Health and Social Services Committee HSS-03-02(min)

MINUTES

Date: Wednesday, 23 January 2002
Time: 9.00am to 12.40pm
Venue: Committee Room1, National Assembly for Wales

Attendance:

Members of Health & Social Services Committee	
Kirsty Williams **(Chair)**	Brecon and Radnorshire
Brian Gibbons	Aberavon
Geraint Davies	Rhondda
Brian Hancock	Islwyn
Jane Hutt (Minister)	Vale of Glamorgan
Ann Jones	Vale of Clwyd
Dai Lloyd	South Wales West
David Melding	South Wales Central
In Attendance	
Officials	
Dr Bernadette Fuge	NHS Quality Division
Dr Ruth Hall	Chief Medical Officer
Ann Lloyd	Director, NHS in Wales
Maria Michael	Deputy Chief Social Services Inspector
Nick Patel	Project Director, Resource Allocation Review
Richard Tebboth	Deputy Chief Social Services Inspector
Graham Williams	Chief Social Services Inspector
Bob Woodward	Deputy Chief Social Services Inspector
Professor Peter Townsend	Chair National Steering Group on Resource Allocation Review
Dr David Gordon	Head of the Research Team, Resource Allocation Review
Professor Sir Michael Rawlins	Chair, National Institute for Clinical Excellence
Roy Luff	Non Executive Director, NICE
Andrew Dillon	Chief Executive, NICE
Secretariat:	
Jane Westlake	Committee Clerk

Item 1: Apologies and Substitutions

1.1 Apologies were received from Rod Richards and Lynne Neagle. There was no substitution.

1.2 Members were reminded of the requirement, under Standing Order 4.5, to declare any interests before taking part in proceedings. The following declarations were made:

- Geraint Davies, pharmacist and member of Rhondda Cynon Taff County Borough Council;
- Dai Lloyd, general practitioner and member of the Council of the City and County of Swansea.

Item 2: Annual Report of the Chief Inspector of Social Services
Paper: HSS-03-02(p1)

Graham Williams gave a brief overview of his report, the development programme and the inspection programme. The Inspectorate was developing a framework for evaluation of social services work and strengthening the management information from local authorities was a key part of the process. The Inspectorate was increasingly working with other inspection and audit agencies. Three main themes emerged from the report:

- the pressure on funding for core services to enable social service departments to implement good practice and address shortfalls in services for the elderly and community services;
- the need to improve recruitment and training of the workforce; and
- the need to strengthen leadership at political, corporate and director level and to clarify responsibilities.

Brian Gibbons declared an interest: his wife was a social worker.

The Chief Inspector and his colleagues gave the following responses to questions and comments from members:

- it was recognised that "whistleblowers" had to be supported and codes of practice were being developed.
- Staff suspended during a period of investigation were in a neutral position. The question of how the Department of Work and Pensions regarded their employment status during that time would be taken up with that Department.
- Information on staff vacancies was not collected at an all Wales level. There was a problem in movement of staff between local authorities and evidence that staff were leaving because of poor development opportunities.
- The focus of resources on child protection and looked after children resulted in less preventative work being done, which exacerbated the problems.
- There was concern about the quality of data on care assessments; local authorities applied different thresholds and some had been tightening their criteria. The Inspectorate was consulting on guidance on fair access to care.
- The Best Value initiative was beginning to impact on the delivery of social services.
- The Inspectorate and the WLGA were working together to address accountability and quality issues emanating from the restructuring of local authorities. There was a statutory requirement for

a Director of Social Services.
- The educational achievements of looked after children were monitored and each child had a plan.

The Minister referred to the new policy agreements that formed part of the revenue support grant (RSG) settlement. There were 10 social service indicators that would ensure quality outcomes. In addition to RSG local authorities received substantial funding under special grants that were ring fenced. These underpinned many of the partnership projects undertaken with the voluntary sector. She stressed the importance of good management information. She said that social services often had to respond to crises and engaging in preventative work which required collaboration with other departments and agencies was not their priority.

Statement on the Repayment by Health Authorities and Trusts of Loans issued before1 March 2001 by the National Assembly

The Minister made a statement, the text of which is at Annex 1.

Some members expressed concern that the debts of some were being met at a cost to those authorities and trusts that had managed their affairs more prudently. The Minister assured the Committee that the waiving of repayment was a technical issue and did not involve any money being top sliced from health authorities' and trusts' budgets. The Director of the NHS said there would be a requirement for the authorities and trusts to live within their budgets for the next two years before the debt would be wiped out.

Item 3: Resource Allocation Review
Paper HSS-03-02(p2)

Professor Townsend updated the Committee on the work that had been done since he presented his initial report in July. There had been widespread consultation on it and generally the response had been favourable. Some respondents had expressed concerns about the detail and timing of the new approach of directly measuring health need in the allocation formula. The National Steering Group had taken these concerns into account in its report which changed, added to or confirmed the recommendations in the original report. The overall conclusion was that there was a need to do more than revise the allocation formula. The report recommended three parallel strategies, which the Committee went on to discuss.

The Dual Strategy

The Minister said that action to improve health and reduce inequalities of access had to be taken in a wide range of policy areas, not just health. Impact assessments, for example on free school meals, could establish what was being done and what needed to be done in other areas.

Members supported the recommendation for a dual strategy.

Reliable Financial Information

The Committee agreed that it would be important to have reliable financial information to enable costs and spending to be tracked to post code level.

The Director of the NHS confirmed Professor's Townsend's statement that it was expected that piloting work would produce reliable baseline information. This would be available in June. It could resolve some of the concerns about the implementation of the new formula.

Professor Townsend cautioned that initially information might only go to Local Health Board (LHB) level, but that it should be possible to develop it further in time.

New Allocation Formula

The following responses were given in answer to the questions and concerns of members:

- Professor Townsend said that the baseline information that would be available in the summer would enable the Minister to make judgements about phasing in the new formula.
- Dr Gordon said the research team had been charged with producing a scientifically sound method at LHB level. He also said that there was no technical reason why children should not be covered in the Welsh Health Survey.
- The Chief Medical Officer said that there was a working group reviewing the content of the survey.
- Professor Townsend said that the speed at which the new formula could be introduced depended on how the overall level of resources available for distribution might increase. The level of other health budgets, such as escalating pharmaceutical costs, needed examination.

David Melding said that the Conservative group could not support the introduction of the new formula until there was more information available on how it would impact and said that it should not be introduced until 2005, to allow the new structure of the NHS to settle. In the meantime the Health Inequalities fund should be increased to prevent further divergence.

Other members supported the early introduction of the new formula.

The Minister informed Committee that Professor Townsend had agreed to chair the Standing Group to be set up to oversee the development of the allocation formula and to ensure that progress on outstanding work is made.

Action: the Chair would write to the Minister to confirm the Committee's conclusions.

Item 4: Annual Report of the National Institute for Clinical Excellence (NICE)
Paper HSS-03-02(p3)

Professor Sir Michael Rawlins, Roy Luff and Andrew Dillon gave a presentation on NICE's work to date. A copy of the presentation and a supplementary memorandum is at Annex 2.

Sir Michael said that there was evidence from around the world that health services were struggling with the tensions between demand and resources. Governments in the UK were openly airing the issues of finite resources and value for money. Sir Michael and his colleagues made the following points in discussion with members:

- NICE had adopted the quality adjusted life years measure as the most objective way of assessing cost benefit of interventions. It was acknowledged that there was no one perfect measure to assess how an intervention added quality to an individual's life and value judgements would be involved at some stage. Neither was it easy for an individual member of the public to accept that one drug was rated more highly than others using that measure; the patient naturally looked at the potential benefit to themselves and their particular illness or disability. NICE had commissioned further work on an overall framework within which the Appraisal committee would work;
- There was no ceiling on the value that could be attached to quality adjusted life years, despite some speculation that it was £30,000.
- Assessments of some interventions had taken a longer time than would have been wished , due to openness and transparency of the systems employed by NICE. Beta interferon was a case in point. The decision had been returned to the Appraisal Committee for further consideration on appeal. As so much of the outcome hinged on cost effectiveness in this particular case, further work on an economic model was commissioned and NICE expected to issue a final decision shortly. The Welsh Assembly Government was in discussion with the Department of Health about a scheme for sharing risk with manufacturers for beta interferon and glatarimer acetate.
- NICE had looked at 12 drugs within two years of their being licensed, two or three at the licensing stage.
- All the current collaboration centres were in London but further centres were planned and NICE was exploring the possibility of a centre covering cancer being developed in Wales.

The Minister would be making statutory directions to enforce implementation of NICE guidance and this would be monitored through the performance management framework. An additional £10.5m was being allocated to health authorities from 2002-2003 to help them with development costs, including the implementation of NICE guidance.

The Welsh Assembly Government wanted to ensure Wales was represented on the Citizen's Council and all other NICE Committees and Councils. [

It was agreed that the Committee should meet annually with NICE.

Item 5 Minutes
Paper HSS-01-02(min)

The Minutes of the meeting on 9 January were agreed.

Papers to Note

The following papers were noted:

HSS-03-02(p4)
Substance Misuse – Confiscation of Assets

HSS-03-02(p5)
Health and Social Services Committee

Strategic Forward work programme January 2002 to May 2003

Action: Strategic Forward Work Programme to be sent to other subject committees for comment.

ANNEX 1

MINISTER'S STATEMENT ON DEBT CANCELLATION

- One issue, which I know has been of concern to colleagues, has been the prospect of the new NHS bodies to be established in April 2003 having to repay outstanding loans to the Assembly.

- I am sure that all colleagues will be delighted with the news that the Finance Minister and I have decided, in principle, that all loans issued to NHS Wales trusts and health authorities before 31 March 2001 will not need to be re-paid to the Assembly. Letters will be issued to the service, setting out the detailed terms upon which this decision will be implemented.

- This means all NHS bodies can start the new financial year with a clean slate and on an equal footing.

- Whereas, for example, if a Trust had debts of £7 million and had been required to pay them back

over say 7 years, they would have had to repay back £1,000,000 a year. Now, with that debt written off, that money will be available for patient care.

- I must stress that it is absolutely essential that the NHS bodies are required to live within their budgets.

- I expect them to take full advantage of this opportunity to direct funding to improvement in patient services.

ANNEX 2

NATIONAL INSTITUTE FOR CLINICAL EXCELLENCE

MEMORANDUM TO THE NATIONAL ASSEMBLY FOR WALES

JANUARY 2002

1. Background

1.1 Health care systems throughout the world seek to provide high quality care and the efficient use of resources. Whilst most developed countries are developing schemes to provide patients with the highest attainable standards of care few (at least overtly) attempt to take account of both clinical and cost effectiveness. The National Institute for Clinical Excellence (NICE) is unique amongst those that do so because of its scope and its position in the National Health Service (NHS) in Wales and England.

1.2 The Institute was conceived as part of a strategy to promote the highest attainable quality of care that included:

- the setting of standards (through National Service Frameworks and NICE);
- the delivery of these standards (through clinical governance and professional self-regulation); and
- the monitoring of standards (by the Commission for Health Improvement, and through the National Framework for Assessing Performance and the National Survey of Patient and User Experience).

1.3 NICE was expected to set clinical standards for the NHS by providing advice to health professionals and patients in the form of:-

- guidance on the appropriate use of selected health technologies (by *appraising* pharmaceuticals, medical devices, procedures, diagnostic methods and health promotion);

- *clinical guidelines* for the treatment of specific diseases and conditions; and
- appropriate *clinical audit* methods.
- All NICE guidance is based on evidence of clinical and cost effectiveness; and its production involves patient/carer organisations, health professionals and manufacturers.

1.4 The Institute is accountable to the National Assembly for Wales and the Secretary of State for Health for England. The relationship is described the NICE's Framework Document

2 The Institute

2.1 NICE was established in April 1999 with a financial allocation (£10,112,000) largely derived from existing budgets. Its recurring allocation in the financial year 2001/2 is £13,075,000 with separate contributions from the Assembly and the Department of Health.

2.2 The Institute was founded on the principle that it would operate most effectively by maintaining a small central team but creating a network of relationships with professional, academic and NHS organisations across Wales and England. A core of 40 staff works at NICE's offices in London, but the "virtual" Institute in Wales and England involve individuals and organisations providing expertise and advice.

2.3 NICE is supported by the Partners Council drawn from organisations representing key stakeholders (patients/carers, the medical Royal Colleges and other professional organisations, academics and NHS service interests). The experience, skill and knowledge of its members means that it is an invaluable source of individual and collective advice on a range of issues; and provides a forum for the exchange of ideas and the development of strategy.

2.4 During 2002/2003 NICE will be establishing a Citizens Council to advise on the value judgements that should underpin its evaluation of clinical and cost effectiveness and reflect more closely the values of the people in Wales and England. Members will be drawn from those living in the two countries who neither work for, nor supply, the NHS. The views of the Council will inform the deliberations of the Board and its advisory committees.

2.5 NICE has attempted to ensure that patient/carer organisations are fully engaged in its governance and in the development of its guidance. The Board includes two non-executive directors with experience of patient/carer advocacy. A quarter of the Partners Council represents patient/carer interests. All the Institute's advisory committees and guideline development groups include individual with experience of patient/carer advocacy. And NICE has created a patient /carer support unit, in association with the College of Health, to help those involved with guideline development contribute most effectively to the process.

2.6 The Institute holds all its Board meetings in public. They take places in towns and cities across Wales and England and attract about 50 observers. The agenda and papers for meetings are published on

the Institute's web-site and members of the audience are given an opportunity to comment or ask questions between each agenda item.

3. Progress to date

3.1 The Institute has embarked on the largest programme of original clinical guidance development ever attempted by a national health care system. The Institute has completed and disseminated clinical guidance that includes:-

- the publication of 31 technology appraisals with a further 43 in development
- the publication of 4 clinical guidelines with a further 32 in development;
- completion of 9 national audit projects with a further 7 in progress;
- the publication of guidance on good referral practice covering 11 common conditions;

3.2 The Institute has established advisory committees to formulate its guidance. Members (whose expertise is recognised both nationally and internationally) are drawn from the NHS, patient and carer organisations and academia.

3.3 The Institute has created six multidisciplinary National Collaborating Centres. These bring together groups of healthcare professionals, patient/carer representatives and academics that develop clinical guidelines and audit advice for the NHS in Wales and England. The centres cover:-

- Acute Care
- Chronic Disease
- Nursing and Supportive Care
- Mental Health
- Primary Care
- Women and Children's Health

3.4 Their creation is testimony to the commitment that the organisations representing NHS health professionals (including the Royal Colleges) are making to the NICE and its work.

3.5 The Institute has also established two units to support the work of the National Collaborating Centres:-

- The National Guidelines and Audit Patient Involvement Unit provides advice on patient/carer involvement and support and training for patients and carers in guideline and audit development.
- The National Guidelines Support and Research Unit provides advice on methodological issues, training and education for the National Collaborating Centres, and undertakes research to increase understanding of methodological research to increase understanding of guideline construction and implementation.

3.6 The Institute has reviewed, and is now re-organising, the four National Confidential Enquiries to enable them to enhance their quality and scope; and to extend their contributions for improving the quality of care.

3.7 The Institute has reviewed the national publications transferred to the Institute (*MeReC Bulletins, Effectiveness Bulletins* and *Prescribers Journal*). NICE continues to fund the *MeReC Bulletins* and the *Effectiveness Bulletins.*

3.8 The Institute provides a forum, through its Annual Conferences, for health professionals, patient/ carer organisations, academics, the healthcare industries and other NHS organisations to share examples of good practice and ideas for quality improvement.

3.9 The Institute has developed a dissemination strategy using a variety of methods. This aims is to provide key information (via paper-based systems and email) to those with the responsibility for delivering NICE guidance, and allowing more detailed information to be drawn from the NICE website.

- In 2000/2001 more than 1.5 million documents were printed and circulated to the NHS in Wales and England.

- NICE's website (which has disability access, patient/carer versions, and Welsh language texts) has around 15,000 visits per day rising to 30-40,000 when guidance of special interest is published. Over 500,000 copies of NICE guidance has been downloaded over the past six months.

- NICE guidance is also available from NHS Direct Online, the National Electronic Library for Health, PRODIGY (a decision support tool for primary care), standard reference works and many NHS Trust Intranets.

3.10 The Institute has developed *A Guide to Implementing NICE Guidance* based on extensive discussions with a wide range of experienced health professionals in health authorities and NHS Trusts.

3.11 The Institute has developed *Principles for Best Practice in Clinical Audit* that offers health professionals practical advice on undertaking clinical audits in their own environment. This is scheduled for publication in Spring 2002.

4. The Nature of NICE Guidance

4.1 The Institute's guidance is prepared by the independent expert members of its advisory committees (especially the Appraisals Committee and the Guidelines Advisory Committee) and clinical guideline development groups. Members are draw from the NHS, patients and carers, and from academia. Although they seek the views of the Institute's stakeholders (the professions, patient/carer organisations, professional bodies and manufacturers) their advice is independent of any vested interests. Additional experts, nominated by patient/carer organisations and professional bodies, inform individual appraisals.

4.2 The evidence used by the Appraisal Committee is comprises submissions received from patient/carer organisations, professional bodies and manufacturers. In addition, the committee is provided with a systematic review of the relevant literature undertaken by an independent group commissioned by the National Coordinating Centre for Health Technology Assessment. The independence and credibility this systematic review underpins the integrity and credibility of the Institute's guidance.

4.3 Although there are differences in the development of technology appraisal guidance and clinical guidelines, the Institute has taken care to ensure that each is transparent, objective, inclusive, and offers adequate opportunity for consultation. This not only involves inviting submissions from stakeholders, but also offering them to comment on the Institute's emerging conclusions.

4.4 The Institute's guidance is based, primarily, on clinical need (in relation to the nature, prognosis, and current treatment options, of the underlying condition) and on the best available evidence of clinical and cost effectiveness. Evidence of clinical effectiveness is, ideally, derived from the results of randomised clinical trials but other approaches are necessary where such data are lacking. Economic evaluations underpinning NICE's guidance are derived from estimates of increased longevity or improved quality of life. The balance between clinical and cost effectiveness is, necessarily, based on the judgements of the Institute's advisory committees and the Board has deliberately avoided defining a "threshold".

4.5 Although its guidance is intended solely for the NHS in England and Wales it has become clear that it is being used as a benchmark by other organisations. This includes those offering private health care in the UK as well as by health care providers in Europe, North America, parts of South America and Australasia. The Institute's work has gained an international reputation and government agencies and acadsemic institutions from have visited the organisation across the world. What marks NICE out as different from most, if not all, comparable organisations is the strength of its association with its home healthcare system and the robustness and openness of its processes.

4.6 Independent commentators have commended the robustness if NICE's approach to interpreting clinical and cost effectiveness data and to the openness with which it is developed. They have also noted the subtlety of NICE's approach to advising helping to ensure that the best value for money is obtained for the technologies it recommends.

4.7 The extent to which NICE guidance is implemented is of obvious concern to the Institute. Guidance that is not implemented, or not implementable, is valueless. Informal discussions with senior officers of the Royal Colleges and other professional associations leads us to believe that NICE guidance is broadly welcomed; considered to be robust and authoritative; and of considerable value in routine clinical practice. This is supported by the results of a recent survey carried out on behalf of the pharmaceutical industry.

4.8 An independent survey of health Authorities in Wales and England, commissioned by CancerBACUP, suggests that the majority (80-%) have a written policy for assessing the clinical and

financial implications of implementing NICE guidance; 65% have a written policy for disseminating NICE guidance locally whilst others follow existing national dissemination practice; 47.5% have a policy for monitoring compliance with NICE guidance. The survey also showed that more than 90% of suitable patients with breast cancer are now offered treatment with a taxane; and that nearly 90% of suitable patients with ovarian cancer are offered treatment with paclitaxol. This contrasts with the fact that, in 1999, only 25% of health authorities funded treatment with taxanes for any indication.

4.9 Nevertheless, much of what is said about the way the NHS has responded to NICE guidance is anecdotal. The Institute has therefore commissioned a substantial research programme, from York University (under the direction of Professor Trevor Sheldon) to assess the implementation of the Institute's advice. The results of this will become available in the summer of 2002 and will be made publicly available.

5. The Future

5.1 The *Report of the Public Inquiry into Children's Heart Surgery at the Bristol Royal Infirmary 1984-1995* (Kennedy Report) made a number of proposals that would, if implemented, have a major impact on the Institute. The Institute's own views on the Report have been published and the response of the Assembly and the Department of Health is now available.

5.2 The Report suggested that the Institute should become a non-departmental public body (analogous to the Food Standards Agency) and independent of the Assembly and the Department of Health. Although the Institute supported most of Kennedy's conclusions it did not believe that this particular measure would be appropriate. The Board is proud to be part of the NHS. Continuing as part of the service is critically important to securing the confidence of health professionals and patients/carers. It enables NICE to secure, more readily, the commitment and goodwill of NHS personal involved in developing NICE guidance. And it allows the Institute to be more closely aligned with the implementation of the advice it gives. The Board is therefore pleased to know that the Assembly and the Department of Health share this view and that the Institute is to remain a Special Health Authority.

5.3 The Institute's independence is most important where it can demonstrate that its advice is insulated from inappropriate stakeholder influence. NICE and its advisory bodies firmly believe that this is the case, and that its guidance is solely concerned with ensuring that the totality of NHS patients receive the care they deserve. There are measures, however, that the Board believed would enhance the perceived independence of the Institute and improve its efficiency:

5.4 The Institute wishes its work programme to be constructed in a more open and inclusive manner. In particular there is insufficient opportunity for NHS staff to propose either appraisal or clinical guideline topics. This is important because clinicians will often be the best judge of where the need for guidance is greatest. The Board looks forward to the consultation document that is shortly to be published describing a revised topic selection process.

5.4.1 There are a number of the Institute's appointments where prior ministerial agreement is required. Although such agreement has never been withheld, the Institute is pleased to learn that these appointments will be devolved to the Board.

5.4.2 Powers to establish, or disestablish, committees of the Board (with the exception of those necessary to comply with NHS corporate governance) will, in future, rest solely with the Board.

5.4.3 The Board will, in future, not require prior approval from the Assembly or the Department of Health before issuing its guidance.

5.4.4 NICE is at present only able to cover, in its appraisals and clinical guidelines programmes, a proportion of emerging and established health technologies and clinical conditions. The Institute strongly endorses the proposal, in the Kennedy Report, that NICE should be given the task of extending its programmes to cover the major areas of morbidity and mortality. The Board believes that only a comprehensive suite of clinical guidelines will secure, for patients, the quality of care they deserve. Such a programme would require several components:-

- An increase in the Institute's funding would be necessary to cover the initial development and the regular revision of such a suite of NHS guidelines.
- NICE would need to embark on a programme to develop national capacity for a robust guideline development programme. This would almost certainly involve increasing the number of National Collaborating Centres.
- The Kennedy Report proposed that NICE should be responsible for "all action relating to the setting, issuing and keeping under review of national standards". The Board welcomes this opportunity. Whilst it believes that the responsibilities of the National Screening Committee, the Safety and Efficacy Review of New Interventional Procedures (SERNIP) and the Joint Committee on Vaccination will fall comfortably (and logically) within the scope of the Institute, some areas will need to remain with other agencies which issue guidance to clinicians (Medicines Control Agency, Medical Devices Agency, Human Fertility and Embryology Authority). Nevertheless, the Institute would accept the need to ensure that consistent advice is provided for NHS health professionals and their patients.

5.5 There is evidence to show that, for a variety of reasons, patients are denied access to new treatments of established clinical and cost effectiveness. Whilst NICE cannot, alone, provide faster access to new treatments it has been independently argued that a recommendation by the Institute will lead to faster and more uniform access. In future, to ensure that the phenomenon of "postcode prescribing" does not re-emerge, NICE is anxious to provide appraisals of novel health technologies as soon as possible after licensing (eg within three months). For pharmaceuticals and devices this would involve starting the appraisal process around the time of submissions for marketing authorisation. Although the pharmaceutical industry has expressed reservations about the ability of the Institute to appraise new medicines within two to three years of their launch, the Institute's experience shows that these anxieties are unfounded. Over the past 18 months NICE has appraised 12 new medicines within 2 years of their

launch: in only one instance did the manufacturer appeal against the Appraisal Committee's advice; and in at least 6 cases the company has used the Institute's "endorsement" in its promotional material.

5.6 Early appraisals will, however, sometimes be controversial. There is in Britain a degree of therapeutic conservatism that has already been manifest in relation to NICE's completed appraisals (eg zanamivir for influenza, glycoprotein IIb/IIIa inhibitors for myocardial ischaemia, sibutramine for obesity). The conclusions of the Appraisal Committee will, ultimately depend on the collective judgement of its members. The Board believes, however, that the Appraisal Committee should invariably draw conclusions that are in the best interests of patients as a whole.

6. Conclusions

6.1 NICE is a unique venture and the Institute has adopted an evolutionary and flexible approach to its structure, its programmes and its processes. The Board believes that the Institute is, already, making a difference to the treatment of patient who seek their care from the NHS.

6.2 There are changes to the Institute's establishment arrangements, and enhancements to its responsibilities, that the Board would welcome. Collectively, these would increase public and professional confidence in the Institute, as well as provide patients with greater security and certainty about the clinical care they can expect to receive from the NHS.

National Institute for Clinical Excellence

January 2002

NICE Powerpoint Presentation