA)	June 2007
Heart failure – biventricular pacing (cardiac resynchronisation)	July 2007
Smoking cessation – varenicline (STA)	July 2007
Heart failure (acute decompensated) – nesiritide (STA)	August 2007
Hypercholesterolemia – ezetimibe	August 2007
Osteoporosis – primary prevention	August 2007
Osteoporosis – secondary prevention including strontium ranelate	August 2007
Haemorrhoid – stapled haemorrhoidectomy	September 2007
Macular degeneration (age-related) – pegaptanib and ranibizumab	September 2007
Mesothelioma – pemetrexed disodium	September 2007
Anaemia (cancer-treatment induced) – erythropoietin (alpha and beta) and darbepoetin	November 2007
Asthma (in adults) – corticosteroids	November 2007
Asthma (in children) – corticosteroids	November 2007
Follicular lymphoma – rituximab (STA)	December 2007
Dementia (non-Alzheimer's) – new pharmaceutical treatments (suspended)	January 2008
Glioma (recurrent) – carmustine implants (STA)	January 2008
Ischaemic heart disease – coronary artery stents (review)	January 2008
Lung cancer (non-small-cell) – bevacizumab (STA)	January 2008
Sleep apnoea – continuous positive airways pressure (CPAP)	January 2008
Thrombophilia	January 2008
Atypical psychosis (first onset) – neuro-imaging	February 2008
Pulmonary arterial hypertension (adults) – drugs	April 2008
Diabetes – insulin pump therapy	May 2008
Hearing impairment – cochlear implants	May 2008
Crohn's disease – infliximab (review), certolizumab pegol, natalizumab and adalimumab	July 2008
Abdominal aortic aneurysm – endovascular stent-grafts	November 2008
Ankylosing spondylitis – adalimumab, etanercept and infliximab	To be confirmed

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Reaching out

NICE seeks to reach out to stakeholders in a wide variety of ways. From the continually improving and updated website through to participation in regional, national and international events, the Institute has fostered a two-way dialogue with stakeholders and partner organisations

NICE 2006 conference

The 2006 NICE annual conference took place at the ICC in Birmingham on 6–7 December 2006 with the theme of 'Tackling health priorities'. Nearly 1000 delegates, including 47 patient and carer representatives subsidised under NICE's bursary scheme and 139 speakers attended. Almost 70 exhibitors joined the associated exhibition.

Through plenary sessions, workshops, masterclasses, fringe events and discussion, the conference explored:

- how priorities are set nationally and locally and how they can be reconciled
- using evidence to inform choices
- the ways in which patient advocates, the healthcare industries and commentators should contribute to an informed debate on setting priorities
- how NICE guidance is developed and how it supports informed decision-making.

Board meetings and NICE Question Time sessions

NICE holds six public Board meetings a year. In 2006/7, these were held in Carlisle, Manchester, Hull, London, Sunderland and Worcester. Alongside these meetings, NICE held six 'Question time' sessions at which local NHS employees and public health staff quizzed the Board and discussed the Institute's latest work.

Next year the NICE Board is looking forward to increased engagement with stakeholders within public health and will use 'Question time' sessions to focus on their issues.

Title	Publication date*
Asthma (uncontrolled) – omalizumab (STA)	To be confirmed
Atrial fibrillation – idraparinux sodium (STA)	To be confirmed
Atrial fibrillation – ximelagatran (suspended)	To be confirmed
Breast cancer (advanced or metastatic) – lapatinib (STA)	To be confirmed
Colitis (ulcerative) – infliximab (STA)	To be confirmed
Colon cancer (adjuvant) – irinotecan (STA)	To be confirmed
Diabetic retinopathy – ruboxistaurin (STA) (suspended)	To be confirmed
Falls – fallers' clinics (suspended)	To be confirmed
Glaucoma – lerdelimumab (CAT-152) (STA) (suspended)	To be confirmed
Growth failure (in children) – human growth hormone (HGH) (suspended)	To be confirmed
Head and neck cancer – cetuximab (STA)	To be confirmed
Lung cancer (non-small-cell) – erlotinib (STA)	To be confirmed
Lung cancer (non-small-cell) – gefitinib (suspended)	To be confirmed
Lung cancer (non-small-cell) – pemetrexed (STA)	To be confirmed
Multiple myeloma – bortezomib (STA)	To be confirmed
Multiple sclerosis – cannabinoids (STA) (suspended)	To be confirmed
Multiple sclerosis – natalizumab (STA)	To be confirmed
Osteoarthritis and rheumatoid arthritis – cox II inhibitors (review) (suspended)	To be confirmed
Pancreatic cancer – gemcitabine (suspended)	To be confirmed
Prostate cancer (hormone refractory) – atrasentan (STA) (suspended)	To be confirmed
Psoriasis – infliximab (STA)	To be confirmed
Psoriatic arthritis (moderate to severe) – adalimumab (STA)	To be confirmed
Psoriatic arthritis (moderate to severe) – leflunomide (STA)	To be confirmed
Rheumatoid arthritis – adalimumab, etanercept and infliximab	To be confirmed
Rheumatoid arthritis (refractory) – abatacept (STA)	To be confirmed
Rheumatoid arthritis (refractory) – rituximab (STA)	To be confirmed
Venous thromboembolism (recurrent) – idraparinux sodium (STA)	To be confirmed
Venous thromboembolism (VTE) – ximelagatran (suspended)	To be confirmed

*at time of going to press

STA; single technology appraisal

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Case study 10

Laying the foundations

The Patient and Public Involvement Programme (PPIP) supports all lay members on NICE's committee and lay member groups. Barbara Greggains has served as a lay member on a NICE Guideline Development Group, and is now on a Technology Appraisal Committee.

She said, 'The Patient and Public Involvement Programme ensures that the views and experiences of patients and the public are fed into all aspects of the work of NICE, providing the essential reality check that is needed to help shape the guidance and recommendations that NICE produce.

The programme identifies, trains and supports lay people who can bring relevant experience and knowledge to the various NICE committees. Beyond this, it has developed a large web of contacts consisting of both formal national patient organisations and less formal links. All opinions and personal experiences of healthcare conditions are welcomed and there is support for those who might have difficulty in expressing their views.

The PPIP has influence at every level of NICE's complex organisation and as such is constantly expanding and adapting as NICE's role develops. This is no token gesture operation – it is a highly effective, organised and conscientious patient and public involvement programme. The PPIP has helped to empower me and others who speak up on behalf of patients and the public and is essential in supporting the development and implementation of NICE guidance.'

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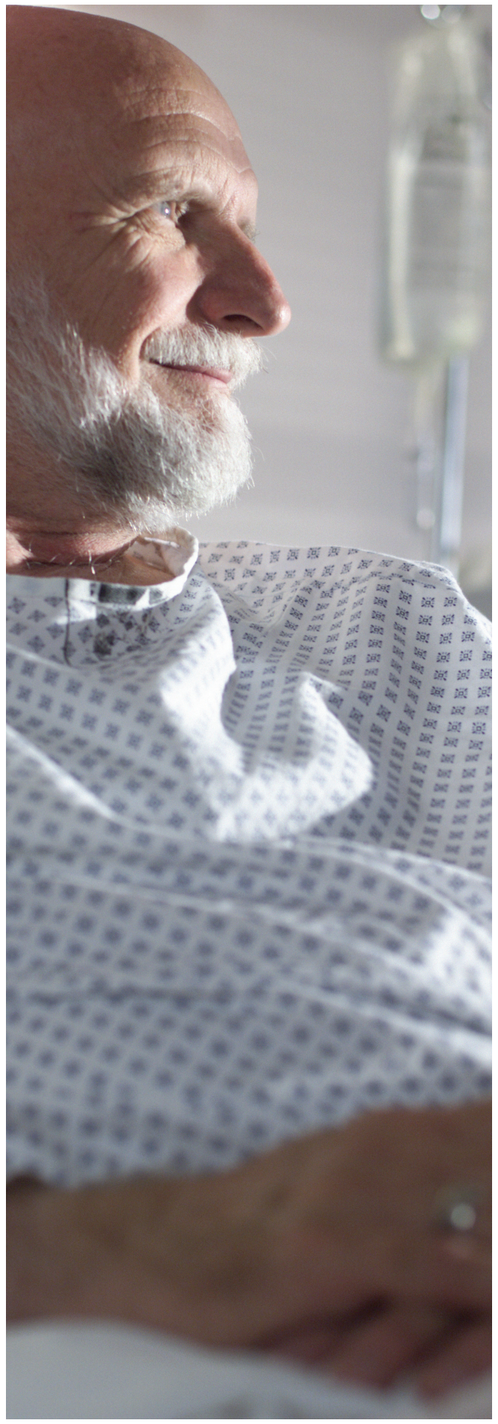

PPIP also ran seven training days and workshops for patients and members of the public, and once again ran the successful bursary scheme to enable 47 patient and voluntary sector organisations to attend the 2006 NICE conference.

PPIP published two new 'how to' guides for patients and carers. These guides explain how patient groups and individuals can contribute to the development of NICE clinical guidelines and interventional procedures guidance. They complement an existing guide for technology appraisals.

International interest in PPIP

The World Health Organization's review of the Institute's clinical guidelines programme cited our work with patients and other stakeholders as 'leading the way internationally'. Over the past year, international interest in the ways that NICE involves patients, carers and the public in its work has increased. The PPIP has welcomed a number of visitors from guidance-producing organisations in Europe, North America and the Far East, and spoken at several international conferences, both on the methods NICE uses to ensure meaningful involvement, and on the practical influence that patients, carers and members of the public have brought to NICE's processes and products. Guidance-producing groups in countries including Canada, France and Japan are adapting our methods for patient and public involvement and using PPIP materials to develop their own training and support for lay people involved in their work.

The Citizens Council

The Citizens Council brings the views of the public to NICE decision-making about guidance on the promotion of good health and the prevention and treatment of ill health. A group of 30 people drawn from all walks of life, the Citizens Council, tackles challenging questions about values – such as fairness and need.

The Citizens Council met twice in 2006/7. At its first meeting, which took place from 8 to 10 June 2006, the Council considered the social value judgements around tackling health inequalities. At its second meeting, from 25 to 27 January 2007, the Council considered the social value judgements around 'only in research' recommendations.

Clinical guidelines

NICE clinical guidelines provide advice on the appropriate treatment and care of people with specific diseases and conditions. Atrial fibrillation, postnatal care and bipolar disorder were among the 13 guidelines produced by the Institute this year

International experts review clinical guidelines programme

This year saw five international experts from the World Health Organization (WHO), the United Nations' health agency, undertake an independent peer review of the Institute's clinical guidelines programme. They analysed the methodology and process used for developing NICE guidelines and reviewed a series of recently published guidelines, one from each of the National Collaborating Centres (NCCs) that NICE commissions to develop them.

The WHO panel identified many strengths, such as the programme's overall organisation, its links with the Royal Colleges, the use of a respected methodology and its excellent work on patient and stakeholder involvement.

The WHO made a number of recommendations to help us improve our process and methodology for guideline development. We have already made substantial progress with implementation of these recommendations and will continue to do so throughout 2007/8.

NICE to help NHS reduce spending on treatments that do not improve patient care

In September 2006 Health Minister Andy Burnham asked NICE to launch a new programme of work to help the NHS identify interventions that are not effective or do not improve patient care. In response to this request, NICE developed three new types of product:

- Clinical guidelines and technology appraisals aimed at reducing optimal practice. For example, NICE is looking at when it is appropriate to use grommets to treat glue ear. This technique has its place in treating this condition, but we need to make sure that it is not being over-used. Between 10 and 30% of children will experience glue ear before the age of 3 and they can be treated using grommets or with other techniques, including 'watchful waiting', which means keeping a careful eye on the child to see whether the condition resolves itself without further intervention. NICE expects to issue guidance on this topic in 2008.

- Reminders highlighting recommendations from existing NICE guidance to advise the NHS to stop an intervention that is ineffective or poor value for money. To date, NICE has issued online reminders on drugs for the treatment of eczema, long-acting reversible contraception and treatments for post-traumatic stress disorder.
- Guides offering practical web-based advice for NHS commissioners on how to commission routine services in line with NICE recommendations. The first commissioning guide on upper gastrointestinal endoscopy services was published in October 2006, underpinned by NICE guidelines on dyspepsia and referral for suspected cancer. Four further commissioning guides have been published, covering anticoagulation therapy services, pulmonary rehabilitation for chronic obstructive pulmonary disease (COPD), assisted discharge scheme for COPD and diabetes foot care services.

Gillian Leng, NICE Implementation Director commented, 'NICE already advises the NHS on when it should invest in new drugs and treatments that work well for patients. It's common sense for us to also advise the NHS on when it is appropriate to stop using treatments that don't benefit patients or do not represent good value for money where there are better alternatives available.'

New guideline topics welcomed

In August 2006, the Secretary of State for Health referred two new clinical guideline topics to NICE. These were the diagnosis and management of metastatic spinal cord compression and the diagnosis and management of irritable bowel syndrome. A further two topics were referred in February 2007. These were rheumatoid arthritis in adults and diarrhoea and vomiting in children. In addition, in December 2006 prophylaxis for infective endocarditis was referred for development under the new short guideline process.

Involving patients and the public

NICE works with patients, carers, patient organisations and the wider public to produce guidance that reflects their views and meets their healthcare needs. In 2006/7 the Institute continued to develop its work in this area

Getting involved

Patients, carers and the public can get involved with NICE by:

- suggesting a topic for guidance
- commenting on draft guidance
- joining a NICE committee, working group or the Citizens Council
- helping disseminate guidance and encouraging its implementation.

National organisations representing patients and carers can also register an interest in a NICE work topic via the NICE website (www.nice.org.uk). This gives them the opportunity to comment on all the draft guidance and to submit evidence on patients' views and experiences that might not otherwise be captured by a standard systematic review.

Patient and Public Involvement Programme

The Patient and Public Involvement Programme (PPIP) advises and supports all NICE's work programmes on methods and strategies for involving patients, carers and members of the public. It also recruits, trains and supports the patients, carers and lay members of all NICE advisory bodies, as well as patient and carer experts attending NICE technology appraisal committees.

In 2006/7 the PPIP attracted applications from more than 400 people for:

- five lay members for the NICE technology appraisal committees (completing the quota of three lay people per committee)
- six lay members for the NICE Appeal Panel (bringing the total to eight)
- two new Partners Council lay members
- 14 lay members for NICE topic selection consideration panels
- two lay members for all new guideline and programme development groups.

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Case study 5

New guideline for bipolar disorder

It takes an average of 8 years from a person experiencing the first symptoms of bipolar disorder to receiving a diagnosis. 'This is far too long,' said Stephen Pilling, consultant clinical psychologist and joint director of the National Collaborating Centre for Mental Health. Speaking at the launch of a new guideline on the identification, treatment and management of bipolar disorder in children and adults, he said, 'More needs to be done to improve awareness, identification and recognition of this problem so that appropriate treatments are prescribed and symptoms can be better controlled.'

Bipolar disorder (formerly known as manic depression) is a serious mental health condition characterised by the presence of episodes of mania and depression. The guideline calls for more to be done to ensure that bipolar disorder is correctly identified and recognised by health professionals. It sets out the criteria for when patients need to be referred on for specialist psychiatric assessment and treatment, and the drug treatment options for people with bipolar disorder, and emphasises the need to involve service users in treatment decisions.

Professor Richard Morris, Professor of Psychiatry, University of Nottingham and Guideline Development Group member said, 'Bipolar disorder is a lifelong condition that requires continuity of care. Too often patients do not have access to the medical help they require. The guideline should clarify the assessment and treatment needed and give hope to people with bipolar that with proper continuing treatment they can lead a relatively normal and fulfilled life.'

Case study 6

Gold standard for hypertension endorsed

June 2006 saw publication of the keenly awaited updated clinical guideline on the management of hypertension, published jointly with the British Hypertension Society (BHS).

Around four in ten adults in England and Wales have hypertension – a risk factor for cardiovascular diseases such as stroke and coronary heart disease and for chronic renal failure. In 2001, the NHS paid for 90 million prescriptions for drugs that lower blood pressure, accounting for nearly 15% of the total annual cost of all primary care drugs. Nonetheless, hypertension is often inadequately treated.

The new guideline is the gold standard for the optimum pharmacological management of hypertension, seeking to decrease the morbidity and mortality of diseases for which hypertension is a significant risk factor.

Professor Morris Brown, President of the BHS and member of the Guideline Development Group said, 'The British Hypertension Society is pleased to be a partner in the first joint guideline between NICE and a specialist society. I hope that the new guideline will both stimulate and enable doctors to review treatment of all their patients with hypertension.'

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Clinical guidelines and cancer service guidance published during 2006/7

NICE has established seven National Collaborating Centres (NCCs) to help develop the clinical guidelines. Each is a professionally led group harnessing the expertise of the royal medical colleges, professional bodies and patient/carer organisations. The NCCs are:

- National Collaborating Centre for Acute Care
- National Collaborating Centre for Cancer
- National Collaborating Centre for Chronic Conditions
- National Collaborating Centre for Mental Health
- National Collaborating Centre for Nursing and Supportive Care
- National Collaborating Centre for Primary Care
- National Collaborating Centre for Women's and Children's Health

In 2006/7 they published 12 new guidelines and the last in NICE's cancer service guidance series.

Title	Publication date
Brain tumours (cancer service guidance)	June 2006
Hypertension (CG34)	June 2006
Parkinson's disease (CG35)	June 2006
Atrial fibrillation (CG36)	June 2006
Postnatal care (CG37)	July 2006
Bipolar disorder (CG38)	July 2006
Anaemia management in chronic kidney disease (CG39)	September 2006
Urinary incontinence (CG40)	October 2006
Familial breast cancer (CG41)	October 2006
Dementia (CG42)	November 2006
Obesity (CG43)	December 2006
Heavy menstrual bleeding (CG44)	January 2007
Antenatal and postnatal mental health (CG45)	February 2007

Implementation uptake reports published in 2006/7

Title	Publication date
NICE commissioned surveys and reports	October 2006
Anakinra	December 2006
Atypical antipsychotics	December 2006
Cox II selective inhibitors	December 2006
Drotrecogin alfa (activated)	December 2006
Drugs for obesity – orlistat and sibutramine	December 2006
Riluzole	December 2006

Forthcoming implementation uptake reports

Title	Publication date
Attention deficit hyperactivity disorder	April 2007
Epilepsy (adults) (children) – newer drugs	April 2007
Glitazones (rosiglitazone and pioglitazone)	April 2007
Insomnia – newer hypnotic drugs	April 2007
Insulin glargine	April 2007

Commissioning guides

During autumn 2006, NICE produced a new set of resources to help the NHS in England commission evidence-based care for patients. These web-based, topic-specific commissioning guides are primarily targeted at clinical leads and commissioning staff in primary care trusts and practice-based commissioning practices/groups. They are underpinned by NICE clinical guidelines.

The commissioning guides offer detailed practical advice on a range of issues, including local needs assessment and opportunities for clinical service redesign. They signpost and provide information on key clinical and service-related issues to consider during the commissioning process.

Within each guide is an interactive commissioning tool that provides a resource to estimate and inform the level of service needed locally and the cost of local commissioning decisions. The tool was made available to commissioners in practices and PCTs in England through a secure registration process. User visits to the commissioning guides increased month on month from the date of their launch to an average of 4800 per guide by the end of March 2007. Over 70% of PCTs have registered to access the commissioning tools.

Commissioning guides published in 2006/7

Title	Publication date
Assisted-discharge service for people with COPD	October 2006
Pulmonary rehabilitation service for people with COPD	October 2006
Upper GI endoscopy services	October 2006
Anticoagulation therapy service	November 2006
Foot care service for people with diabetes	November 2006

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Case study 8

Providing the personal touch

When Chris Connell, implementation consultant in the West Midlands, made his first visit to Walsall Teaching PCT he started a ball rolling.

He had intended just to introduce himself and his role to the director of public health and members of the clinical effectiveness department at Walsall Teaching PCT. However, they grabbed the opportunity with both hands. They were already working on implementing the new clinical guideline on obesity and invited him back to discuss options for developing local strategies for implementation, audit and evaluation. Chris also demonstrated the implementation tools, such as how to apply the costing tool to their work on obesity.

It was a two-way street, with the clinical effectiveness team offering valuable feedback on local views about NICE. They also demonstrated Walsall Teaching PCT's impressive computerised system for recording and tracking the implementation of NICE guidance. Chris suggested that the team consider making a submission to the NICE shared learning database.

'It certainly was a worthwhile visit,' said Sara Saville, clinical effectiveness manager at Walsall PCT. 'Chris was able to brief us on the latest news from NICE and we were able to provide NICE with feedback. We were delighted that Chris thought that our approach to NICE implementation might be of interest and help to other organisations.'

Implementation tools published

In 2006/7 NICE produced a series of tools to support implementation of its guidance at local level. These included:

- help with planning
- slide sets to help raise awareness and support discussion
- costing tools to inform financial planning
- audit criteria to support local audit programmes.

Shared learning database

The shared learning database was launched at the NICE conference in December 2006 and is available on the NICE website (www.nice.org.uk/sharedlearning). The database contains examples of local implementation projects and aims to share learning across the NHS and organisations responsible for delivering public health programmes.

By the end of the year, the database included over 30 examples of implementation initiatives from NHS, other public sector and voluntary organisations. Examples range from the implementation of specific pieces of NICE guidance by specialist services to organisation-wide implementation systems that ensure all NICE guidance is assessed and appropriate implementation plans are put in place.

Next year, NICE will draw on the database for a new shared learning award to replace the posters that have traditionally been exhibited at the NICE annual conference.

Case study 9

A trouble shared…

Gill Gant is head of care governance at Torbay Care Trust and is a keen user of the NICE shared learning database. She explained why.

'The shared learning database allows healthcare professionals to connect with each other and to share tips and ideas on how best to implement NICE guidance. I particularly value the section on examples of implementation.

I have downloaded several contributions to read and find it very useful to compare what other PCTs are doing. I am hoping that I will see examples of excellent practice that I can borrow.

I also intend to make use of the database to share my own PCT's experience of implementing NICE guidelines in an integrated health and social care organisation.

The shared learning database is such a simple idea, but so useful. It is easy to use, and already full of examples of work going on all over the country. It will probably grow in popularity and therefore become a superb resource as it matures.

Already it is extremely valuable and is probably one of the most useful resources that NICE has created to support the implementation of its guidance.'

ERNIE database launched

The Evaluation and Review of NICE Implementation Evidence (ERNIE) database was launched at the NICE conference in December 2006 and is available on the NICE website (www.nice.org.uk/ernie). It is a source of information on the implementation and uptake of NICE guidance. One of its main purposes is to ensure implementers can see national reports and other data that help to set the context of implementation.

ERNIE provides a bank of guidance-specific NICE implementation uptake reports produced in-house, as well as references to external literature. A simple classification system summarising the uptake of NICE guidance helps users to see whether NICE considers practice to be in line with guidance, not in line with guidance or a mixture of the two.

Clinical guidelines under development

Title	Publication date*
Anxiety (amendment)	April 2007
Depression (amendment)	April 2007
Venous thromboembolism	April 2007
Feverish illness in children	May 2007
MI: secondary prevention	May 2007
Faecal incontinence	June 2007
Acutely ill patients in hospital (SCG)	July 2007
Drug misuse – opioid detoxification	July 2007
Drug misuse – psychosocial interventions	July 2007
Chronic fatigue syndrome/myalgic encephalomyelitis	August 2007
Urinary tract infection in children	August 2007
Head injury (update)	September 2007
Intrapartum care	September 2007
Atopic eczema in children	December 2007
Lipid modification	January 2008
Osteoarthritis	January 2008
Prostate cancer	January 2008
Irritable bowel syndrome	February 2008
Ventilation tubes	Feburary 2008
Antenatal care	March 2008
Diabetes in pregnancy	March 2008
Diabetes – type 2 (update)	March 2008
Prophylaxis for infective endocarditis (SCG)	March 2008
Perioperative hypothermia (inadvertent)	April 2008
Osteoporosis	To be confirmed
Induction of labour (update)	June 2008
Respiratory tract infection (SCG)	June 2008
Attention deficit hyperactivity disorder	July 2008
Stroke – acute management	July 2008
Familial hypercholesterolaemia	August 2008
Surgical site infection	August 2008
Chronic kidney disease	September 2008
Metastatic spinal cord compression	November 2008
Suspected child abuse	November 2008 (TBC)
Antisocial personality disorders	December 2008
Medicines concordance	December 2008
Personality disorders – borderline	December 2008
Breast cancer (advanced)	January 2009
Breast cancer (early)	January 2009
Schizophrenia (update)	January 2009
Rheumatoid arthritis in adults	February 2009
Depression in primary and secondary care (update)	March 2009 (TBC)
Depression with chronic physical health problems (update)	March 2009 (TBC)
Low back pain	March 2009
Diarrhoea and vomiting in children	April 2009
Glaucoma	April 2009
Venous thromboembolism – prevention in patients admitted to hospital	June 2009 (TBC)
Acute chest pain	September 2009 (TBC)
Benign prostatic hyperplasia	September 2009 (TBC)
Substance misuse in pregnant women	September 2009 (TBC)
Meningococcal disease and meningitis in children and adolescents	October 2009

*at time of going to press

SCG; short clinical guideline

Implementation

NICE guidance benefits everyone – patients, carers, the public and the NHS and it helps ensure consistent improvements in people's health. In 2006/7 NICE launched a significant new programme of work to support implementation of its guidance, including two new online databases and a team of implementation consultants

Implementation consultants start work

In July 2006 five NICE implementation consultants began helping NHS organisations put guidance into practice. The consultants are home-based and supported from the Manchester office by the Implementation Directorate's systems team.

Excellent progress has been made against the consultants' initial objective, to visit every NHS trust, primary care trust and strategic health authority in England. Just a handful remain. Meanwhile, a rolling programme of visits and follow-up visits continues.

The implementation consultants offer:

- updates and advice to help senior management teams in NHS organisations implement NICE guidance
- problem solving, by sharing examples of how organisations have worked together to implement guidance
- advice on how to use the NICE implementation support tools
- a chance for clinicians and managers to feed back to NICE on local issues, ideas for new topics and suggestions for improvement
- regular feedback to the NICE board, centres and directorates of results from fieldwork.

A survey of the impact of consultants' visits was undertaken in March 2007. It showed that they are effective in raising awareness of NICE guidance and helpful in providing practical advice. For example, 46% of 130 NHS respondents found their visit extremely useful and 52% found it moderately useful.

Next year, implementation consultants will start a programme of visits to the 150 English local authorities that provide social services. These visits will raise awareness of the NICE public health programme and provide an opportunity for the consultants to identify the best ways for the Institute to communicate with this new audience. Consultants also propose to work with clinical and managerial networks that are often the focus of collaborative approaches to putting NICE guidance into practice.

If you would like to receive a visit from your local implementation consultant, their contact details are on the NICE website at www.nice.org.uk/implementationCons

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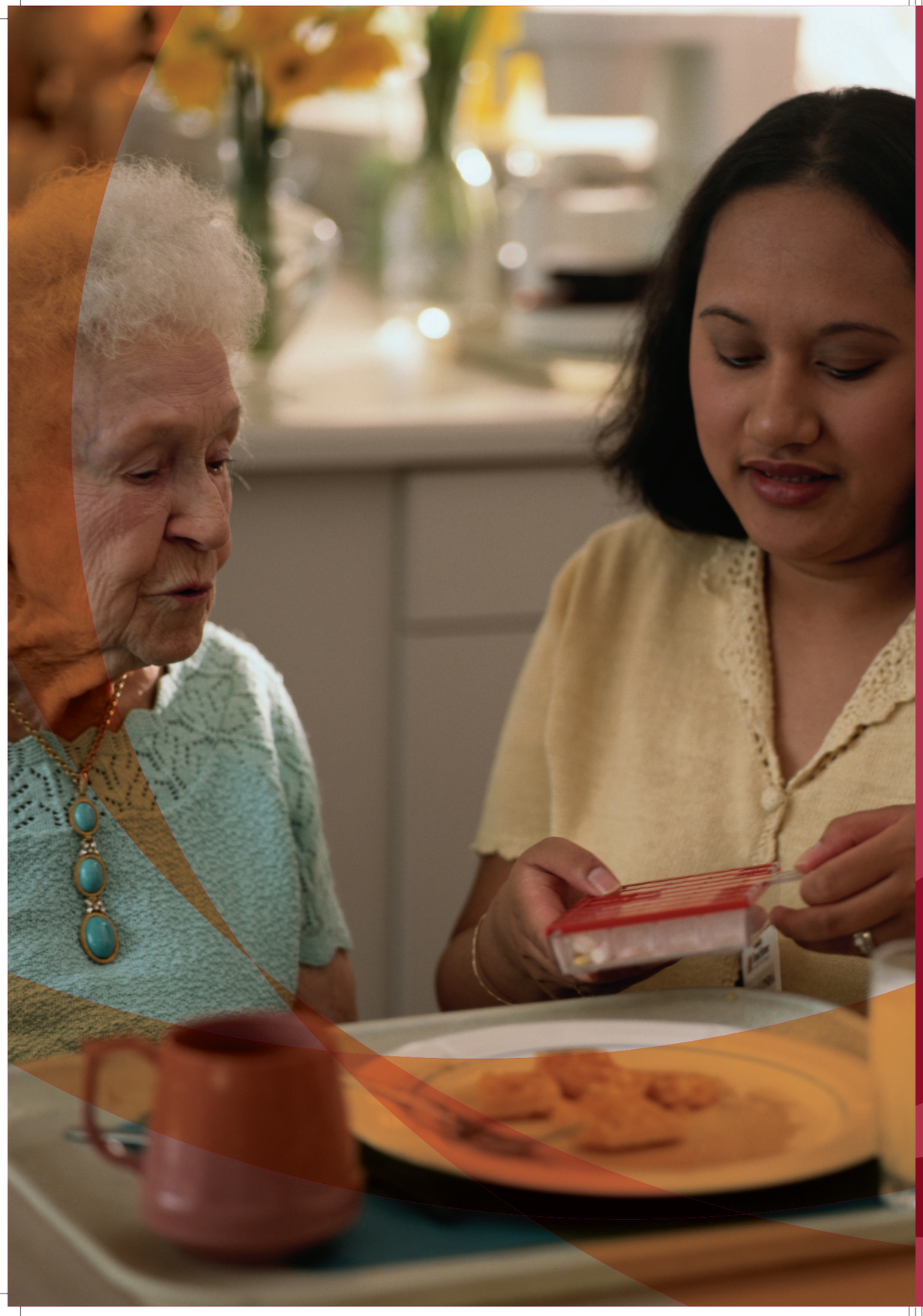

Interventional procedures

NICE guidance on interventional procedures determines not only whether a procedure is safe enough but also whether it works well enough for routine use in the diagnosis and treatment of NHS patients. The Institute published guidance on 50 such procedures last year, on topics such as using lasers or ultrasonic scalpels to remove tonsils, removing kidney tumours with frozen nitrogen, living-donor liver transplants and surgical techniques on the unborn fetus

Case study 7

Introducing IPAC

Professor Bruce Campbell is a vascular surgeon. He chairs NICE's Interventional Procedures Advisory Committee (IPAC), which was set up as a result of the Bristol Royal Infirmary Enquiry to help ensure the safety of NHS patients undergoing new procedures.

He said, 'IPAC reviews the evidence on how well new procedures work and whether they are sufficiently safe. As well as information from clinical trials, IPAC takes into account the views of specialist advisors, who are doctors, and other health professionals with knowledge of the procedure, as well as the views of patients who have undergone the procedure. Our guidance then sets out what (if any) special arrangements should be put in place by NHS trusts in order for them to offer the procedure to patients.

These special arrangements usually involve making sure the patient knows that the procedure is new and making sure the outcomes of the procedure are accurately recorded. We also provide information for patients about the procedure.

So far NICE has issued guidance on over 200 procedures, including guidance on treatments for cancer, heart disease, and spinal and eye problems. We have also issued important guidance on reducing the risk of transmission of CJD through surgical instruments.

By providing guidance on how safe procedures are and how well they work, we make it possible for new treatments and tests to be introduced into the NHS in a responsible way, which helps ensure patients are kept safe without stifling innovation.'

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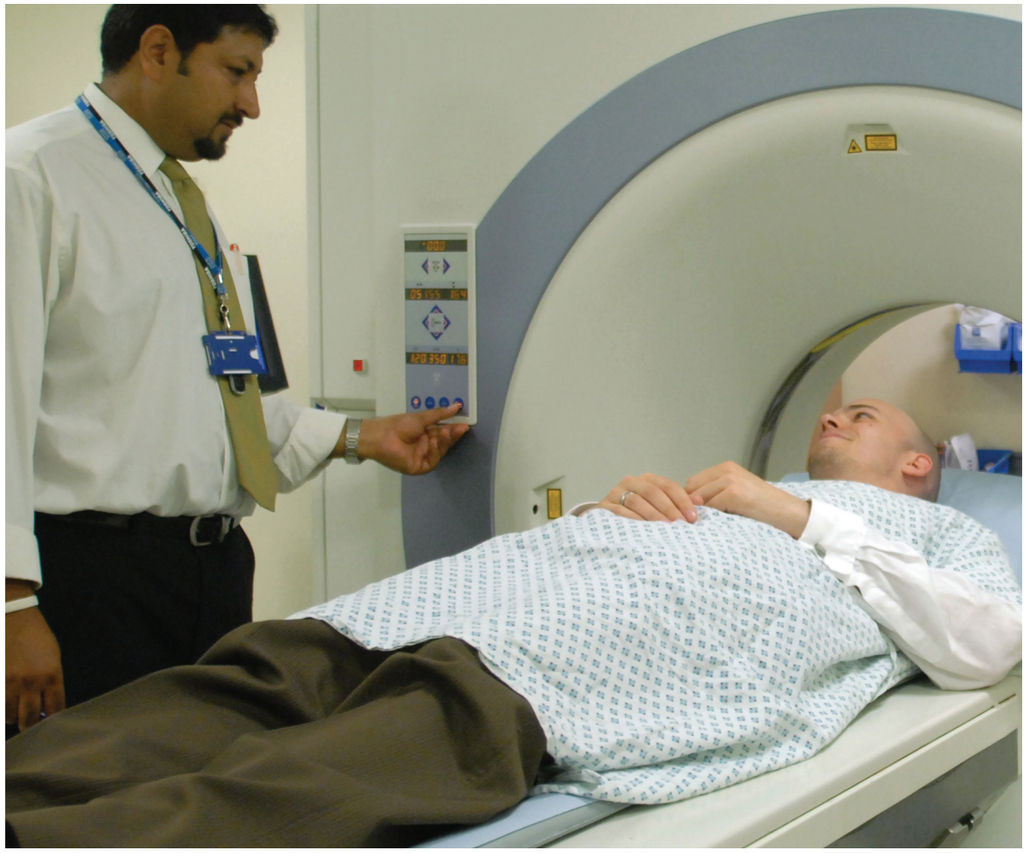
Interventional procedures published during 2006/7

Title	Publication date
Balloon kyphoplasty for vertebral compression fractures (IPG166)	April 2006
Retrograde urethral sphincterometry (IPG167)	April 2006
Percutaneous radiofrequency catheter ablation for atrial fibrillation (IPG168)	April 2006
Stapled transanal rectal resection for obstructed defaecation syndrome (IPG169)	April 2006
Living donor lung transplantation for end-stage lung disease (IPG170)	May 2006
Laparoscopic helium plasma coagulation for the treatment of endometriosis (IPG171)	May 2006
Endovascular closure of perimembranous ventricular septal defect (IPG172)	May 2006
Percutaneous disc decompression using coblation for lower back pain (IPG173)	May 2006
High dose rate brachytherapy for prostate cancer (IPG174)	May 2006
Percutaneous fetal balloon valvuloplasty for aortic stenosis (IPG175)	May 2006
Percutaneous fetal balloon valvuloplasty for pulmonary atresia with intact ventricular septum (IPG176)	May 2006
Short-term circulatory support with left ventricular assist devices as a bridge to cardiac transplantation or recovery (IPG177)	June 2006
Tonsillectomy using ultrasonic scalpel (IPG178)	June 2006
Percutaneous cementoplasty for palliative treatment of bony malignancies (IPG179)	June 2006
Percutaneous laser therapy for fetal tumours (IPG180)	June 2006
Percutaneous occlusion of left atrial appendage (IPG181)	June 2006
Ultrasound guided foam sclerotherapy for varicose veins (IPG182)	June 2006
Non-rigid stabilisation techniques for the treatment of low back pain (IPG183)	June 2006



Title	Publication date
High intensity focused ultrasound ablation for atrial fibrillation as an associated procedure with other cardiac surgery (IPG184)	July 2006
Percutaneous radiofrequency ablation for primary and secondary lung cancers (IPG185)	July 2006
Tonsillectomy using laser (IPG186)	July 2006
Catheterless oesophageal pH monitoring (IPG187)	July 2006
Deep brain stimulation for tremor and dystonia (excluding Parkinson's disease) (IPG188)	August 2006
Thoracoscopically assisted oesophagectomy (IPG189)	August 2006
Insertion of pleuro–amniotic shunt for fetal pleural effusion (IPG190)	September 2006
Carotid artery stent placement for carotid stenosis (IPG191)	September 2006
Amnioinfusion for oligohydramnios during pregnancy (IPG192)	November 2006
Laparoscopic radical prostatectomy (IPG193)	November 2006
Living-donor liver transplantation (IPG194)	November 2006
Selective dorsal rhizotomy for spasticity in cerebral palsy (IPG195)	November 2006
Patient safety and reduction of risk of transmission of Creutzfeldt–Jakob disease (CJD) via interventional procedures (IPG196)	November 2006
Intramedullary distraction for lower limb lengthening (IPG197)	December 2006
Intrauterine laser ablation of placental vessels for the treatment of twin-to-twin transfusion syndrome (IPG198)	December 2006
Septostomy with or without amnioreduction for the treatment of twin-to-twin transfusion syndrome (IPG199)	December 2006
Photo-dynamic therapy for early oesophageal cancer (IPG200)	December 2006
Preoperative high dose rate brachytherapy for rectal cancer (IPG201)	December 2006
Fetal vesico-amniotic shunt for lower urinary tract outflow obstruction (IPG202)	December 2006
Open femoro-acetabular surgery for hip impingement syndrome (IPG203)	January 2007
Laparoscopic distal pancreatectomy (IPG204)	January 2007
Fetal cystoscopy for diagnosis and treatment of lower urinary outflow tract obstruction (IPG205)	January 2007
Palliative photodynamic therapy for advanced oesophageal cancer (IPG206)	January 2007
Cryotherapy for renal cancers (IPG207)	January 2007
Laparoscopic insertion of peritoneal dialysis catheter (IPG208)	February 2007
Implantation of accommodating intraocular lenses for cataract (IPG209)	February 2007
Injectable bulking agents for faecal incontinence (IPG210)	February 2007
Radiofrequency-assisted liver resection (IPG211)	February 2007
Laparoscopic nephrolithotomy and pyelolithotomy (IPG212)	March 2007
Arthroscopic femoro-acetabular surgery for hip impingement syndrome (IPG213)	March 2007
Microwave ablation of hepatocellular carcinoma (IPG214)	March 2007
Mesh sacrocolpopexy for vaginal vault prolapse (IPG215)	March 2007

Note: topics for the interventional procedures programme are self-notified by the clinical community and other stakeholders, after which work begins almost immediately. A long-term forward planner of expected issue dates is therefore not available.

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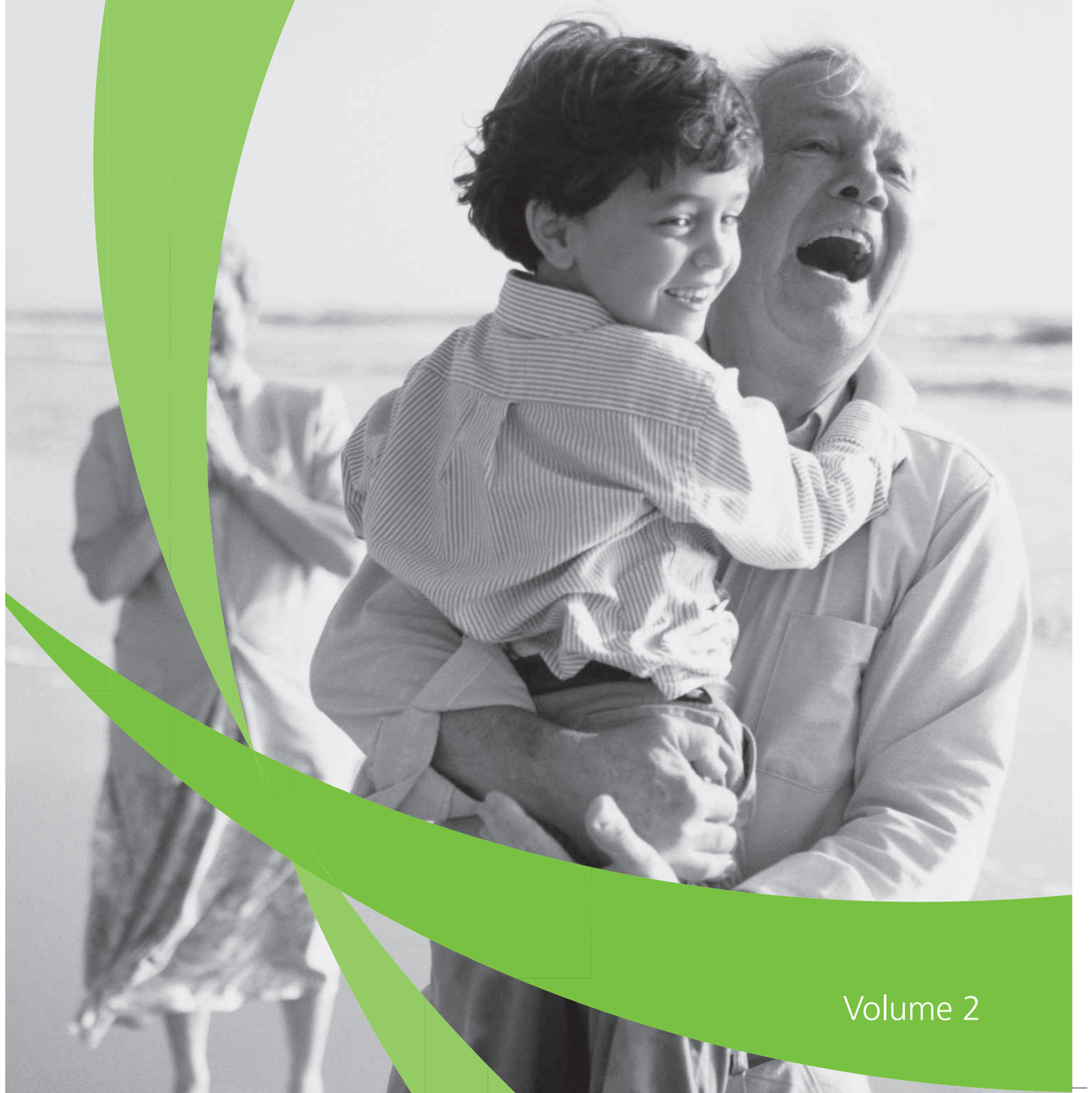
NHS

National Institute for Health and Clinical Excellence

Annual Report and Accounts 2006/7



Volume 2

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Financial liabilities

There were no financial liabilities.

Foreign currency risk

The Institute has negligible foreign currency income or expenditure.

19 Intra-government

	Debtors: amounts falling due within one year £000	Creditors: amounts falling due within one year £000
Balances with other central government bodies	1,755	50
Balances with local authorities	26	0
Balances with NHS bodies	8	23
Balances with public corporations and trading funds	0	21
Balances with bodies external to government	183	1,306
At 31 March 2007	**1,972**	**1,400**
Balances with other central government bodies	1708	194
Balances with local authorities	2	0
Balances with NHS bodies	232	138
Balances with public corporations and trading funds	22	224
Balances with bodies external to government	48	523
At 31 March 2006	2,012	1,079

There were no debtors or creditors falling due after more than one year.

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Annual Report and Accounts 2006/7

Volume 2

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HC 702-II London: The Stationery Office

17 Post Balance Sheet Events

This Annual Report and Accounts has been authorised for issue on 13 July 2007 by the Chief Executive and Accounting Officer. The financial statements do not reflect events after this date.

18 Financial Instruments

FRS 13, Derivatives and Other Financial Instruments, requires disclosure of the role that financial instruments have had during the period in creating or changing the risks an entity faces in undertaking its activities. Because of the way special health authorities are financed, the Institute is not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk than would be typical of the listed companies to which FRS 13 mainly applies. The Institute has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the Institute in undertaking its activities.

As allowed by FRS 13, debtors and creditors that are due to mature or become payable within 12 months from the balance sheet date have been omitted from the currency profile.

Liquidity risk

The Institute's net operating costs are financed from resources voted annually by Parliament. The Institute largely finances its capital expenditure from funds made available from Government under an agreed capital resource limit. NICE is not, therefore, exposed to significant liquidity risks.

Interest rate risk

The Institute's financial assets and 100% of its financial liabilities carry nil or fixed rates of interest. NICE is not, therefore, exposed to significant interest rate risk. The following table show the interest rate profile of the Institute's financial liabilities:

Financial assets

Currency	Total £000	Floating rate £000	Fixed rate £000	Non-interest bearing £000
At 31 March 2007				
Sterling	**0**	**0**	**0**	**0**
Other	**0**	**0**	**0**	**0**
Gross financial assets	**0**	**0**	**0**	**0**
At 31 March 2006				
Sterling	1	0	1	0
Other	0	0	0	0
Gross financial assets	1	0	1	0

14 Commitments under operating leases

Expenses of the Institute include the following in respect of hire and operating lease rentals:

	2006-07 £000	2005-06 £000
Hire of plant and machinery	**26**	32
Other operating leases	**3**	3
	29	35

Commitments under non-cancellable operating leases to pay rentals during the year following the year of these accounts are given in the table below, analysed according to the period in which the lease expires:

Land and buildings		**£000**	£000
Operating leases which expire:	within 1 year	**0**	0
	between 1 and 5 years	**932**	0
	after 5 years	**0**	938
		932	938
Other leases	within 1 year	**0**	0
	between 1 and 5 years	**15**	23
	after 5 years	**0**	0
		15	23

15 Losses and Special Payments

There were 35 cases, totalling £66k, of losses and special payments during 2006-07 (2005-06 – no cases).

16 Related parties

The Institute is a body corporate established by order of the Secretary of State for Health.

The Department of Health is regarded as a controlling related party. During the year the Institute has had a significant number of material transactions with the Department, and with other entities for which the Department is regarded as the parent Department, i.e.:

- The Institute receives part funding from the Welsh Assembly Government. This amounted to £600,000 in 2006-07.
- The Institute receives part funding from Quality Improvement Scotland. This amounted to £115,000 in 2006-07.
- The Institute receives part funding from the Northern Ireland Assembly. This amounted to £170,000 in 2006-07.
- The Institute has been charged £826,802 by the Velindre NHS Trust relating to the Collaborating Centre for Cancer which is hosted by the Trust.
- Liverpool Primary Care Trust (formerly Central Liverpool PCT) hosts the National Prescribing Centre which has charged the Institute £415,000 for the provision of national information.
- Financial Services are provided to the Institute by NHS Shared Business Services and charges of £64,041 have been made for this service.

Management Commentary

Introduction

These accounts have been produced as a supplement to the annual report. Detailed information about the membership of the Board and about the performance of the organisation during 2006-7 is contained in the main body of the annual report. Further information about the Institute and its activities is available on our website: www.nice.org.uk

Overall position

The Institute instigated a number of new programmes and activities during the year including topic selection, short guidelines, single technology appraisals and set up a field team of implementation consultants. The funding for these developments was made available from within existing resources through cost saving measures that the Institute initiated in the previous financial year. The Institute had a target as part of the Department of Health's (DH) arms length bodies review to make cost efficiency savings of £2.6m by the end of 2008. This target was achieved in 2006. New activity relating to optimal practice guidance for the NHS was also funded from within existing resources.

During the year the Institute identified three key areas where it would not be able to apply the resources it had allocated during 2006-7. The DH therefore agreed that the £2.7m resource allocation relating to these could be carried forward into 2007-8. They were:

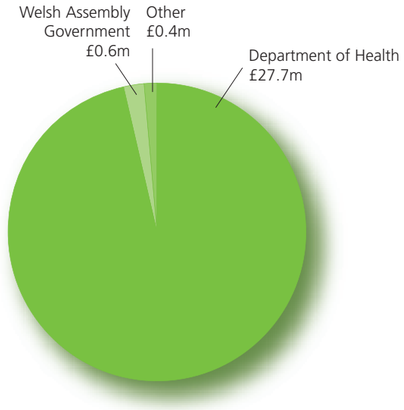
- slippage in the establishment of a permanent Manchester office
- optimal practice guidance not commencing until the last quarter
- a delay in referral of public health topics.

After the transfer of this £2.7m out of the 2006-7 budget into 2007-8 the Institute ended the year with an overall underspend of £29,000.

How is the Institute funded?

Most of the Institute's funding comes from the Department of Health. This year it received £27.7m as shown in figure 1. It also received £0.6m from the Welsh Assembly Government and £0.4m from other sources.

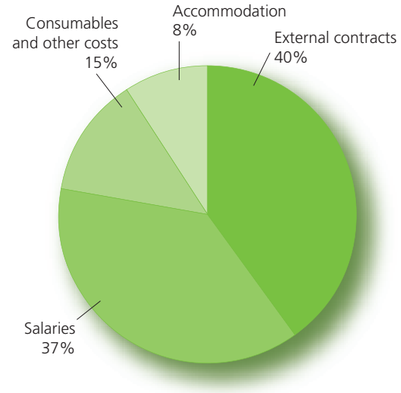
Figure 1



How the funding was used

Figure 2 shows what the money was spent on in 2006-7. The main areas of expenditure are external contracts and salaries. External contracts include expenditure on the National Collaborating Centres which help us to produce clinical and public health guidance.

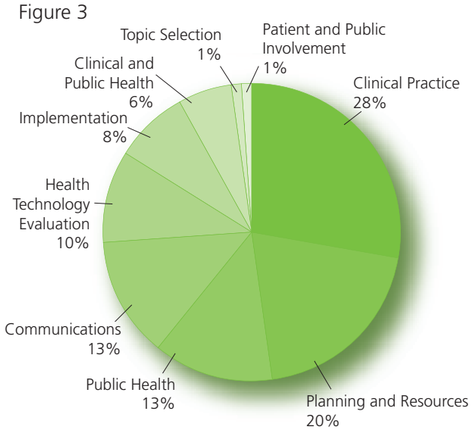
Figure 2



Programme costs

Figure 3 shows how the spending was split between the Institute's work programmes and support functions.

Figure 3



Statutory framework

The accounts for the year ended 31 March 2007 have been prepared in accordance with the direction given by the Secretary of State in accordance with Paragraph 6 (3), Section 232, Schedule 15 of the National Health Service Act 2006 and in a format determined by the Department of Health with the approval of the Treasury.

The Institute was established as the National Institute for Clinical Excellence on 26 February 1999 as a Special Health Authority to become operational on 1 April 1999. On 1 April 2005 the National Institute for Health and Clinical Excellence was established, which incorporated the functions of the Health Development Agency which had been disestablished on 31 March 2005. Founding legislation includes the National Health Services Act 2006 c49, S.I. 1999/220, S.I. 260 and S.I. 2005/497. It is required to produce an annual report on its activities and finances to the Secretary of State for Health.

Other information

The Institute's performance under the Better Payments Practice Code is detailed in note 2.3 on page 20

Auditors

The accounts have been audited by the Comptroller and Auditor General in accordance with the National Health Service Act 2006. The Audit certificate can be found on pages 8 to 9.

The Comptroller and Auditor General is Sir John Bourn. His address is:

National Audit Office
157-197 Buckingham Palace Road
Victoria
London SW1W 9SP

Audit assurance

As far as I am aware, there is no relevant audit information of which NICE's auditors are unaware. I have taken all the steps that I ought to have taken to make myself aware of any relevant audit information and to establish that NICE's auditors are aware of that information.

Signed
Andrew Dillon CBE
Chief Executive and Accounting Officer

Dated 2 July 2007

11 Reserves

11.1 The movement on the general fund in the year comprised:

	2006-07 £000	2005-06 £000
Balance at 31 March 2006	1,970	629
Net operating costs for the year	**(27,679)**	(25,992)
Net Parliamentary funding	**26,753**	27,276
Transfer of realised profits/losses from revaluation reserve	**15**	7
Capital charge interest (Non-cash item)	**59**	50
Balance at 31 March 2007	**1,118**	1,970

11.2 The movement on the revaluation reserve in the year comprised:

	2006-07 £000	2005-06 £000
Balance at 31 March 2006	135	127
Indexation of fixed assets	**23**	15
Transfer to general fund: realised revaluation	**(15)**	(7)
Balance at 31 March 2007	**143**	135

12 Reconciliation of operating cost to operating cash flows

	Notes	2006-07 £000	2005-06 £000
Net operating cost before interest for the year		**27,679**	25,991
Adjust for non-cash transactions	2.1	**(290)**	(549)
Adjust for movements in working capital other than cash	10	**(725)**	1,263
(Increase)/decrease in provisions	9	**44**	419
Net cash outflow from operating activities		**26,708**	27,124

13 Contingent liabilities

NICE's process for developing guidance on the use of certain drugs is currently the subject of judicial review. If the review were to find in favour of the applicants, NICE could be liable for an element of the legal costs incurred by the applicants. NICE consider the claim without foundation and have not provided for the potential liability in the 2006/7 accounts.

9 Provision for liabilities and charges

	Total £000
At 31 March 2006	244
Arising during the year	**208**
Utilised during the year	(219)
Reversed unused	**(33)**
At 31 March 2007	**200**
Expected timing of cash flows:	
Within 1 year	**200**
1-5 years	**0**
Over 5 years	**0**

As at 31 March 2007 the Institute has made a provision of £100k in respect of costs associated with a retrospective rent review. A provision of £100k has also been made in respect of legal costs.

10 Movements in working capital other than cash

	2006-07 £000	2005-06 £000
Increase/(decrease) in debtors	**(381)**	1,374
(Increase)/decrease in creditors	**(344)**	(111)
	(725)	1,263

Remuneration Report

The remuneration of the Chairman and non executive directors is set by the Secretary of State. The Chairman did not receive all of this payment. Approximately half was paid by the Institute directly to University of Newcastle which was his employer.

The remuneration of the senior managers detailed in the table below is set by the Remuneration Committee. However the salaries of the three consultant clinicians are subject to direction from the Secretary of State and the remuneration of the Chief Executive is subject to approval by the Department of Health. The tables below have been subject to audit.

Salaries and Allowances – Senior Managers' Remuneration

		2006-07			2005-06		
Name	**Title**	**Salary (bands of £5000) £000**	**Other Renumeration (bands of £5000) £000**	**Benefits in kind (rounded to the nearest £00)**	**Salary (bands of £5000) £000**	**Other Renumeration (bands of £5000) £000**	**Benefits in kind (rounded to the nearest £00)**
Prof Sir Michael Rawlins [6]	Chair	35 to 40	nil	nil	20 to 25	nil	nil
Dr Susannah Lawrence OBE [5]	Vice Chair	0 to 5	nil	nil	5 to 10	nil	nil
Mark Taylor	Vice Chair	5 to 10	nil	nil	5 to 10	nil	nil
Prof Leon Fine [2]	Non Executive Director	0 to 5	nil	nil	5 to 10	nil	nil
Frederick George	Non Executive Director	5 to 10	nil	nil	5 to 10	nil	nil
Mercy Jeyasingham	Non Executive Director	5 to 10	nil	nil	5 to 10	nil	nil
Roy Luff OBE [3]	Non Executive Director	0 to 5	nil	nil	5 to 10	nil	nil
Mary McClarey [1]	Non Executive Director	5 to 10	nil	nil	5 to 10	nil	nil
Prof Helen Roberts	Non Executive Director	5 to 10	nil	nil	5 to 10	nil	nil
Prof Shah Ebrahim	Non Executive Director	5 to 10	nil	nil	0 to 5	nil	nil
Jenny Griffiths	Non Executive Director	5 to 10	nil	nil	0 to 5	nil	nil
Dr Margaret Helliwell [4]	Non Executive Director	0 to 5	nil	nil	0	N/A	N/A
Jonathan Tross CB [4]	Non Executive Director	0 to 5	nil	nil	0	N/A	N/A
Andrew Dillon CBE	Chief Executive	165 to 170	nil	nil	150 to 155	nil	nil
Andrea Sutcliffe	Deputy Chief Executive and Planning & Resources Director	110 to 115	nil	nil	105 to 110	nil	nil
Prof Peter Littlejohns	Clinical & Public Health Director	165 to 170	nil	nil	160 to 165	nil	nil
Dr Gillian Leng	Implementation Systems Director	105 to 110	nil	nil	100 to 105	nil	nil
Dr Carole Longson	Health Technology Evaluation Centre Director	100 to 105	nil	nil	95 to 100	nil	nil
Prof Michael Kelly	Public Health Excellence Director	85 to 90	nil	nil	80 to 85	nil	nil
Dr Mercia Page	Clinical Practice Centre Director	90 to 95	nil	nil	85 to 90	nil	nil
Louise Fish	Communications Director	80 to 85	nil	nil	65 to 70	nil	nil

End of Non Exec Service 31/03/07 [1]
End of Non Exec Service 31/01/07 [2]
End of Non Exec Service 31/12/06 [3]
Non Exec Director from 01/01/07 [4]
End of Non Exec Services 30/09/06 [5]
On NICE payroll from 01/10/06, previously remuneration paid to Newcastle University [6]

Pension Benefits – Senior Management

Name	Title	Real Increase in Pension at 60 (bands of £2500) £000	Lump Sum at aged 60 related to real increase in pension (bands of £2500) £000	Total accrued pension at age 60 at 31 March 2007 (bands of £5000) £000	Lump Sum at age 60 related to accrued pension at 31 March 2007 (bands of £5000) £000	Cash Equivalent Transfer Value at 31 March 2007 £000	Cash Equivalent Transfer Value at 31 March 2006 £000	Real Increase in Cash Equivalent Transfer Value	Employers contribution to growth in CETV	Employers contribution to Stakeholder Pension
Andrew Dillon CBE	Chief Executive	2.5 to 5	12.5 to 15	60 to 65	180 to 185	1000	873	105,526	73,868	0
Andrea Sutcliffe	Deputy Chief Executive and Planning & Resources Director	0 to 2.5	5 to 7.5	5 to 10	25 to 30	116	88	25,537	17,876	0
Prof Peter Littlejohns	Clinical & Public Health Director	2.5 to 5	7.5 to 10	55 to 60	170 to 175	907	818	67,810	47,467	0
Dr Gillian Leng	Implementation Systems Director	2.5 to 5	7.5 to 10	25 to 30	75 to 80	360	304	47,968	33,577	0
Dr Carole Longson	Health Technology Evaluation Centre Director	0 to 2.5	2.5 to 5	5 to 10	20 to 25	107	86	18,506	12,955	0
Prof Michael Kelly	Public Health Excellence Director	2.5 to 5	5 to 7.5	30 to 35	100 to 105	579	530	36,235	25,365	0
Dr Mercia Page	Clinical Practice Centre Director	0 to 2.5	5 to 7.5	10 to 15	40 to 45	204	161	38,850	27,195	0
Louise Fish	Communications Director	0 to 2.5	2.5 to 5	5 to 10	15 to 20	53	35	16,191	11,334	0

Cash Equivalent Transfer Value

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme.
A CETV is a payment made by a pension scheme or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which disclosure applies. The CETV figures and the other pension details include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

Real Increase in CETV

This reflects the increase in CETV effectively funded by the employer. It takes account of the increase in accrued pension due to inflation, contributions paid by the employee (including the value of any benefits transferred from another scheme or arrangement) and uses common market valuation factors for the start and end of the period.

Signed
Andrew Dillon CBE
Chief Executive and Accounting Officer

Dated 2 July 2007

7 Analysis of changes in cash

	At 31 March 2006 £000	Change during the year £000	At 31 March 2007 £000
Cash at OPG	1	(1)	0
Cash at commercial banks and in hand	0	0	0
	1	**(1)**	**0**

8 Amounts falling due within one year

	2006-07 £000	2005-06 £000
NHS creditors	**(78)**	(225)
Other creditors	**(1,322)**	(854)
Accruals	**(921)**	(898)
Total creditors	**(2,321)**	(1,977)

5.3 Profit/(loss) on disposal of fixed assets

	2006-07 £000	2005-06 £000
Profit/(Loss) on disposal of intangible fixed assets	**0**	(34)
Profit/(Loss) on disposal of plant and equipment	**0**	(155)
	0	(189)

6 Debtors

	£000	£000
Amounts falling due within one year		
NHS debtors	**240**	504
Prepayments	**1,087**	1,428
Other debtors	**1,732**	1,508
Total debtors	**3,059**	3,440

Statement of the Board's and Chief Executive's responsibilities

Under the National Health Service Act 2006 and directions made thereunder by the Secretary of State with the approval of HM Treasury, the National Institute for Health and Clinical Excellence (NICE) is required to prepare a statement of accounts for each financial year in the form and on the basis determined by the Secretary of State, with the approval of HM Treasury. The accounts are prepared on an accruals basis and must give a true and fair view of NICE's state of affairs at the year end and of its net resource outturn, recognised gains and losses and cash flows for the financial year.

The Accounting Officer for the Department of Health has appointed the Chief Executive of the National Institute for Health and Clinical Excellence as the Accounting Officer, with responsibility for preparing the Institute's accounts and for transmitting them to the Comptroller and Auditor General.

In preparing the accounts, the Board and Accounting Officer are required to:

- observe the accounts direction issued by the Secretary of State, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis;
- make judgements and estimates on a reasonable basis;
- state whether applicable accounting standards have been followed and disclose and explain any material departures in the financial statements; and
- prepare the financial statements on a going concern basis, unless inappropriate to presume that the National Institute for Health and Clinical Excellence will continue in operation.

The Chief Executive's relevant responsibilities as Accounting Officer, including responsibility for the propriety and regularity of the public funds and assets vested in the National Institute for Health and Clinical Excellence, and for the keeping of proper records, are set out in the Accounting Officers' Memorandum issued by the Department of Health.

Signed
Andrew Dillon CBE
Accounting Officer

Statement on Internal Control 2006/7

1. Scope of responsibility

As Accounting Officer, I have responsibility, together with the Board of the National Institute for Health and Clinical Excellence for maintaining a sound system of internal control that supports the achievement of the Institute's policies, aims and objectives. I also have responsibility for safeguarding the public funds and the organisation's assets for which I am personally responsible as set out in the Accounting Officer Memorandum issued by the Department of Health.

The Institute works closely with its sponsor branch at the Department of Health and the Welsh Assembly Government and there are arrangements in place for regular performance monitoring and review.

2. The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to:

- identify and prioritise the risks to the achievement of the organisation's policies, aims and objectives
- evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically.

The system of internal control has been in place in the Institute for the year ended 31 March 2007 and up to the date of approval of the annual accounts.

The Institute's Assurance Framework includes the identification and documentation of risks that are drawn from the business planning processes. These are monitored through senior management team meetings, the audit committee and by the Board.

3. Capacity to handle risk

From 1 April 2006 the audit committee has dealt with risk management. The committee oversees the operation of the risk management processes and receives reports on specific risk issues as they arise. The senior management team (SMT) acts as the risk management group and reviews the risk register. Managers are required to consider risk issues in the formal annual business planning processes and also in relation to any changes that arise during the year. They receive appropriate support and guidance in this from the compliance manager. When unforeseen adverse events occur the Institute has processes in place to carry out a retrospective review of the causes so that the underlying risks can be identified and reassessed, and appropriate management action taken.

4. The risk and control framework

Risk management assessment is carried out annually by the SMT as part of the business planning process. Key risks and handling strategies were included in a section of the business plan and reported to the Board. The business plan was also reviewed by the Partners Council. Resources required to enable implementation of the plan are fully considered by the SMT and assigned priority within the constraints of the resources available.

A separate risk assessment exercise was carried out to establish the Board's assurance framework and to identify areas of organisational risk. This included a review of the organisation's systems, equipment, policies and premises.

These assessment exercises resulted in a prioritised risk management register highlighting the key controls in place and assurances on those controls. This was reported to the audit committee. The minutes of the meetings of the audit committee are received by the Board at its public meetings.

5.2 Tangible fixed assets

	Buildings £000	Plant and machinery £000	Information technology £000	Furniture and fittings £000	Total £000
Cost or valuation at 31 March 2006	101	216	270	697	1,284
Indexation	**9**	**5**	**0**	**19**	**33**
Additions – purchased	**0**	**25**	**0**	**7**	**32**
Disposals	**0**	**0**	**(39)**	**0**	**(39)**
Gross cost at 31 March 2007	**110**	**246**	**231**	**723**	**1,310**
Accumulated depreciation at 31 March 2006	0	167	145	192	504
Indexation	**1**	**4**	**0**	**5**	**10**
Provided during the year	**12**	**34**	**70**	**73**	**189**
Disposals	**0**	**0**	**(39)**	**0**	**(39)**
Accumulated depreciation at 31 March 2007	**13**	**205**	**176**	**270**	**664**
Net book value:					
Purchased at 31 March 2006	101	49	125	505	780
Donated at 31 March 2006	0	0	0	0	0
Total at 31 March 2006	101	49	125	505	780
Net book value:					
Purchased at 31 March 2007	**97**	**41**	**55**	**453**	**646**
Donated at 31 March 2007	**0**	**0**	**0**	**0**	**0**
Total at 31 March 2007	**97**	**41**	**55**	**453**	**646**

There were no assets held under finance leases or hire purchase contracts at the balance sheet date.

5.1 Intangible fixed assets

	Software licences £000
Gross cost at 31 March 2006	186
Additions – purchased	**14**
Gross cost at 31 March 2007	**200**
Accumulated amortisation at 31 March 2006	81
Provided during the year	**42**
Accumulated amortisation at 31 March 2007	**123**
Net book value:	
Purchased at 31 March 2006	105
Donated at 31 March 2006	0
Total at 31 March 2006	105
Net book value:	
Purchased at 31 March 2007	**77**
Donated at 31 March 2007	**0**
Total at 31 March 2007	**77**

5. Review of effectiveness

As Accounting Officer, I have responsibility, together with the Board, for reviewing the effectiveness of the system of internal control. My review is informed in a number of ways. The head of internal audit provides me with an opinion on the overall arrangements for gaining assurance through the Assurance Framework and on the controls reviewed as part of the internal audit work. Senior managers within the organisation who have responsibility for the development and maintenance of the system of internal control provide me with assurance. The Assurance Framework itself provides me with evidence that the effectiveness of controls that manage the risks to the organisation achieving its principal objectives have been reviewed. My review is also informed by the work of our external auditors. Particular aspects of the Institute's activities are from time to time the subject of external review.

I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the audit committee and the Board. The effectiveness of the system of internal control has been subject to review by our internal auditors who, in liaison with the external auditors, plan and carry out a programme of work that is approved by the audit committee, to review the design and operation of the systems of internal financial control. Where weaknesses have been identified these are reported to the audit committee and an action plan agreed with management to implement the recommendations agreed as part of this process.

Andrew Dillon CBE
Chief Executive

2 July 2007

The Certificate and Report of the Comptroller and Auditor General to the Houses of Parliament

I certify that I have audited the financial statements of the National Institute for Health and Clinical Excellence for the year ended 31 March 2007 under the National Health Service Act 2006. These comprise the Operating Cost Statement, the Balance Sheet, the Cashflow Statement and Statement of Recognised Gains and Losses and the related notes. These financial statements have been prepared under the accounting policies set out within them. I have also audited the information in the Remuneration Report that is described in that report as having been audited.

Respective responsibilities of the Chief Executive and auditor

The Chief Executive as Accounting Officer is responsible for preparing the Annual Report, the Remuneration Report and the financial statements in accordance with the National Health Service Act 2006 and directions made thereunder by the Secretary of State with the approval of HM Treasury and for ensuring the regularity of financial transactions. These responsibilities are set out in the Statement of Chief Executive's Responsibilities.

My responsibility is to audit the financial statements and the part of the Remuneration Report to be audited in accordance with relevant legal and regulatory requirements, and with International Standards on Auditing (UK and Ireland).

I report to you my opinion as to whether the financial statements give a true and fair view and whether the financial statements and the part of the Remuneration Report to be audited have been properly prepared in accordance with the National Health Service Act 2006 and directions made thereunder by the Secretary of State with the approval of HM Treasury. I report to you whether, in my opinion, certain information given in the Annual Report, which comprises the Management Commentary, Overall Position, Institute Funding, Programme Costs, Statutory Framework and Remuneration Report, is consistent with the financial statements. I also report whether in all material respects the expenditure and income have been applied to the purposes intended by Parliament and the financial transactions conform to the authorities which govern them.

In addition, I report to you if the National Institute for Health and Clinical Excellence has not kept proper accounting records, if I have not received all the information and explanations I require for my audit, or if information specified by HM Treasury regarding remuneration and other transactions is not disclosed.

I review whether the Statement on Internal Control reflects the National Institute for Health and Clinical Excellence's compliance with HM Treasury's guidance, and I report if it does not. I am not required to consider whether this statement covers all risks and controls, or form an opinion on the effectiveness of the National Institute for Health and Clinical Excellence's corporate governance procedures or its risk and control procedures.

I read the other information contained in the Annual Report and consider whether it is consistent with the audited financial statements. I consider the implications for my report if I become aware of any apparent misstatements or material inconsistencies with the financial statements. My responsibilities do not extend to any other information.

Basis of audit opinion

I conducted my audit in accordance with International Standards on Auditing (UK and Ireland) issued by the Auditing Practices Board. My audit includes examination, on a test basis, of evidence relevant to the amounts, disclosures and regularity of financial transactions included in the financial statements and the part of the Remuneration Report to be audited. It also includes an assessment of the significant estimates and judgments made by the Chief Executive in the preparation of the financial statements, and of whether the accounting policies are most appropriate to the National Institute for Health and Clinical Excellence's circumstances, consistently applied and adequately disclosed.

I planned and performed my audit so as to obtain all the information and explanations which I considered necessary in order to provide me with sufficient evidence to give reasonable assurance that the financial statements and the part of the Remuneration Report to be audited are free from material misstatement, whether caused by fraud or error, and that in all material respects

3.2 Reconciliation of Gross Capital Expenditure to Capital Resource Limit

	£000	£000
Gross capital expenditure	**46**	244
NBV of assets disposed	**0**	283
Net capital resource outturn	**46**	(39)
Capital resource limit	**50**	0
(Over)/underspend against limit	**4**	39

4 Operating income analysed by classification and activity, is as follows:

	2006-07 Total £000	2005-06 £000
Programme income:		
Fees & charges to external customers	**87**	20
Income received from Scottish Parliament	**115**	110
Income received from National Assembly for Wales	**600**	600
Income received from Northern Ireland Assembly	**170**	0
Income received from Department of Health	**0**	0
Income received from other Government Departments	**0**	2
Other	**6**	4
Total	**978**	736

All income was classified as Appropriated in Aid.

2.3 Better Payment Practice Code – measure of compliance

	Number	£000
Total non NHS bills paid 2006-07	**6,609**	**17,303**
Total non NHS bills paid within target	**6,176**	**15,475**
Percentage of non NHS bills paid within target	**93.4%**	**89.4%**
Total NHS bills paid 2006-07	117	1,750
Total NHS bills paid within target	87	1,494
Percentage of NHS bills paid within target	74.4%	85.4%

The Late Payment of Commercial Debts (Interest) Act 1998	**2006-07 £000**	2005-06 £000
Amounts included within interest payable arising from claims made by small businesses under this legislation	**0**	1
Compensation paid to cover debt recovery costs under this legislation	**0**	0

3.1 Reconciliation of net operating cost to net resource outturn

	2006-07 £000	2005-06 £000
Net operating cost	**27,679**	25,992
Prior period adjustment	**0**	0
Net resource outturn	**27,679**	25,992
Revenue resource limit	**27,708**	27,031
(Over)/underspend against limit	**29**	1,039

the expenditure and income have been applied to the purposes intended by Parliament and the financial transactions conform to the authorities which govern them. In forming my opinion I also evaluated the overall adequacy of the presentation of information in the financial statements and the part of the Remuneration Report to be audited.

Opinions

Audit Opinion

In my opinion:

- the financial statements give a true and fair view, in accordance with the National Health Service Act 2006 and directions made thereunder by the Secretary of State with the approval of HM Treasury, of the state of the National Institute for Health and Clinical Excellence's affairs as at 31 March 2007 and of its net resource outturn, recognised gains and losses and cashflows for the year then ended;
- the financial statements and the part of the Remuneration Report to be audited have been properly prepared in accordance with the National Health Service Act 2006 and directions made thereunder by the Secretary of State with the approval of HM Treasury; and
- information given within the Annual Report, which comprises the Management Commentary, Overall Position, Institute Funding, Programme Costs, Statutory Framework and Remuneration Report, is consistent with the financial statements.

Audit Opinion on Regularity

In my opinion, in all material respects the expenditure and income have been applied to the purposes intended by Parliament and the financial transactions conform to the authorities which govern them.

Report

I have no observations to make on these financial statements.

John Bourn
Comptroller and
Auditor General

National Audit Office
157-197
Buckingham Palace Road
Victoria
London SW1W 9SP

5 July 2007

Operating Cost Statement for the year ended 31 March 2007

Continuing operations

	Notes	**2006-07 £000**	2005-06 £000
Programme costs	2.1	**28,657**	26,727
Operating income	4	**(978)**	(736)
Net operating cost before interest		**27,679**	25,991
Interest Payable		**0**	1
Net Operating Cost		**27,679**	25,992
Net resource outturn	3.1	**27,679**	25,992

Statement of recognised gains and losses for the year ended 31 March 2007

		2006-07 £000	2005-06 £000
Unrealised surplus/(deficit) on the revaluation of fixed assets	11.2	**(15)**	(7)
Unrealised surplus/(deficit) on the indexation of fixed assets	11.2	**23**	15
Fixed asset impairment losses	11.2	**0**	0
Recognised gains and (losses) for the financial year		**8**	8

The notes at pages 13 to 30 form part of these accounts.

2.2 Staff numbers and related costs

	2006-07 Total £000	**Permanently Employed Staff £000**	**Other £000**	2005-06 £000
Salaries and wages	**8,808**	**7,838**	**970**	8,796
Social security costs	**758**	**758**		727
Employer contributions to NHSPA	**1,096**	**1,096**		996
Other pension costs	**7**	**7**		446
Redundancies	**17**	**17**		111
	10,686	**9,716**	**970**	11,076

The average number of employees during the year was:

	2006-07 Total Number	**Permanently Employed Staff Number**	**Other Number**	**Number**
	221	206	15	185

Expenditure on staff benefits

The amount spent on staff benefits during the year totalled £20,445 (2005-06: £29,301).

Retirements due to ill health

This note discloses the number and additional pension costs for individuals who retired early on ill-health grounds during the year. There was no retirement during 2006-07.

General operating costs

2.1 Programme costs

	Notes	£000	2006-07 £000	2005-06 £000
Non-executive members' remuneration			**96**	72
Staff costs	2.2		**10,686**	11,076
Capital: Depreciation and amortisation	5.1, 5.2	**231**		310
Capital charges interest		**59**		50
(Profit)/loss on disposal	5.3	**0**		189
			290	
Premises and fixed plant			**2,366**	1,935
Transport and moveable plant			**20**	14
External contractors			**11,385**	10,232
Publications & conferences			**1,040**	678
Establishment expenses			**2,603**	1,966
Auditor's remuneration: audit fees*			**45**	45
Supplies and services – general			**126**	160
			28,657	26,727

*No non-audit fees were charged

Balance Sheet as at 31 March 2007

	Notes	31 March 2007 £000	31 March 2006 £000
Fixed assets			
Intangible assets	5.1	**77**	105
Tangible assets	5.2	**646**	780
		723	885
Current assets			
Stocks		**0**	0
Debtors	6	**3,059**	3,440
Cash at bank and in hand	7	**0**	1
		3,059	3,441
Creditors: amounts falling due within one year		**(2,321)**	(1,977)
Net current assets/liabilities		**738**	1,464
Total assets less current liabilities		**1,461**	2,349
Provisions for liabilities and charges	9	**(200)**	(244)
		1,261	2,105
Taxpayers' equity			
General Fund	11.1	**1,118**	1,970
Revaluation reserve	11.2	**143**	135
		1,261	2,105

The financial statements on pages 10-12 were approved by the Board on 28 June and signed by

Signed: Date: 2 July 2007

Andrew Dillon CBE
Accounting Officer

Cash flow statement for the year ended 31 March 2007

	Notes	2006-07 £000	2005-06 £000
Net cash (outflow) from operating activities	12	**(26,708)**	(27,124)
Servicing of finance			
Interest paid		**0**	(1)
Net cash (outflow) from servicing finance		**0**	(1)
Capital expenditure and financial investment			
(Payments) to acquire intangible fixed assets	5.1	**(14)**	(9)
(Payments) to acquire tangible fixed assets	5.2	**(32)**	(142)
Net cash outflow from investing activities		**(46)**	(151)
Net cash outflow before financing		**(26,754)**	(27,276)
Financing			
Net Parliamentary funding		**26,753**	27,276
(Decrease)/increase in cash in the period	7	**(1)**	0

The notes at pages 13 to 30 form part of this account.

1.9 Research and development

Research and development expenditure is charged against income in the year in which it is incurred, except insofar as development expenditure relates to a clearly defined project and the benefits of it can reasonably be regarded as assured. Expenditure so deferred is limited to the value of future benefits expected and is amortised through the operating cost statement on a systematic basis over the period expected to benefit from the project. It should be revalued on the basis of current cost. The amortisation charge is calculated on the same basis as used for depreciation, i.e. on a quarterly basis.

1.10 Foreign exchange

Transactions which are denominated in a foreign currency are translated into sterling at the exchange rate ruling on the date of each transaction, except where rates do not fluctuate significantly, in which case an average rate for a period is used.

1.11 Leases

Assets held under finance leases and hire purchase contracts are capitalised in the balance sheet and are depreciated over their useful lives or primary lease term. Rentals under operating leases are charged on a straight line basis over the terms of the lease.

1.12 Provisions

The Institute provides for legal or constructive obligations that are of uncertain timing or amount at the balance sheet date on the basis of the best estimate of the expenditure required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using the Treasury's discount rate of 2.2% in real terms. This is a change from the rate of 3.5% applied from 2003-04. The effect of the change is to increase the carrying value of the provision, which is shown in Note 9.

1.8 Pension costs

Past and present employees are covered by the provisions of the NHS Pension Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, General Practices and other bodies, allowed under the direction of Secretary of State, in England and Wales. As a consequence it is not possible for the Institute to identify its share of the underlying scheme liabilities. Therefore, the scheme is accounted for as a defined contribution scheme and the cost of the scheme is equal to the contributions payable to the scheme for the accounting period.

The scheme is subject to a full valuation for FRS17 purposes every four years. The last valuation on this basis took place as at 31 March 2003. The scheme is also subject to a full valuation by the Government Actuary to assess the scheme's assets and liabilities to allow a review of the employers' contribution rates; this valuation took place as at 31 March 2004 and has yet to be finalised. The last published valuation on which contributions are based covered the period 1 April 1994 to 31 March 1999. Between valuations, the Government Actuary provides an update of the scheme liabilities on an annual basis. The latest assessment of the liabilities of the scheme is contained in the Scheme Actuary Report, which forms part of the NHS Pension Scheme (England and Wales) Resource Account, published annually. These accounts can be viewed on the NHS Pensions Agency website at (www.nhspa.gov.uk). Copies can also be obtained from The Stationery Office.

The conclusion from the 1999 valuation was that the scheme continues to operate on a sound financial basis and the notional surplus of the scheme is £1.1billion. It was recommended that employers' contributions are set at 14% of pensionable pay from 1 April 2003. On advice from the actuary the contribution may be varied from time to time to reflect changes in the scheme's liabilities. Employees pay contributions of 6% (manual staff 5%) of their pensionable pay.

The scheme is a 'final salary' scheme. Annual pensions are normally based on 1/80th of the best of the last 3 years pensionable pay for each year of service. A lump sum normally equivalent to 3 years pension is payable on retirement. Annual increases are applied to pension payments at rates defined by the Pensions (Increase) Act 1971, and are based on changes in retail prices in the twelve months ending 30 September in the previous calendar year. On death, a pension of 50% of the member's pension is normally payable to the surviving spouse.

Early payment of a pension, with enhancement, is available to members of the scheme who are permanently incapable of fulfilling their duties effectively through illness or infirmity. Additional pension liabilities arising from early retirements are not funded by the scheme except where retirement is due to ill health. For early retirements not funded by the scheme, the full amount of the liability for the additional costs is charged to the Operating Cost Statement at the time the Institute commits itself to the retirement, regardless of the method of payment.

A death gratuity of twice the final year pensionable pay for death in service, and up to five times their annual pension for death after retirement, less pensions already paid, subject to a maximum amount equal to twice the member's final year's pensionable pay less their retirement lump sum for those who die after retirement, is payable.

The scheme provides the opportunity to members to increase their benefits through money purchase additional voluntary contributions (AVCs) provided by an approved panel of life companies. Under the arrangement the employee can make contributions to enhance their pension benefits. The benefits payable relate directly to the value of the investments made.

Notes to the accounts

1. Accounting policies

The financial statements have been prepared in accordance with the Government Financial Reporting Manual issued by HM Treasury. The particular accounting policies adopted by the Institute are described below. They have been consistently applied in dealing with items considered material in relation to the accounts.

1.1 Accounting convention

This account is prepared under the historical cost convention, modified to account for the revaluation of fixed assets at their value to the business by reference to their current cost. This is in accordance with directions issued by the Secretary of State for Health and approved by HM Treasury.

Acquisitions and Discontinued Operations

Activities are considered to be 'acquired' only if they are acquired from outside the public sector. Activities are considered to be 'discontinued' only if they cease entirely. They are not considered to be 'discontinued' if they transfer from one NHS body to another.

1.2 Income

Income is accounted for applying the accruals convention. The main source of funding for the Institute is Parliamentary grant from the Department of Health from Request for Resources 1/2 within an approved cash limit, which is credited to the general fund. Parliamentary funding is recognised in the financial period in which the cash is received.

Operating income is income which relates directly to the operating activities of the Institute. It principally comprises fees and charges for services provided on a full-cost basis to external customers, but it also includes other income such as that from the Department of Health, NHS Quality Improvement Scotland and the Welsh Assembly. It includes both income appropriated-in-aid and income to the Consolidated Fund which HM Treasury has agreed should be treated as miscellaneous income. Where income is received for a specific activity which is to be delivered in the following financial year, that income is deferred.

1.3 Taxation

The Institute is not liable to pay corporation tax. Expenditure is shown net of recoverable VAT. Irrecoverable VAT is charged to the most appropriate expenditure heading or capitalised if it relates to an asset.

1.4 Capital charges

The treatment of fixed assets in the account is in accordance with the principal capital charges objective to ensure that such charges are fully reflected in the cost of capital. The interest rate applied to capital charges in the financial year 2006-07 was 3.5% (2005-06 3.5%) on all assets less liabilities, except for cash balances with the Office of the Paymaster General (OPG), where the charge is nil.

1.5 Fixed assets

a. Capitalisation

i) All assets falling into the following categories are capitalised:

ii) Purchased computer software licences are capitalised as intangible fixed assets where expenditure of at least £5,000 is incurred.

iii) Tangible assets which are capable of being used for more than one year, and they:

- individually have a cost equal to or greater than £5,000
- collectively have a cost of at least £5,000, and an individual cost of more than £250, where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control or
- form part of the initial setting-up cost of a new building, irrespective of their individual or collective cost.

b. Valuation

Intangible fixed assets

Intangible fixed assets held for operational use are valued at historical cost. Surplus intangible assets are valued at the net recoverable amount.

The carrying value of intangible assets is reviewed for impairment at the end of the first full year following acquisition and in other periods if events or changes in circumstances indicate the carrying value may not be recoverable.

Tangible fixed assets

Tangible fixed assets are stated at the lower of replacement cost and recoverable amount. On initial recognition they are measured at cost (for leased assets, fair value) including any costs such as installation directly attributable to bringing them into working condition. They are restated to current value each year. The carrying values of tangible fixed assets are reviewed for impairment in periods if events or changes in circumstances indicate the carrying value may not be recoverable.

i) Land, buildings, installations and fittings

Valuations are carried out by the District Valuer of the Inland Revenue Government Department at five-yearly intervals in accordance with FRS 15. Between valuations price indices appropriate to the category of asset are applied to arrive at the current value. The buildings indexation is based on the All in Tender Price Index published by the Building Cost Information Service (BCIS). The land index is based on the residential building land values reported in the Property Market Report published by the Valuation Office. The valuations were carried out in accordance with the Royal Institute of Chartered Surveyors (RICS) Appraisal and Valuation Manual insofar as these terms are consistent with the agreed requirements of the Department of Health and HM Treasury. In accordance with the requirements of the Department of Health, the asset valuations were undertaken in 2004 as at the prospective valuation date of 1 April 2005.

The valuations have been carried out primarily on the basis of Depreciated Replacement Cost for specialised operational property and Existing Use Value for non-specialised operational property. In respect of non-operational properties, including surplus land, the valuations have been carried out at Open Market Value. The value of land for existing use purposes is assessed to Existing Use Value. The valuations do not include notional directly attributable acquisition costs nor have selling costs been deducted, since they are regarded as not material.

To meet the underlying objectives established by the Department of Health the following accepted variations of the RICS Appraisal and Valuation Manual have been required:

- specialised operational assets have been valued on a replacement rather than modern substitute basis;
- no adjustment has been made to the cost figures of operational assets in respect of dilapidations; and
- additional alternative Open Market Value figures have only been supplied for operational assets scheduled for imminent closure and subsequent disposal.

ii) Operational equipment is valued at net current replacement costs through annual uplift by the change in the value of the GDP deflator. Equipment surplus to requirements is valued at net recoverable amount.

iii) Assets in the course of construction are valued at current cost, using the index as for land and buildings. These assets include any existing land or buildings under the control of a contractor.

iv) All adjustments arising from indexation and five-yearly revaluations are taken to the Revaluation Reserve. All impairments resulting from price changes are charged to the Statement of Recognised Gains and Losses. Falls in value when newly constructed assets are brought into use are also charged there. These falls in value result from the adoption of ideal conditions as the basis for depreciated replacement cost valuations.

c. Depreciation and amortisation

Depreciation is charged on each individual fixed asset as follows:

i) Intangible assets are amortised, on a straight line basis, over the estimated lives of the assets

ii) Purchased computer software licences are amortised over the shorter of the term of the licence and their useful economic lives

iii) Land and assets under construction are not depreciated

iv) Buildings are depreciated on their revalued amount over the assessed remaining life of the asset as advised by the District Valuer. Leaseholds are depreciated over the primary lease term

v) Each equipment asset is depreciated evenly over the expected useful life:

	Years
Furniture	10
Office, information technology, and other equipment	3-5

1.6 Stocks and work in progress

The net realisable value of publication stocks is nil. The Institute has no other stocks or work in progress.

1.7 Losses and special payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way each individual case is handled.

Losses and special payments are charged to the relevant functional headings, including losses which would have been made good through insurance cover had the Institute not been bearing its own risks (with insurance premiums then being included as normal revenue expenditure).