Thinks

Insight & Strategy

May 2024

NICE Listens Prioritisation Dialogue | Appendix

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1. Who took part in the Prioritisation Dialogue: a detailed breakdown

Members of the public

Intended sample's demographic criteria

Demographic	Criteria
Age	Min. 7 aged 18-24 Min. 7 aged 25-44 Min. 7 aged 45-64 Min. 7 aged 65-74 Min. 5 aged 75+
Gender	Min. 25 men Min. 25 women Including other / prefer not to specify
Ethnicity	Min.15 participants who identify as non-white across the whole sample (based on local dynamics) Mix of ethnicities across the whole sample, interlocking to ensure mix of gender and SEG
Socio-economic group (SEG)	Min. 10 x AB Min. 10 x C1 Min. 10 x C2 Min. 10 x DE
Location	4 areas selected for fieldwork, with mix of participants living in surrounding urban/suburban/rural locations. 14 x participants in each location: • London • Blackpool • Norwich • Birmingham
Life-stage	Min. 10 to live with children under 16 Min. 10 to live with partner Min. 5 to live alone

	Min. 5 to live with friends / other shared accommodation
Sexuality	Min.5 who identify as LGBTQI+

Intended sample's health experiences and behaviours criteria

Health experiences and behaviours	**Criteria**
Long term health condition (LTHC) or disability	20 who identify as disabled / having a LTHC of which: • Min. 4 participants with physical or sensory impairment • Min. 10 with recurrent conditions (e.g., diabetes, cardiovascular disease) • Min. 5 with multiple conditions • Min. 5 with mental health issues
Recent primary, urgent or emergency care use	Min. 20 to have used primary, urgent or emergency care services in the last 6 months • Including min. 10 who do not have a LTHC or disability
Carer	Min. 10 informal carers
NHS waiting list status	Min. 10 to be on NHS waiting list
Social care use	Min. 10 to interact with social care (including carers)
Adverse health behaviours	Min. 5 smokers Min. 5 to consume high levels of alcohol Min. 10 to be physically inactive
Positive health behaviours	Min. 10 to be physically active Min. 5 to consume a healthy diet Min. 5 to practice activities related to wellbeing (e.g. meditation)

Intended sample's demographic criteria

Demographic	Criteria
Location	14 participants in each location: Preston, London, Birmingham and Plymouth: 56 Urban: 37 Suburban: 16 Rural:3
Gender	Male: 27 Female: 29
Age	18-24: 10 25-44: 16 45-64: 16 65-74: 8 75+: 6
Ethnicity	Identify as non-white: 17
Life-stage	Live with children under 16: 14 Live with partner: 16 Live alone: 13 Live with friends / other shared accommodation: 6
Socio-economic group (SEG)	AB: 9 C1: 29 C2: 5 DE: 13
Sexuality	Identify as LGBTQI+: 5

Intended sample's health experiences and behaviours criteria

Health experiences and behaviours	**Criteria**
Long term health condition (LTHC) or disability	Long term health condition: 21 Mental health condition: 5
Recent primary, urgent or emergency care use	Used primary, urgent or emergency care services in the last 6 months: 25
Carers	Provide informal care: 18
NHS waiting list status	On NHS waiting list after being sent for a referral or treatment within the last 12 months: 15 On NHS waiting list after being sent for a referral or treatment within past 24 months: 22
Social care use	In receipt of social care (themselves or a close family member): 10
Adverse health behaviours	Smokers: 8 Consume high levels of alcohol: 19 Physically inactive: 18
Positive health behaviours	Physically active: 35 Consume a healthy diet: 24 Practice activities related to wellbeing: 43

Participant attendance across the dialogue

Workshop 1	56
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Specialists

To identify appropriate specialist individuals, we developed a longlist in collaboration with the NICE project team, drawing on their contacts and our own desk research. We recruited people with a wide range of professional backgrounds, from academia, policy making, the public sector, and those working day-to-day on the frontline of health and social care services. The specialists' role involved presenting information and engaging in discussion (e.g. challenge and probe participants' viewpoints with the support of Thinks facilitators).

The following specialists took part in workshops 2-4.

Name	Role / Organisation
Bryony Kendall	General Practitioner (GP), NHS
Peter Barry	Consultant Clinical Adviser, NICE
Clare Morgan	Director of Implementation & Partnerships, NICE
Neil O'Brien	GP and Executive Medical Director for North England and Cumbria Integrated Care System
Jason Lane	Programme Leader (Contracts, Commissioning and Market Management), Adults and Health Directorate, Leeds City Council
Deb O'Callaghan	Associate Director, NICE
Sasha Henriques	Genetic Counsellor, NHS
Jonathan Ives	Professor of Empirical Bioethics, University of Bristol
Sarah Ouanhnon	Senior Net Zero Delivery Lead, Greener NHS Programme, NHS England
Keith Moore	Programme Coordinator, Sustainable Healthcare Coalition

Oversight group

List of oversight group members:

Name	**Role / Organisation**
Simon Denegri OBE (Chair)	Executive Director, Academy of Medical Sciences
Helen Dent	Chief Executive Officer, British In Vitro Diagnostics Association
Jonathan Ives	Professor of Empirical Bioethics, University of Bristol
Luella Trickett	Director Value & Access, Association of British HealthTech Industries
Genevieve Cameron	Senior Strategy and Programme Manager, The Health Foundation
Jason Lane	Programme Leader (Contracts, Commissioning and Market Management), Adults and Health Directorate, Leeds City Council
Meera Sookee	Head of Quality Strategy & Clinical Programmes, NHS England
David Wright	Head of NICE Sponsorship, Department of Health & Social Care
Debra Dulake	Helpline Adviser, The Patients Association
Hashum Mahmood	Senior Policy Adviser, NHS Confederation
Jenny Camaradou	Lay member
Alan Thomas	Lay member

List of NICE Representatives:

Name	**Role / Organisation**
Sarah Byron	Programme Director for Devices, Diagnostics and Digital
Deborah O'Callaghan	Associate Director of Field Team
Claire Mulrenan	Clinical Fellow
Jess Bailey	Public Involvement Advisor
Farhan Ismail	Associate Director of the Office for Digital Health and Topic Intelligence for Health Tech
Lesley Owen	Technical Adviser (Health Economics), Centre for Guidelines
Chris Carmona	Technical Adviser, Centre for Guidelines

Stakeholder Engagement

List of stakeholders who take part in the design phase of the dialogue:

Name	**Role / Organisation**
Jonathan Ives	Professor of Empirical Bioethics, University of Bristol
Helen Dent	Chief Executive Officer, British In Vitro Diagnostics Association
Louise Fish	Chief Executive, Genetic Alliance
Luella Trickett	Director Value & Access, Association of British HealthTech Industries
Deb O'Callaghan	Associate Director, NICE
Nicholas Timmins	Senior Fellow, Kings Fund
Juliet Kenny	Technical Adviser, NICE

Sally Gainsbury	Senior Policy Analyst, Nuffield Trust
James Jagroo	Senior Technical Analyst, NICE
Jason Lane	Programme Leader (Contracts, Commissioning and Market Management), Adults and Health Directorate, Leeds City Council
Colette Scrace	Clinical Genomics Nurse Lead – Cancer and Rare Diseases, NHS England
Marion Goldsmith	Senior Commissioner - Better Care Fund, Wiltshire Council
Eileen Burns	Consultant Geriatrician and National Speciality Adviser for older people and integrated person-centred care, NHS
Ibtisam Ahmed	Head of Policy and Research, LGBT Foundation
Judith Richardson	Programme Director, NICE

Stakeholder Discussion Guide

Section 1: Welcome and introductions

- Thinks researcher to introduce themselves and the purpose of the interview.
- Your current role and organisation.
- Your area of work.

NICE are developing a prioritisation framework to help them allocate their resources, make effective use of their skills, and deliver guidance which has the most positive impact for people using the H&SC system in the UK.

- In your work/organisation, how do you make decisions about prioritising different tasks or resources? For example, weighing up urgency and availability.
    - What are the types of things / criteria that you consider when prioritising? This could be a structured approach that you or your organisation uses or something more informal.
    - Do any of these prioritisation measures have a social or clinical impact?

Section 2: The need for prioritisation

- Why is it important for NICE to prioritise?
- What makes it challenging to prioritise areas of focus?
- What makes it easier?
- What impact would better prioritisation have on NICE / your organisation / health outcomes / the public?

Section 3: Criteria (domains) for prioritisation

Ask all none-NICE stakeholders:

- In your opinion, what do you think are the key criteria that need to be factored into the way that NICE prioritises its areas of focus? Why are these important / useful?
- What are some of the trade-offs that you think might need to be made?
- NICE has already started thinking about the domains that will be used for prioritisation [share list of domains/criteria below and ask the following questions:]
    - What is your response to this?
    - Would you change any of these criteria? Why?
    - In what ways could of these criteria could be controversial? Why?
    - What, if anything, do you know about how the public feel about this?

Ask NICE stakeholders:

- NICE has already started thinking about the criteria that will be used for prioritisation [share list of domains/criteria below and ask the following questions:]
    - Is there anything, in your opinion, that is missing?
    - What are some of the trade-offs that you think might need to be made?
    - Are there any aspects of prioritisation that could be potentially contentious/controversial? Why?
    - What, if anything, do you know about how the public feel about this? Or how other users within NICE may feel?

NICE has already started thinking about what these criteria could be. Currently, this includes:

- **Budget impact:** What is the potential impact on health and care system budgets within X years of producing this guidance?
- **System impact:** What is the potential impact of this guidance on health and care infrastructure, and capacity for implementation?
- **Evidence availability:** Is there available/expected evidence on this guidance's potential impact on best practice in clinical/social care and cost effectiveness?
- **Health inequalities:** What is the potential of this guidance to introduce, increase, or decrease health inequalities?
- **Sustainability:** Could this guidance reduce the need for healthcare services through the prevention of ill-health, or support disinvestment and reinvestment plans?

Section 5: Deeper criteria (domain) dive

Ask all none-NICE stakeholders and tweak for relevant NICE stakeholders depending on how involved in the process:

- I'd now like to focus on a specific element of criteria that's relevant to your role … [Moderator to check domain spreadsheet for relevance]
    - Why do you think it is important to be included in a prioritisation framework for NICE?
    - What are the pros and cons of including this domain in the framework?
    - Is there any counter argument you can put forward for why this shouldn't be included as criteria?
    - Do you think it deserves more weight than the other criteria I've shared with you today? Why/Why not?
    - Can you think of any topic or a medical technology that would score highly on this specific criteria?
    - If you were to describe [insert relevant domain] to the public, what examples would you look to use?

Ask all none-NICE stakeholders from relevant 'Health and care need' domain:

- I'd like to talk about health and care need when referencing specific NICE topics. We've defined this as 'For this topic, how significant is the burden of illness/care, premature mortality, and reduction in quality of life?'
    - What elements within health and care needs need to be looked at when deciding on medical guidance?
    - How do you weigh up different elements with health and care? E.g. rareness of the disease, severity of the disease, how prevalent it is etc.
    - If you were to describe health and care needs and the trade-offs that happen within it to the public, are there any examples you would look to use?

Section 6: Impact of the prioritisation framework

- What would 'good' look like for NICE's prioritisation framework?
- What would it allow NICE to do?
- What impact would it have?
    - For your organisation?
    - For you personally?
    - Budget?
    - For others?

Section 7: Ensuring a balanced dialogue with access to expertise

- Who do you think participants need to hear from to help them form an opinion on this topic and the areas of prioritisation?
- Are there people / organisations with a different perspective to you? Who, and in what respect?
- Would you be open to taking part in the dialogue as an expert participant? (This would involve attending a workshop with members of the public, and at this stage we are looking for interest only not a firm commitment)

2. The format of the Prioritisation Dialogue

Workshop	Time and date	Content
1.	Saturday 18th November 2023, 1 – 4.30pm (face-to-face)	• Introductions and getting to know each other. • Discussion of the challenges and opportunities facing the health and care system. • NICE representatives introduce the prioritisation challenge. • Discussion of prioritisation and why it is important / necessary to NICE.
2.	Thursday 23rd November, 6-8pm (online via Zoom)	• Discussion of what is important when considering the health and care need and evidence availability domains. • Specialist presentations of the current challenges and opportunities within each area. • Discussion of the implications and trade-offs of prioritising based on health and care need and evidence availability.
3.	Tuesday 28th November, 6-8pm (online via Zoom)	• Presentation of information about budget and system impact. • Panel discussion with specialists. • Exploration of implications of prioritising based on budget and system impact through case studies.
4	Thursday 30th November, 6-8pm (online via Zoom)	• Presentation of information about health inequalities and environmental sustainability.

		• Question and answer with specialists. • Discussion of the trade-offs and what is important within each area.
5	Saturday 9th December, 1-4.30pm (face-to-face)	• Return and review of key content covered in workshops 2-4. • Exploration of the trade-offs between and within areas through pairwise ranking. • Exploration of what matters most – the importance ascribed to the different domains. • Discussion of edge cases to identify key principles that should underlie NICE's prioritisation framework, including the boundaries and conditionalities.

3. Context Setting: Workshop 1

Workshop 1: Discussion Guide

Section and aim	Key questions and probes	Time
Introduction and warm-up Aim: To welcome participants to the dialogue and explain the focus for the day	Table plan by door of pre-allocated names for 2 x breakout groups. Facilitators to sign participants in and help people work out at which table they are sat. Lead facilitator in plenary: **<u>How we will work together</u>** **Welcome from lead facilitator** My name is [XXX] and I work for an independent engagement company called Thinks Insight & Strategy. Our job is to understand what members of the public (such as yourselves) think about important issues that affect citizens all around the country. **Why we are here** Over the course of this dialogue, we will be talking about the UK health and care system. Introduce 'problem statement': • The health and social care system currently faces many challenges in meeting the health and care needs of the population. • NICE is an organisation that supports the system by providing health and care practitioners with guidance on best practice and value for money – for example, recommending certain types of treatments or medical technologies, based on the health benefits they offer in relation to their cost. • NICE can't produce guidance on everything, everywhere, all at once. And even if they could, the system couldn't cope with all that change. They need to prioritise their resources and focus on what matters most. • Our big question for this dialogue is: **How can NICE decide what matters most?** **Who's in the room**	15 min 1-1:15pm

	• **Thinks Insight & Strategy:** We will be leading the conversations that we have over the course of the 5 dialogue sessions. • **NICE & Sciencewise:** Have commissioned this engagement and are committed to using your input to shape NICE's plans going forward. • **Participants (you!):** Have been invited to participate in this dialogue as representatives of the 'citizen' perspective. Your views are important to making sure that NICE's policies reflect the values and aspirations of the public – and what matters most to you. **About the dialogue / What we're doing together** • Overview of the dialogue process **How we'll work together** • Explain tone and nature of the dialogue (relaxed and informal) • Cover ground rules (respecting each others' views, no right or wrong answers, plenty to cover) • Expectations of everyone in the room (Thinks, NICE/SW, participants) • How data is used (ethics, confidentiality) **The agenda for today** • Overview of the agenda **Introductions** Lead facilitator to provide instructions: Participants to introduce themselves to the person sitting next to them. Each participant to then introduce their partner to the rest of the group: • Please tell us your partner's first name, whereabouts they live, and what they do with their spare time?	
Inclusive language Aim: To build understanding of the	**<u>Inclusive language</u>** In plenary:	10 min 1:15-1:25pm

importance of language in speaking about experiences	We're going to be talking about the health and care system, which impacts a lot of different people in society in different ways. **What is inclusive language?** Inclusive language is language that is free from words, phrases or tones that reflect prejudiced, stereotyped, or discriminatory views of particular people or groups. It's not about avoiding words that are 'not politically correct', it's about recognising that the way we talk about other people can affect them, even if we don't intend to. **Why is inclusive language important?** Using inclusive language helps us to: • Promote dialogue and a comfortable environment for everyone • Avoid false assumptions about people • Promote respectful relationships and interactions that bring everyone into the conversation We are going to complete a short activity to get us thinking about the language that we use over the course of the coming dialogue sessions, and how we make sure we are being inclusive. You will be spending time today working in smaller breakout groups, which you will go into now. In breakout groups: This worksheet has some examples of, and alternatives to, language that could be discriminatory. • Please look at one sentence each and take a minute to think about whether anything in that sentence could be difficult for someone to hear, and how it could be phrased differently. Facilitator to allocate one sentence to each participant and allow 1 min for them to complete the worksheet. Then ask them to share their revised sentences and explanations for why the example is not inclusive. If participants struggle to provide an answer, refer to the answer key.	

How the health system works (1) Aim: To build contextual understanding of how the health and care system works	Lead facilitator to thank participants for completing the inclusive language activity and set up the next session: exploring the health and care system in the UK. In breakout groups: • NICE provides guidance and advice to improve outcomes for people using health and social care. Therefore, throughout the sessions we will use the phrase the 'health and social care system'. • Before we get started, it would be great to understand your impressions of how our health and social care system works for people and any challenges it currently faces. • Please note – this isn't about testing you on your knowledge, we just want to hear about the different parts of the system that you know about and your impressions of these. Facilitator to check participants have post-it notes and pens. **Talk** through each of the following, allowing participants time to **write down** their thoughts at each stage (one thought per post-it). Facilitator to arrange post-its on the **flipchart** to build the map of the health and care system (using the template worksheet as an example). If participants struggle to identify services beyond the 'typical' e.g. GP, hospital, encourage them to think about how they manage their health and care more generally. 1. What health or social care services have you used recently? 2. Who did you see? 3. Where did you see them? 4. Who did they work for? 5. Who was in charge of them? Who makes sure they are providing good quality care? • What challenges or opportunities do you think the health and care system currently faces? • Which parts of the system do you think face more or different challenges / opportunities to the others?	15 min 1:25-1:40pm

	Facilitator to write challenges on post-it notes and add to the diagram mapped out previously.	
How the health system works (2) Aim: To build contextual understanding of how the health and care system works	In plenary, lead facilitator to introduce the next activity: We'd now like you to give you some more information about the health and care system. **Play video** on how the health and social care system works and current challenges faced. Video to cover: • Chain of responsibility from Government setting health and care priorities, to NHS England and local organisations organising and commissioning services. These services are delivered by hospitals, GP surgeries etc. • There are organisations that provide guidance, check on quality and help the system to improve e.g. CQC (note that they perform a different role to NICE, with the latter not assessing performance 'on the ground') • NICE issues guidance about how to deliver the best health and care, and it covers anything from medicines, bandages, pace-makers and treatments. • What's happening in the health and care system now – organisations working together in different ways, technology having an impact, more pressure on the system. • This is the background in which NICE is trying to provide advice on best practice and getting value for money. Around the room you will see that there are various pieces of information about the health and care system, ranging from how it works to key issues/challenges. In pairs, we'd like you to complete the **Discovery activity in your workbook** using the information dotted around the room and our previous exercise. If you find information about any parts of the health and care system which we did not discuss previously, you can pop them on a post-it and add them to our H&C map. Please also take a look at the other breakout	25 min 1:40-2:05pm

	group's H&C map, and be prepared to report back to your group on how it was similar or different. We will then discuss what you've found in your breakout groups. Facilitator to ensure participants each have their workbook and know where to complete the activity. Allow participants 15 minutes to complete the activity in pairs and once complete probe the following when back in breakout groups: • How do you feel about what you've just found out? • What things stood out? In what ways? • Considering we've already discussed the health and care system, what bits of what you found out surprised you? In what ways? • Are there any further questions or information you'd want to know? Why? We've also included key issues/pressures on the health and care system. • Which of these stood out? Why? • Which ones were new to you? • And are there any you think are missing? Breakout group facilitators to note down participant questions throughout. Support facilitator will share these via Teams chat while participants are completing the next activity. NICE representatives attending can answer these in the following section, or questions can be 'held' and answered by experts in the online session.	
Introduction to NICE and their role Aim: To explain NICE's role and clarify its remit and ensure the	Participants from both breakout groups to view projector/main screen. Lead facilitator, in plenary – this section will be conducted 'live' via Zoom to provide all locations with an opportunity to hear from each other and participate in Q&A with NICE. Now we're going to learn more about NICE, their role, and the importance of your input into this dialogue.	25 min 2:05-2:30pm

dialogue stays focused on this	**NICE Executive Director of NICE's Science Evidence and Analytics Directorate (Nick Crabb) to welcome participants and reiterate the importance of their input as part of this dialogue.** Lead facilitator in to introduce Nick who will explain who NICE are and what they do. Close with a conversation between lead facilitator and Nick about which elements of the H&C map NICE covers. Content to cover: • Who NICE are and what they do • NICE's purpose and remit • Who NICE advises • Discussion of which parts of the system NICE interacts with using an example of a map created by participants earlier in the workshop **NICE representative to present slides on NICE and how they provide guidance.** Lead facilitator to ask participants to take 2 minutes to write down their questions about NICE's role and remit. • Facilitators will collate questions on a central 'live' Thinks document, and prime volunteers in each location to ask their question directly to the NICE team as part of the Q&A via Zoom Moderator to ask each location to ask 1-2 questions directly, with further questions also to be answered in the Q&A if time allows (otherwise questions are logged and fed back after the break). NICE representatives to join Q&A	
Break	**–**	15 min 2:30-2:45pm
The importance of prioritisation – Why prioritise? Aim: To build familiarity with	Lead facilitator to welcome back participants, in plenary. Now we're going to talk about prioritisation: what this means in everyday life, and then specifically what it means for NICE. In breakout groups for around 3-4 minutes:	20 min 2:45-3:05pm

the concept of prioritisation, and how and why NICE does this	• What does the word 'prioritise' mean to you? [Looking to differentiate prioritisation i.e. what to do first, vs rationing i.e. what to cut back on] • Thinking about your everyday life, which situations require you to prioritise, when you have a set amount of resources e.g. money or time? • How do you make those decisions? • Are there things that you trade-off or balance as part of making those decisions? In plenary, lead facilitator: I'd now like to share a presentation from Jonathan Benger, Chief Medical Officer at NICE who is leading on the new prioritisation process. He will speak about this project in more detail, and more importantly, why NICE prioritises and the importance behind it. **[Play Jonathan's pre-recorded presentation]** Content to cover: • What NICE does and doesn't do • Example of NICE's guidance in action • How NICE makes decisions (and the role of the public within this) • Focus for this dialogue – How can NICE decide what matters most? Summary of narrative: The scale of what NICE covers is huge. We have heard about the context of pressure facing the health and care system. NICE can't produce recommendations on everything all the time because: 1. The health and care system can't follow or keep track of them all 2. NICE don't have the resource/ capacity to do this All of NICE's guidance aims to offer value, but some areas will be more valuable than others for the health and care system. NICE therefore needs to focus on what matters most. But there are key questions we need to answer – and gain your views on – in order to do this:	

	• How can NICE decide what matters most? • What should NICE consider when they think about this? In breakout groups: • Before we explore prioritisation in more detail, do you have any initial questions about what you've just heard? Participants from both breakout groups to view projector/main screen. Moderator in Preston to facilitate in plenary, short clarification Q&A with NICE representatives via Zoom with questions from each location.	
Prioritisation in practice Aim: To explore examples of how NICE prioritises, and the importance of doing so well	In breakout groups. Thinking about everything you have heard about NICE's role, and the challenges within the health and care system: • What types of issues or concerns do you think would be at the 'top' of NICE's priority list? Why? Facilitator to encourage participants to start thinking about 'ordering' priorities and differentiating between topics that are a high priority (e.g. maternity care or older people) and the reason for them being a priority (e.g. clinical need, inequality etc) Aim is to capture high level spontaneous views on perceived domains of prioritisation, based on the key challenges raised earlier – encouraging the group to think about key issues / considerations rather than getting into specifics of e.g. certain treatments. To return to this in later discussion about 'what NICE should focus on'. Based on what you have heard about how and why NICE prioritises, we're now going to talk about how prioritisation could help NICE achieve positive impacts. • What would be a 'positive' outcome of NICE prioritising effectively? Why? ○ How would this impact some of the challenges we have discussed?	30 min 3:05-3:35pm

	• What would be a 'negative' outcome, or missed opportunity, as a result of NICE prioritising ineffectively? Why?
	  ○ How would this impact some of the challenges we have discussed?
	
	NICE wants to make sure that they do not miss opportunities to help the system by developing guidance on high priority areas. We're going to discuss some hypothetical examples of the impact that NICE's prioritisation could have. Please note, as for all the case studies we will be showing you throughout this dialogue, these are not real scenarios. They are just situations that might reflect the types of issues that NICE has to consider.
	
	Facilitator to share three hypothetical 'impact' scenarios, and discuss response to each in turn:
	1. NICE commits to developing a new guideline on one big area as part of its workload for that year. It would take about 2 years to produce. This means delaying guidance in other areas until resources are available.
	2. NICE prioritises developing guidance that has potential to improve health and care outcomes for as many people as possible (e.g. for a large group of people with a common condition)
	3. NICE prioritises developing guidance on an area that is not considered a key priority or 'challenge' by the health and care system
	
	• What is your response to this?
	• What do you think the outcome of this hypothetical situation would be? Why?
	  ○ For who?	

What NICE should focus on Aim: To surface	In breakout groups: Let's revisit our earlier discussion about the types of things that NICE might prioritise.	20 min 3:35-3:55pm

spontaneous views on what NICE should consider when prioritising	• Based on everything we have discussed, how do you think NICE should decide what is most important to focus on?
	• What areas should NICE consider in order to identify what matters most? Why these?
	• What would be the benefits of considering these areas?
	  ○ For who?
	  ○ Probe on perceived impact for patients, health and care system
	  ○ Facilitators to understand spontaneous views of key criteria, to understand baseline expectations before sharing the domains. If participants struggle to grasp this activity, encourage them to think back to their earlier conversation about the things NICE should prioritise, and what should inform that.
	• What would your 'top 3' areas of consideration be?
	
	Facilitators to capture the 'top 3' areas for each breakout group in the table in the running slides, for the lead facilitator in London to share via shared Zoom link at the start of the next section.	

Sharing and introducing NICE domains Aim: To explore initial responses to the domains and identify any missing gaps	Participants from both breakout groups to view projector/main screen. In plenary – via Zoom link Lead facilitator in London to talk through the top 3 areas of consideration that have been shared by each location – 'here is what we heard from all of you' – as a starting point before exploring the domain areas currently being considered by NICE. Here are some areas that NICE thinks are important to consider, based on what we know about the challenges facing the health and care system. We are going to discuss these in more detail: • **Health and care need:** How many people are affected by the problem, and what impact does it have on their lives? • **Evidence availability:** How confident are we about the impact this guidance could have?	30min 3:55pm - 4:25pm

	• **Budget impact:** What impact will this guidance have on health and care system budgets? • **System impact:** What will change in the health and care system if we produce this guidance? • **Health inequalities:** Would this guidance help to ensure that people from different backgrounds don't experience different health outcomes? • **Sustainability:** Would this guidance reduce the environmental impact of the health and care system? In breakout groups, facilitator to facilitate discussion of criteria: • What are your initial reactions to this? • How do these areas compare with those you felt are important for NICE to consider? • What other criteria could you add to this? What makes you say that? In breakout groups, participants to use example diagram to draw their own diagram ranking the topics in terms of the ones they think are most important, then briefly discuss as a group: We will be discussing these areas in much greater depth in the upcoming sessions, but at this stage we would like to hear which you think are the most important and least important. • Are there any areas not currently included here which you would add? Refer back to earlier discussion if needed Facilitators to collect ranking sheets from their participants. Ranking exercise to be repeated throughout the dialogue sessions.	
Wrap-up and close	Participants from both breakout groups to view projector/main screen. In plenary- via Zoom link Brief 1 minute summary of discussion from each lead facilitator across all four locations via Zoom link. Back in each location, in plenary, lead facilitator to:	5 min 4:25-4:30pm

	• Briefly recap what has been covered/discussed in the session. • Remind participants of what is coming up in the fieldwork period and when (next 3 sessions are online). • Explain that incentives will be paid via our payment platform, Ayda. • Ask participants to fill out evaluation questionnaires (lead facilitator or Sciencewise observer to hand out) • Thank everyone for their hard work and close.	

Stimulus

The materials used in workshop 1 include:

- Running slides, participant workbook, impact scenarios, and posters providing contextual information on the health and care system. These are available upon request.
- Some videos were shown to participants which are not in the public domain. These include a video explaining the structure of the health and social care system, and an interview recording with Jonathan Benger, Chief Medical Officer, at NICE who is leading on the new prioritisation process.

Participant Workbook

Participants were provided with a workbook at the beginning of the dialogue. This included a summary of the contextual information discussed in Workshop 1 such as an overview of the key challenges facing the health and care system and an introduction to NICE. The original version of the participant workbook is available upon request.

Page 1: Welcome

Thanks for taking part in the project!

We are Thinks Insight & Strategy, an independent research company running this research on behalf of the National Institute for Health and Care Excellence (NICE).

In the sessions, we would like to find out more about your views on how NICE can decide what matters most to the health and care system.

If you have any questions at any point, please get in touch with us on 020 7845 5880 or email: nice-listens@thinksinsight.com

Thanks again for agreeing to participate and we really look forward to working with you!

Page 2: Using this workbook

This workbook contains information about the topics we will be discussing throughout the workshops.

This includes more context about the health and care system and some of the challenges it is facing.

There are also spaces for you to write down your thoughts and complete some short activities.

If you need extra space to write your thoughts down, feel free to use the extra sheets of paper, at the back of the booklet.

Page 3: The health and care system

At a glance:

Most health and care services in England are paid for from our taxes. That means that the Government is responsible for setting overall priorities and budgets. The Government doesn't organise the health and care services you receive directly, they delegate that to NHS England.

NHS England commissions some specialist health services directly. But most of the time they allocate funding to a more local level.

Local organisations (called integrated care systems) work together with other local groups to commission the healthcare that people in their area need.

Under that you have all the health services which deliver the care (e.g. GP surgeries, hospitals).

Social care is funded mostly by local authorities. They commission local services from a range of different companies and organisations.

Public health is also delivered locally, and includes services aimed at preventing people from getting ill in the first place, like sexual health clinics and vaccination programmes.

Ensuring quality:

There are several different organisations that provide guidance, check up on quality and help health and care organisations improve.

The Care Quality Commission (CQC) inspect different health and care settings to make sure they're up to scratch. The CQC have an important role in ensuring that organisations are run safely, but they don't advise them on the best treatments to offer.

The National Institute for Health and Care Excellence (NICE) produce guidance to help practitioners and commissioners get the best care to patients while ensuring value for the taxpayer.

The guidance can cover anything from medicines, to blood tests and pacemakers to whole guidelines on how to diagnose and manage a condition. Some of NICE's guidance is mandatory for healthcare providers to follow, and some is advisory.

NICE differs from CQC, in that they do not assess performance 'on the ground'.

Page 4: Key challenges facing the health and care system

The health and social care system is currently under a lot of pressure. Some of these challenges include:

- **High demand and an ageing population**: The UK has an ageing population, with increasingly complex healthcare needs. People are living longer and, as they age, their healthcare needs change (e.g. managing multiple conditions and a rise in non-communicable diseases). This means there is a greater number of people relying on our health and care systems.
- **Workforce shortages**: Although the NHS workforce has been growing, demand for NHS services has been growing faster, and the health service hasn't been able to recruit and retain enough staff to keep up with demand.

- **Health inequalities**: Health inequalities are avoidable, unfair and systematic differences in the status of people's health, and between different groups of people. In the UK, health outcomes vary for different groups of people, based on things like their age, gender, income and where they live.
- **Keeping up with new innovations**: Both a challenge and an opportunity, there are many new technological innovations which could revolutionise the way in which health and care are delivered in the UK. However, these are often costly and difficult to implement, which makes it hard to keep up with change.

Page 5: Discovery Activity

Q1. What is an example of a service that the health and care system commissions?

Q2. What are three key opportunities where the NHS could innovate?

Q3. What are three key pressures on the NHS?

Q4. What is causing increased demand for NHS services?

Q5. What are some of the pressures NHS workers face?

Q6. Name one public health campaign launched by the Government

Q7. Please list four groups of people who are vulnerable to health inequalities

Q8. Were there any differences between your breakout group's map of the health and care system, and the other group's?

Please note down any other comments or reflections on any of the information posters in the space below.

Page 6: Introduction to NICE

Who are NICE?

NICE is an organisation that provides national guidance and advice to improve health and social care.

They help health and social care practitioners and commissioners to get the best care to people, while ensuring value for the taxpayer.

NICE uses the best available evidence to develop recommendations. Guidance can take between 6 months to 2 years for development. Guidance and recommendations are made by independent committees.

Example of NICE's work in action:

- A guideline for clinicians on diagnosing, monitoring and managing chronic asthma. Includes an aid to help patients and clinicians consider the environmental impact of each inhaler choice
- NICE recommends 4 digital mental health therapies for early use on the NHS to help children and young people with symptoms of mild to moderate anxiety

Page 7: What do NICE produce guidance on?

- **Guidelines**: NICE develops guidelines for managing health conditions – called 'clinical' guidelines – as well as for broader services (e.g. social care) and improving community health (e.g. through public health).
- **Antimicrobial prescribing**: NICE provides guidance for managing common infections in relation to tackling antimicrobial resistance. This happens when bacteria and viruses no longer respond to medicines (e.g. antibiotics).
- **Technology appraisals**: NICE provides recommendations on the use of new and existing medicines and technologies within the NHS, as well as surgical procedures and medical devices. *(Note: medicines are not in scope for this dialogue)*
- **Interventional procedures**: Interventional procedures are used to diagnose or treat conditions. NICE guidance recommends whether procedures (e.g. laser treatments for eye problems) are effective and safe.
- **Medical technologies:** NICE evaluates and provides guidance on innovative new medical devices and diagnostics (e.g. devices implanted during surgical procedures, or to monitor conditions).

Page 8: NICE's prioritisation challenge

The scale of what NICE covers is huge, and there are many different challenges currently facing the health and care system that need to be addressed.

NICE can't produce recommendations on everything all the time because:

1. The health and care system can't follow or keep track of them all
2. NICE don't have the resource/ capacity to do this

All of NICE's guidance aims to offer value, but some areas will be more valuable than others for the health and care system. NICE therefore needs to focus on what matters most.

Our key question for this dialogue is how can NICE decide what matters most?

Page 9: Areas that NICE could consider

NICE has started to think about the areas that could be important to consider when they decide what matters most to the health and care system.

- **Health and care need**: How many people are affected by the problem, and what impact does it have on their lives?
- **Evidence availability**: Is there evidence available to produce impactful guidance?
- **Budget impact**: What impact will this guidance have on health and care budgets?
- **System impact**: What will change in the health and care system if we produce this guidance?
- **Health inequalities**: Would this guidance help to reduce differences in health outcomes for people from different backgrounds?
- **Environmental sustainability**: Would this guidance help to reduce the environmental impact of the health and care system?

4. Deliberation: Workshops 2-4

Workshop 2: Discussion Guide

Section and aim	Key questions and probes	Time

Introduction
 	
Aim: To welcome participants to the session and explain the focus for the day
	Plenary
	
	Lead facilitator to welcome participants and talk through where we are in the process:
	
	• Who is in the room
	  ○ Thinks
	  ○ NICE
	  ○ Specialists:
	  • Bryony Kendall - GP
	  • Peter Barry - Consultant Clinical Adviser, NICE
	
	• What we have done so far, what the online workshops will focus on and what we will cover in the last face-to-face workshop
	• Why we're here
	
	Sharing 'what we covered' in the previous session and the areas NICE could consider.
	
	Sharing key points from 'what we heard' last time.
	
	Alice to spend 5 mins clarifying the 'questions about NICE'
	
	What we will focus on over the course of the coming 3 workshops:
	
	• Today: How NICE thinks about health and care need, and the availability of evidence
	• Next time: The potential impact of the guidance on health and care budgets and the health and care system
	• Third session: The potential impact of the guidance on two big priorities for the health and care system, environmental sustainability and health inequalities
	
	Explain how the breakout groups will work over the coming workshops and introduce the 'home group'.
		15 min
		
		6-6:15pm

Introduction: Health and care need Aim: To introduce the basic concept of health and care need	Plenary Lead facilitator introduces basic definition of health and care need, and key considerations [see running slides], explains that this will be the main focus for today, and that NICE are keen to understand what is most important	5 min 6:15-6:20pm
Activity: What's the health and care need? Aim: to understand participants views on how health and care need is defined, what's important to them within it	THINKS FACILITATOR TO PRESS RECORD In breakout groups. Specialists and NICE spread across groups – one specialist/NICE staff member per breakout group. Breakout facilitator, participants, and specialist to introduce themselves (sharing their name and where they live). **What are your immediate thoughts on the definition of health and care need shared just now?** • How important does this seem as an area for NICE to consider when prioritising topics for guidance? • What is your gut instinct about what's most important within the broad area? [Facilitator to listen out for different ways of measuring/categorising health and care need] Facilitator to introduce activity. **We're going to look at some examples of scenarios that NICE could provide guidance on, you'll see that they cover a wide range of different things from specific treatments, to particular conditions, to public health issues and medical technologies.** [NB: Topics here are drawn from the case studies used in the other areas, building familiarity] **We'd like to hear from you about what you think the health and care need is in each case.**	30 min 6:20-6:50pm

	Each breakout group to cover **3 x scenarios** in-depth. Scenarios to be rotated across breakout groups to ensure coverage. Facilitator to cover for each:
	• What do you think the health and care need is in this scenario?
	• What information would you need to understand the health and care need here?
	• Probe on:
	  ○ Who is impacted?
	  ○ How many people are impacted?
	  ○ How severe is the impact?
	  ○ Does treatment already exist for this?
	  ○ What's the knock-on impact e.g. on peoples' lives / wider society [thinking about social care]
	Once initial views shared by participants, specialists can be prompted:
	• What does this issue look like in practice, in your experience?
	• What else you would mention about this?
	• What other perspectives are there on this issue that we have not discussed?
	And know we'd like to hear which of these topics you would prioritise for new guidance, if you were NICE. [Remind participants that this isn't about prioritising a particular disease or group of patients, it's about what you should take into account when you prioritise.]
	• What would you put at the **top**? What makes you say that?
	• And what would you put at the **bottom**? What makes you say that?
	• Where do you disagree? What do you need to know to make these decisions?
	Facilitator to reorder boxes on slide in line with discussions	

Introduction: evidence availability Aim: To define evidence and	Plenary Lead facilitator to introduce **Next, we're going to talk about evidence. Here's a quick introduction from NICE about the**	5 min 6:50-6:55pm

explain why it is important for NICE to consider	**importance of evidence to them as an organisation.** NICE representative to present slides on the definition of 'evidence availability', and why this is important for NICE.	
Discussion: what does evidence mean to you? Aim: Participants familiarise themselves with the role that evidence can play in decision making	In breakout groups **How do you use evidence to make decisions about your own health and wellbeing?** • Where do you look for information? • Who/what do you trust? • How do you know that the advice you follow is good? • How important is it that the information is up to date? Facilitator to probe on different types of evidence, including scientific, personal experience, word of mouth, patient experience. Facilitator to capture notes on slide: How do you use evidence to make decisions?	10 min 6:55-7:05pm
Panel discussion: Using evidence to make decisions Aim: Participants hear different perspectives on evidence availability – direct from specialists	Plenary Lead facilitator to invite specialists to join a panel discussion. Each to introduce themselves: • Bryony Kendall – GP • Peter Barry - Consultant Clinical Adviser, NICE Each specialist to spend c. 3-4 minutes talking about 1-2 examples of times where evidence has played a part in decision making for them in their role. To include situations where: • Times where there is not a lot of evidence available • Times where the evidence is ambiguous / uncertain • Times where there has been plenty of evidence Examples could be:	15 min 7:05-7:20pm

	• New innovations that promise to make a real difference to participants, but don't have a strong evidence base yet • Urgent issues (e.g. pandemic) which allow no time to develop a mature evidence base • Rare conditions which affect fewer people, so generating evidence can be difficult • Where lots of high-quality evidence exists and there's no variation in practice – so perhaps NICE doesn't really need to produce guidance? Examples should follow this basic structure: • The challenge you faced • What worked well? • What could've been better?	

Importance of evidence
 	
Aim: Participants to discuss the importance evidence based on what they heard from specialists
	In home breakout groups
	
	Specialists and NICE spread across groups – one specialist/NICE staff member per breakout group.
	
	Welcome to your 'home' group. This will be the same group you return to at the end of each online session, so that you can reflect together on the information you are hearing over time.
	
	Participants to introduce themselves: Name and location
	
	Thinking about everything you have heard:
	
	• How important is it that NICE always considers evidence?
	  • Why / Why not?
	  • Probe on caveats to this e.g. ensuring quality/standards of evidence, as well as prioritising it
	
	• How should NICE respond when:
	  ○ There is not enough evidence?
	  ○ The evidence is ambiguous?
	  ○ There is plenty of evidence?
	  ▪ For all situations: What makes you say that?
	  ▪ In what sorts of situations would you feel differently about this? In what ways is this different?
		20 min
		
		7:20-7:40pm

	○ Facilitator to be alert for differences of opinion among participants and probe on these Facilitator to capture notes on slide Once initial views shared by participants, specialists can be prompted / ask for clarification: • What does this issue look like in practice, in your experience? • What else you would mention about this? • What other perspectives are there on this issue that we have not discussed?	
Discussion: Taking stock of the discussion so far Aim: For participants to reflect on what they have heard that day, and to continue to build their view on balancing the areas and reflect on changes over time	In home breakout groups. **What were your reflections on the discussions you've had this evening?** • How has it informed your views on the importance of health and care need when NICE is prioritising topics? ○ And what about your views on the **most important aspects** of health and care need? • What about evidence? How has tonight's discussion informed your view on how NICE should consider evidence? • What things did you have a different take on or disagreed with? • What further information would be useful to you? In what ways? Capture questions that can be fielded to specialists / NICE representatives, at the next workshop. Facilitator to introduce the diagram as a visual way for us to keep track of how important we think each of the key areas are as we build our understanding of them. • Based on what we have discussed today, where would you place each of the areas? Which feel more or less important? **Why?** • Facilitator to probe on areas of agreement / disagreement and the reasons for this	15 min 7:40-7:55pm

Wrap-up and close Aim: To close the session and answer any questions Plenary	Plenary Lead facilitator to capture key reflections from each breakout group (shared by each facilitator). Thank participants and explain next steps in the process.	5 min 7:55-8:00pm

Workshop 2 Stimulus

Information provided to participants to explain and introduce health and care need

What do we mean by 'health and care need'?

The extent of the health and care problem. For example, people may be living shorter lives or have a reduced quality of life as a result of the problem. There may be a negative impact on family or carers. Or there might be limited treatment options available.

Why is health and care need important for NICE to consider?

It's what NICE are here for. If producing guidance wouldn't help to solve a health and care problem, then it's either not needed at all, or is the responsibility of another organisation.

There are some challenges when thinking about health and care need…

- It's subjective! People's experiences of ill health are very different – how do you measure them?
- It's a numbers game… or is it? Some conditions affect a small number of people very significantly, others affect many people less seriously.
- Emotions can run high. When it comes to some topics, like children's health for example, emotions can run high and lead to very different views, compared with other areas.
- There are so many different types of need, from the acute to the ongoing, from prevention to prediction. It's like comparing apples and oranges.

Health and care need scenarios to consider

- Covid-19: Identifying treatments for a new illness.
- Maternity care: Women from some ethnic groups experience worse outcomes.
- Asthma: 60 million inhalers are used in the UK every year.
- Dementia: Diagnosing people earlier could lead to earlier treatment.
- Smoking: Causes significant levels of preventable ill health.
- End of life care: For patients in the final weeks or months of their life.
- Long waiting lists for hip replacements: Leads to prolonged pressure on the health system.

Information provided to participants to explain and introduce evidence availability

What do we mean by 'evidence availability'?

When developing guidance, NICE reviews the evidence relevant to the topic. That evidence is quality assessed to ensure it is useful and accurate.

Examples of evidence used by NICE:

- Published studies (i.e. experiments trialling an intervention in a test group of patients)
- Expert opinion (of practitioners, people using services, family members and carers)
- ”Real world data" from anonymised databases and healthcare registers

Why is evidence availability important for NICE to consider?

- NICE’s role is to improve health and wellbeing by putting science and evidence at the heart of health and care decision making.
- It's important that decisions and guidance are rooted in evidence that demonstrates the effectiveness of a treatment, technology, or other course of action. Without evidence, we don't know whether a new treatment might harm patients or be a waste of money if it has no effect.
- The quality of that evidence is assessed to understand how reliable it is. Higher quality evidence means that NICE can be more certain about their recommendations.
- Being a good doctor doesn’t necessarily mean being a good research scientist, so part of NICE’s job is to understand the evidence and make it available for practitioners.

Evidence availability scenarios

How should NICE respond when:

- There is plenty of evidence.
- The evidence is not clear.
- There is not enough evidence.

Workshop 3: Discussion Guide

Section and aim	Key questions and probes	Time
Introduction Aim: To welcome participants to the session and explain the focus for the day	Plenary Lead facilitator to welcome participants and talk through where we are in the process: • Who is in the room • Reminder of the purpose of the dialogue What are focusing on over the course of the 3 online workshops: • Last time: Which problems NICE should address with its guidance – health and care need, and evidence availability • This time: The potential impact of the guidance on health and care budgets and the health and care system • Next time: The potential impact of the guidance on two big priorities for the health and care system, environmental sustainability and health inequalities	10 min 6:00-6:10pm
Introducing: Budget impact Aim: To share information about budget impact to facilitate discussion	Plenary We are going to share a bit more information with you about taking budget impact into consideration. If you have any initial questions, please write these in the **chat function** as we go, and we will put these to our specialists. Don't worry if we don't get a chance to ask all of your questions, as our specialists will be rotating around our smaller breakout groups when we go to these. Lead facilitator presents the budget information running slides, covering: • What is meant by budget impact • How the health and care system budget works and key facts • **Explainer video** of how much it costs to use the health and care system	10 min 6:10-6:20pm

	• Why budget impact is important for NICE to consider Lead facilitator to check chat function for any questions and call on participants to ask them to specialists (time allowing). Participants sent to breakout groups, specialists and NICE representatives to be rotated across the groups.	
Activity: What do you need to know before you spend? Aim: For participants to start thinking about how budget features in the decision-making process	Breakout groups Facilitator to present scenario: I'd like you to imagine you are the Head of Finance for a hospital. 3 colleagues come to your office, each asking you to sign off an investment: 1. A new type of device to manage Type 1 diabetes 2. A new type of treatment, used to treat glaucoma 3. A new type of wound dressing, used to treat leg ulcers **Putting yourself in the shoes of the Head of Finance:** • What questions do you ask your colleagues about these investments? • What information do you need to make a decision about these investments? If participants struggle to respond, prompt them to think about what they consider when prioritising themselves, based on financial factors (as discussed in Workshop 1, e.g. long term savings, quality over low cost) Facilitator to note down spontaneous thoughts on slide.	10 min 6:20-6:30pm
Considering budget impact	Plenary Lead facilitator introduces the specialists, who will discuss some **key considerations and challenges** associated with focusing on budget impact. • Main specialist: Clare Morgan, Director of Implementation & Partnerships at NICE	10 6:30-6:40pm

	• Support specialist: Neil O'Brien, GP and Executive Medical Director for North England and Cumbria Integrated Care System & Jason Lane, Programme Leader (Contracts, Commissioning and Market Management), Adults and Health Directorate, Leeds City Council
	
	Lead facilitator to lead discussion by asking Clare questions about budget impact, with Neil & Jason then invited to offer reflections:
	
	• Why is budget impact important when prioritising topics for NICE guidance?
	  ○ Probe on common misinterpretation that NICE might 'rule out' developing guidance on things that are too expensive
	• Are there examples of times where it has been challenging to consider budget impact when developing guidance?
	  ○ E.g. An intervention that has high upfront costs, but lower running costs longer term
	  ○ E.g. An intervention that can offer savings by streamlining services, but will require a lot of wider system investment to make its use feasible
	• How does NICE overcome these challenges? (e.g. making sure decisions that involve substantial costs or savings are informed by rigorous evidence review)
	
	Participants go to breakout groups to discuss in more detail. Specialists and NICE representatives to rotate around each group, and to be on hand to answer questions where possible throughout the discussion.	

Discussion: Budget impact Aim: For participants to discuss	Breakout groups **What was your response to the information presented by the specialists?** • Opportunity for specialists in each group to answer any questions	30 min 6:40-7:10pm

this area in more detail	Group to spend c.8 mins discussing each case study in turn, covering all three. Order to be rotated across groups (case studies expand on the proposals discussed in the warm-up). Facilitator to lead discussion of each case study: • How important is budget impact in this example? • What should NICE consider in relation to budget impact in this example? • What are the trade-offs of considering budget impact here? Case study-specific probes/focus: **1. Wound care (low budget impact)** • How do the short- and long-term costs balance in this example? • What are the trade-offs here? • Probe on: environmental impact of single-use products, system impact of reducing demand on other services **2. Treating Glaucoma (no budget impact)** – likely will spend less time discussing this example • If there is no budget impact, should NICE prioritise developing guidance on this as a 'quick win'? • What are the trade-offs here? • Probe on: health and care need / how many people it impacts, health inequalities **3. Managing Type 1 diabetes (high budget impact)** • How does budget balance with potential health benefit in this example? • What are the trade-offs here? • Probe on: health and care need, high upfront cost and system impact. **Having looked at these three examples, what are the top 3 things that NICE should consider when prioritising based on budget impact? Why are these important?**	

	Facilitator to capture on screen and probe on areas of agreement and disagreement within the group.	

Introducing: System impact
 	
Aim: Introduce system impact and clarify its definition before further exploration
	Plenary
	
	I am going to share some information with you about system impact and what it means.
	
	Lead facilitator presents the system impact definition running slide(s) and covering:
	
	• What do we mean by system impact?
	• Why it's important for NICE to consider system impact.
	
	Lead facilitator introduces the specialists, who will discuss some **key considerations and challenges** associated with focusing on system impact.
	
	• Main specialist: Neil O'Brien
	• Support specialist: Clare Morgan & Jason Lane
	
	Lead facilitator to lead discussion by asking Neil questions about system impact, with Clare & Jason then invited to offer reflections:
	
	• Why is system impact important for NICE to consider?
	• Could you share an example of a time where you rolled out a new service/device/pathway recommended in NICE guidance?
	• What makes it challenging to consider system impact?
	  ○ E.g. The health and care system is constrained by budget, staffing and infrastructure
	  ○ E.g. New interventions may be disruptive when first introduce, but have a positive impact long-term
	  ○ E.g. System changes like increased digital care, might benefit some but exclude others
	  ○ E.g. System changes might improve patient outcomes but impose a burden on healthcare professionals (and vice versa)
		15 min
		
		7:10-7:25pm

	Participants go to breakout groups to discuss in more detail. Specialists and NICE representatives to rotate around each group, and to be on hand to answer questions where possible throughout the discussion.	

Discussion: System impact
 	
Aim: For participants to discuss the domain in more detail
	Breakout groups 'home groups'
	
	What was your initial response to the information shared?
	
	• What, if anything, surprised you? Why?
	• What did it make you think / feel about system impact being considered as part of NICE's prioritisation process?
	
	Specialists to support discussion with their perspective on the trade-offs and challenges.
	
	We're now going to focus on two case studies, each representing a potential topic of NICE guidance and the impact it could have on the health and care system.
	
	You will have a chance to ask our specialist questions about these case studies throughout.
	
	Facilitator to present case studies, rotating which case studies are shown to each group:
	
	• Groups 1,2,3,4 – Cover Virtual Wards, then Falls Prevention
	• Groups 5,6,7,8 – Cover Falls Prevention, then Virtual Wards
	
	Case studies: System impact
	
	Two case studies that speak to different areas and trade-offs that occur when assessing system impact:
	
	• **Case study 1 – Virtual wards:** Trade-off between challenges rolling it out everywhere and potentially negatively impacting a subgroup of patients.
	• Specific probes:
	  ○ Where does the balance sit between benefiting healthcare workers and patients?
	  ○ How much does health inequality need to be factored into decisions which involve big, infrastructure shifts?
		25 min
		
		7:25-7:50pm

	- Does the severity of the condition of the group positively impacted influence your decision? **Case study 2 – Falls prevention programme:** Trade-off between an easily implementable programme vs. cost and potential for health inequality. - Specific probes: - Where does the balance sit between benefiting healthcare workers and patients? If an infrastructure change has the potential to positively impact current structural issues within the NHS, e.g. waiting times for primary treatment, how willing are you to experience an immediate negative impact while the infrastructure is being created? **For each case study:** - What is your response to this example? - Do you have any questions about this example? - How important is system impact in this example? - What should NICE consider in relation to system impact in this example? - What are the trade-offs of considering system impact here? Specialists to be prompted by the facilitator once participants have shared their views to contribute to the discussion: - What does this issue look like in practice, in your experience? - What else you would mention about this? - What other perspectives are there on this issue that we have not discussed? **We're going to return to the case studies you all explored earlier when discussing budget impact:** - What would the system impact be in these case studies?	

	○ What, if anything, did your group discuss in relation to system impact when exploring these? • What are the trade-offs in this case study? • Do you have any other thoughts on the system impact in these case studies, based on what you have heard since? **Having looked at these examples, what are the top 3 things that NICE should consider when prioritising based on system impact? Why are these important?** Facilitator to write down on slide and probe on areas of agreement and disagreement within the group.	
Discussion: Taking stock of the discussion so far Aim: For participants to reflect on what they have heard that day, and to continue to build their view on balancing the areas and reflect on changes over time	Home groups: 6 x groups of 8 – mix of 2 people from each location. • What were your immediate reactions to the discussion you just heard? • Has it changed your view about how important budget and system impact are when NICE are prioritising topics? • Has it changed your view about the most important aspects of budget and system impact? • Did you disagree with anything you heard? Is there anything you would like more information on? Capture questions that can be fielded to specialists / NICE representatives, at the next workshop. Facilitator to introduce the diagram as a visual way for us to keep track of how important we think each of the key areas are as we build our understanding of them. • Based on what we have discussed today, where would you place each of the areas? Which feel more or less important? Why? • Facilitator to probe on areas of agreement / disagreement and the reasons for this	10 min 7:50-8:00pm
Wrap-up and close	Staying in 'home' breakout groups	-

Aim: To close the session and answer any questions	Thank participants and explain next steps in the process. **Remind participants that some of them will receive a new Zoom link for Thursday's session, and to keep an eye out for this on email and text**	

Workshop 3 Stimulus

Information provided to participants to explain and introduce budget impact

What do we mean by 'budget impact'?

The health and care system is under significant financial pressure and works within a fixed budget. This means there is a set amount of money each year that it can spend, and this doesn't change based on how many people get sick or need care.

- The NHS budget is set and funded by the Department of Health and Social Care.

The social care budget is not funded by DHSC; it is funded by local authorities.

Facts about the UK health and care budget:

- The amount spent on health care in the UK increased from around £90 billion in 2000/01 to around £240 billion in 2021/22. This has not accounted for inflation.
- Around 45% of the NHS budget is spent on its workforce (the largest proportion of the budget)
- Local authorities have had their budgets cut by 30% since 2010.

Why is budget impact important for NICE to consider when prioritising guidance?

NICE considers how much something costs, and how much it would save (and would formally assess costs once they have decided to produce guidance on a topic).

Both big savings and big costs are worth NICE providing guidance on because they both potentially make a big difference to the system's budget.

It's not about deciding whether a treatment is too expensive. It's about figuring out where NHS commissioners most need guidance to help them make sensible decisions.

And it's not about making individual treatment decisions – that's for health care professionals to decide.

Budget impact case studies

Case Study: Wound Care

The health and care need: Leg ulcers affect a large number of people in the UK as a result of conditions like diabetes, and this significantly impacts these patients' quality of life.

A new type of wound dressing, UlcerTreat, has been shown to improve the wound healing process for diabetic foot and leg ulcers.

Each individual dressing is not very expensive, but a lot of them are used every year.

Using this type of dressing will mean these patients need fewer GP and hospital appointments to treat their ulcers, and it would also reduce the need for amputations further down the line. There is therefore a longer-term cost saving associated with using this intervention.

The potentially significant budget impact (cost savings) could make it worthwhile for NICE to prioritise developing guidance for this new product.

Note: case study is based on a hypothetical scenario, which is reflective but not representative on an occasion where NICE has previously issued guidance.

Case Study: Treating Glaucoma

The health and care need: Glaucoma is an eye condition that affects almost 500,000 people in the UK, and can lead to vision loss and blindness. People from Black African, Black Caribbean and Asian origin, and older people, are more at risk of developing the condition.

A different type of laser eye technique has been shown to effectively treat glaucoma, and reduces the risk of blindness in a patient as a result.

The technique can be carried out using the existing laser machinery that hospitals currently have in place, but staff will need training.

Using this type of technique will likely have a positive impact for patients and reduce the need for ongoing care to manage the potential impacts of vision loss or blindness.

This technique could offer a 'quick win' with little budget impact, which could make it worthwhile for NICE to prioritise developing guidelines for it.

Note: case study is based on a hypothetical scenario, which is reflective but not representative on an occasion where NICE has previously issued guidance.

Case Study: Managing Type 1 diabetes

The health and care need: Type 1 diabetes is a life-long condition that affects c.400,000 people in the UK, including c.29,000 children. If it is not well-managed, patients are at increased risk of long-term complications such as blindness, kidney failure and some types of heart disease. Current ways to control Type 1 diabetes are burdensome and affect patients' day-to-day life.

The goal of treating Type 1 diabetes is to keep blood glucose within a healthy range by providing the body with additional insulin. Hybrid closed loop systems are devices worn on the body which automatically keep blood glucose levels in a healthy range. They continuously monitor blood glucose, calculate how much insulin is needed and deliver this insulin directly into the body.

Evidence shows these devices are more effective at managing blood glucose than current methods. They also promise to improve quality of life and mental well-being for people with Type 1 diabetes by automating the process of managing blood glucose levels.

However, these devices are a lot more expensive than current treatments. There will also be costs associated with the support package required for these patients, staff training and skills development.

Note: case study is based on a hypothetical scenario, which is reflective but not representative on an occasion where NICE has previously issued guidance.

Information provided to participants to explain and introduce system impact

What do we mean by system impact?

System impact refers to any impact guidance may have on the infrastructure and staff of the NHS.

This includes, but not exclusively, treatment waiting times, and introducing a new service that requires higher staffing levels – or, by contrast, a new service which helps reduce the burden on staff.

The NHS still faces system pressure post-COVID in the form of increased waiting times and staffing shortages. This means it's pivotal for NICE to include this in any guidance discussion.

Why is system impact important for NICE to consider?

NICE must evaluate how its recommendations can enhance the efficiency and effectiveness of the system.

Assessing system impact allows the opportunity to produce guidance that addresses a system need (e.g. relieves pressure or boosts healthcare capacity).

NICE needs to consider whether there is potential for the guidance to be feasibly implemented across the system (e.g. the staff, resources and infrastructure exist to do so).

The potential for a 'knock-on' effect of guidelines for one part of the system negatively impacting other parts of the system.

System impact case studies

Case Study: Virtual wards

The health and care need: The NHS has a shortage of hospital beds, with occupancy rates consistently exceeding safe levels. Bed shortages increase

delays in emergency departments and can delay patient transfer between wards and intensive care units. The pressure on the system has worsened since Covid-19.

Virtual wards allow people to receive treatment and care where they live, rather than in hospital. In some cases, technologies are used that help people monitor their health at home and send information back to health care professionals, such as devices to track pulse, blood pressure or oxygen levels.

Virtual wards can help keep people out of hospital, discharge patients early, reduce clinical time and give patients autonomy and choice.

However, several challenges must be considered. Is the infrastructure in place nationwide to suggest this everywhere without causing health inequalities? Does it run the risk of isolating less tech-savvy patients? How can the need for at-home 'wrap around' care be addressed without long-term investment in social care funding? What is the impact on informal carers?

Note: case study is based on a hypothetical scenario, which is reflective but not representative on an occasion where NICE has previously issued guidance.

Case Study: Falls prevention programme

The health and care need: Falls amongst over-65s is a health concern, with hip fractures, a common fall injury, the most frequent cause of surgery need and accidental death amongst the older population.

On top of the hospital care required immediately after a serious fall, 50% of patients who suffer serious falls those their ability to live independently. This increases strain on social care as more support is required for people with physical disabilities.

The falls prevention programme contains exercise programmes focused on increasing physical activity and reducing falls. A tailored exercise programme can reduce falls by as much as 54%.

While this is guidance that could be easily implemented nationwide, preventing falls requires commissioners, local authorities, and health care professionals from across the whole system to work together. Changing existing processes and sharing data can be very difficult and NICE must consider if the infrastructure exists for this to be rolled out within budget, and equally across the country.

Note: case study is based on a hypothetical scenario, which is reflective but not representative on an occasion where NICE has previously issued guidance.

Workshop 4: Discussion Guide

Section and aim	Key questions and probes	Time
Introduction Aim: To welcome participants to the session and explain the focus for the day	Plenary Lead facilitator to welcome participants and talk through where we are in the process: • Who is in the room • Reminder of the purpose of the dialogue • Reminder of ground rules What are focusing on over the course of the 3 online workshops: • First time: Which problems NICE should address with its guidance – health and care need, and evidence availability • Last time: The potential impact of the guidance on health and care budgets and the health and care system • This time: The potential impact of the guidance on two big priorities for the health and care system, environmental sustainability and health inequalities	5 min 6:00-6:05pm
Introducing: Health inequalities Aim: To share information about health inequalities to facilitate discussion	Plenary I am going to share some information with you about health inequalities and what it means. Lead facilitator presents the health inequalities definition running slide(s) and covering: • What do we mean by health inequalities? (**avoidable** differences) • Why it's important for NICE to consider health inequalities Lead facilitator introduces the specialists, who will discuss some **key considerations and challenges** associated with focusing on health inequalities. Participants asked to **put questions into the chat**, for specialists to answer: • Deb O'Callaghan, Associate Director, NICE • Jonathan Ives, Professor of Empirical Bioethics, University of Bristol	20 min 6:05-6:25pm

	Lead facilitator to lead discussion by asking Deb and Jonathan questions about health inequalities. Questions to focus on key challenges: • **Why are health inequalities important for NICE to consider?** • Access to health and care isn't equal. NICE could recommend a strategy with the potential to help but there could still be areas where to guidance cannot be implemented as easily, so some people remain disadvantaged • Some data on inequalities is limited – for example, on inequalities and mental health, where rates of recognition, reporting, and diagnosis vary between groups. • There is a mix of health-related behaviours (smoking, exercise, diet etc.) which are shaped by cultural, material and social circumstances. Guidance on behaviour change strategies must account for this mix and the reality of people's lives. • Spending resources on any patient group could cause inequalities by limiting resources that could be spent on other areas that may benefit a wider group of people. **Specialist (Deb O'Callaghan) to talk through slides: 'ways of talking about justice', 'mechanisms of health inequalities' diagram and charts.** Lead facilitator to moderate Q&A. Participants go to breakout groups to discuss in more detail. Specialists and NICE representatives to rotate around each group, and to be on hand to answer questions where possible throughout the discussion.	
Discussion: Health inequalities Aim: For participants to discuss the domain in more detail	Breakout groups **Based on what you have heard, how important is it for NICE to consider this area?** • What are the benefits of NICE considering this area? • What is challenging about NICE considering this area? • What are the trade-offs when focusing on this case study?	35 min 6:25-7:00pm

	Specialists to support discussion with their perspective on the trade-offs and challenges.
	
	We're now going to focus on two case studies, each representing a potential topic of NICE guidance and the impact it could have on health inequalities.
	
	You will have a chance to ask our specialist questions about these case studies throughout.
	
	Facilitator to present case studies, rotating which case studies are shown to which group.
	
	For each case study:
	
	• What is your response to this example?
	• Do you have any questions about this example?
	• How important is health inequalities in this example?
	• What should NICE consider in relation to health inequalities in this example?
	• What are the trade-offs of considering health inequalities here?
	
	Case study specific probes:
	
	• **Case study 1: Living in cold homes**
	  ○ How do you feel about NICE focusing on supporting people living in cold homes as an area of health inequality?
	  ○ How do you feel about NICE focusing on vulnerable people as an area of health inequality?
	• **Case study 2: Weight management**
	  ○ How do you feel about NICE focusing on weight management as an area of health inequality?
	  ○ How do you feel about guidance focusing on deprived areas and specific groups?
	What would you like to see NICE do differently in relation to this issue?
	
	Specialists to be prompted by the facilitator once participants have shared their views to contribute to the discussion:
	
	• What does this issue look like in practice, in your experience?
	• What else you would mention about this?
	• What other perspectives are there on this issue that we have not discussed?	

Introducing: Sustainability Aim: For the specialists to share information about sustainability to facilitate discussion	Plenary (group A/B) Lead facilitator introduces basic definition of sustainability and reads through the slides. Lead facilitator introduces the specialists, who will discuss some **key considerations and challenges** associated with focusing on sustainability. Participants asked to **write their questions in the chat** as we go, to return to. • Sarah Ouanhnon, Senior Net Zero Delivery Lead, Greener NHS Programme, NHS England • Keith Moore, Programme Coordinator, Sustainable Healthcare Coalition Lead facilitator to 'interview' specialists on 3 key questions: 1. What does a sustainable healthcare system look like? 2. Why is it so important that the health and care system thinks about sustainability? 3. How do you get staff on board when there are so many other priorities and pressures? Lead facilitator to probe on key challenges: • Some proposals to reduce the NHS's carbon footprint may impact people's experiences of receiving care, such as encouraging patients to manage their conditions at home. • Risk of focusing on short-term targets and measures (e.g. introducing lower carbon alternatives in treatment and health services), and not considering a long-term approach to preventing ill health through action on the wider factors. • Building awareness and knowledge in the NHS workforce around sustainable healthcare measures is essential. There may be a strain on staff and delivery of care while the system adapts to sustainable alternatives. • Balancing the needs of people today with the needs of future generations is difficult and requires judgments. • Incorrect assumptions on something based on incomplete information. A product may have lower carbon emissions vs. an alternative but it may be worse in other environmental impacts like eco-toxicity.	20 min 7:00-7:20pm

	Q&A with specialists Participants sent to breakout groups, specialists and NICE representatives to be rotated across the groups.	
Discussion: sustainability Aim: Exploring participants immediate reactions to the inclusion of sustainability as an area	Home groups **What was your initial response to the information shared?** • Based on what you have heard, how important is it for NICE to consider this area? • What are the benefits of NICE considering this area? • What is challenging about NICE considering this area? • What are the trade-offs when focusing on this case study? • How has this information changed your view, if at all? Specialists to support discussion with their perspective on the trade-offs and challenges. **We're now going to focus on two case studies, each representing a potential topic of NICE guidance and the impact it could have on environmental sustainability.** **You will have a chance to ask our specialist questions about these case studies throughout.** Facilitator to present case studies. **For each case study:** • What is your response to this example? • Do you have any questions about this example? • How important is sustainability in this example? • What should NICE consider in relation to sustainability in this example? • What are the trade-offs of considering sustainability here? Case study specific probes **Case study 1: Asthma inhalers** • Are there other asthma treatments which have a lower environmental impact? • Does asthma affect large or small numbers of the population?	30 min 7:20-7:50pm

	• Even if it is a small number, changing these inhalers has potential to reduce carbon emissions significantly. Does that make a difference? **Case study 2: Cannulation** Are there other types of equipment which are more carbon intensive, which NICE should prioritise developing guidance for over this? Specialists to be prompted by the facilitator once participants have shared their views to contribute to the discussion: • What does this issue look like in practice, in your experience? • What else you would mention about this? • What other perspectives are there on this issue that we have not discussed? **NICE has been thinking about environmental sustainability for some time, and in 2022 they talked to the public about it. Here are some of the main findings of that process.** Facilitator to present key recommendations from NICE Listens Sustainability. **The participants in this dialogue went on a journey with this topic. They were sceptical about how important this is for NICE, but at the end of the dialogue, they felt like it was something that NICE needed to take action on.** **Cover key findings first, probe on response. Then cover recommendations:** • To what extent do you agree with these findings? Is there anything you would change? • How would you advise NICE to think about environmental sustainability in their prioritisation of topics? • Are there some circumstances in which its more relevant than others? How should it be weighed up against the other areas?	
Taking stock of the areas so far	Home groups Reminder of the diagram as a visual way for us to keep track of how important we think each of the key areas are as we build our understanding of them.	10 min 7:50-8:00pm

Aim: For participants to reflect on what they have heard that day, and to continue to build their view on balancing the areas and reflect on changes over time	• What impact, if any, has the discussion today had on how important you think health inequalities and sustainability are when NICE are prioritising topics? • Has it changed your view about the most important aspects of health inequalities and sustainability? • Did you disagree with anything you heard? Is there anything you would like more information on? • Based on what we have discussed today, where would you place each of the key areas? Which feel more or less important? Why? • How, if at all, does this change where you place the other areas? Why? • Facilitator to probe on areas of agreement / disagreement and the reasons for this **Wrap-up** Thank participants and explain next steps in the process.	

Workshop 4 Stimulus

Information provided to participants to explain and introduce health inequalities

What do we mean by 'health inequalities'?

"Unfair and avoidable differences in health across the population and between different groups in society" (NICE definition)

Our health is shaped by the conditions in which we live. Some groups and communities are more likely to experience poorer health than the general population.

National action to reduce health care inequalities at both national and system level.

- Core20 = The most deprived 20% of the national population.
- PLUS = groups identified at a local level.
- 5 = Five clinical areas requiring accelerated improvement: Maternity; severe mental illness; chronic respiratory disease; early cancer diagnosis; hypertension

Why are health inequalities important for NICE to consider?

NICE's Principles state that "guidance should support strategies that improve population health as a whole, while offering particular benefit to the most disadvantaged."

- It is a key priority for the NHS, as evidenced by the Core20PLUS5 approach, and therefore, a key area for NICE.
- Fairness – it is unfair that some groups have worse health outcomes than others and addressing this issue is ethically or morally the right thing to do.

Why they should be addressed and what we know about public opinion

Previous dialogue work and public opinion studies have shown that:

1. There is a broad consensus that health inequalities in England should be addressed.
2. Health inequalities are felt to represent unfair differences determined by circumstances beyond an individual's control.
3. People are uncomfortable with prioritising tackling health inequalities using factors such as gender and ethnicity.
4. There is a sense that health inequalities are mostly linked to social and environmental factors.

Health inequalities case studies

Case Study: Living in cold homes

The health and care need: 55% of households were forecast to fall into fuel poverty (low income and face high costs of keeping warm and other basic energy services). Without additional interventions, this risks greater damage to health. Households with children, low income, living with a disability and/or an ethnic minority are most at risk.

For vulnerable people, living in a cold home increases risk of illness or even death. They are at a higher risk of heart attacks, strokes, flu, breathing problems and depression.

NICE produce guidance for practitioners, commissioners, housing and energy suppliers, as well as for people who have health problems relating to cold homes.

The recommendations could help to develop a local strategy, identify people at risk, train practitioners, raise awareness, and ensure buildings meet required standards.

Note: case study is based on a hypothetical scenario, which is reflective but not representative on an occasion where NICE has previously issued guidance.

Case Study: Weight management

The health and care need: Obesity rates are higher in the most deprived communities, particularly in women and ethnic minority groups. In these deprived areas, obesity-related hospital admissions are 2.4 times greater than in the least deprived areas.

Obesity leads to a bigger risk of diseases such as diabetes, heart disease and some cancers. Former approaches to obesity have had mixed success and lack whole population impact. People who may benefit the most from weight management programmes are not identified very efficiently, so many people experience preventable health problems.

NICE can offer strategies for specific groups that could benefit from interventions such as:

- Weight management programmes and advice of lifestyle changes.
- Medical and/or surgical interventions.
- Better approaches to identifying people who are overweight.
- Long term management.

Information provided to participants to explain and introduce environmental sustainability

Healthcare and the environment

- The health service contributes around 4-5% of total UK carbon emissions and 40% of public sector emissions.
- The carbon footprint of the NHS in England is equivalent to that of the whole of Croatia.
- The NHS has set out an ambition to reduce its contribution to climate change and become the world's first net zero health care system.
    - Including: medications, medical devices and equipment, building use, energy and patient and staff travel.
- NHS England states "the climate emergency is a health emergency". Climate change affects the ability to deliver healthcare.
- Extreme weather impacts the delivery of healthcare. Heatwaves, for example, can cause multiple issues regarding patient and staff health as well as impacting hospital IT systems.
- Pollution, greenhouse gas emissions, and other environmental impact can cause an increase in:
    - Respiratory conditions
    - Cardiovascular conditions
    - Mental health conditions
    - Deaths related to adverse weather events e.g. flooding or extreme hot and cold weather.

Environmental sustainability

What do we mean by 'environmental sustainability'?

- **Prevention**: actions to prevent illnesses or disease can reduce the need for more healthcare and its accompanying carbon footprint.
- **Self-management**: empowering patients to take a greater role in managing their own health and care can reduce the need for more carbon-intensive forms of care.
- **Service delivery**: streamlining care systems, reducing hospital attendances and avoidance of wasteful practises.
- **Low carbon alternatives**: considering treatments and technologies with lower environmental impact.

Why is environmental sustainability important for NICE to consider?

NICE has a responsibility to the health of everyone: people in England currently receiving care, those who may need care in the future and future generations.

- All healthcare has an environmental cost
- The environment affects our health e.g., heatwaves or flooding
- Supporting sustainable healthcare can benefit both patients and the wider system

Achieving net zero by 2045 is a key priority for the NHS, and considering sustainability during prioritisation will enable NICE to consider areas or topics that have the potential to reduce carbon emissions.

Environmental sustainability case studies

Case Study: Asthma inhalers

The health and care need: Asthma is the most common respiratory condition in the UK. Inhalers are a key treatment for respiratory conditions, with approximately 60 million dispensed in England every year.

Some inhalers have a bigger carbon footprint than others. One type of 'metered dose' inhaler (which has 120 doses) has a similar carbon footprint as a 115-mile petrol car journey. That's more than the car journey from Birmingham to Preston.

Using alternatives, such as dry powder inhalers, could result in big emission reductions.

Some people find these more convenient to use. For example, they don’t require a spacer device, which are bulky to carry, and they have a dose counter which shows patients when their inhaler needs to be replaced (meaning less waste).

But switching from what's familiar can be hard and, for some groups, metered dose inhalers are the best option. NICE created a 'decision aid' to help patients and clinicians make these decisions together, with all the information they need.

Note: case study is based on a hypothetical scenario, which is reflective but not representative on an occasion where NICE has previously issued guidance.

Case Study: Cannulation

The health and care need: When patients are seriously ill and attend A&E, they routinely receive a cannula in case it is needed to support the administration of fluids and medicines.

A significant proportion of cannulas are not actually required during a patient’s time in A&E, contributing to a waste of equipment and staff time, as well as patient discomfort and increased risk of infection.

At Charing Cross A&E in London, 86% of patients in a 24-hour period were cannulated yet over 40% were not used. This was potentially costing £125,000 a year and generating excess emissions. The team at the hospital worked to educate colleagues and support economical cannula use. This involved visual prompts, and a ‘traffic light’ system to help decide when cannulation is required.

After 12 months, there was a 25% decrease in cannulation during attendance in A&E. Reducing unnecessary cannula use has improved patient comfort, created cost savings and reduced carbon emissions.

NICE is considering whether to update its guidance on emergency care to include recommendations on efficient use of cannulas. It needs to decide whether this is an update worth prioritising.

Note: case study is based on a hypothetical scenario, which is reflective but not representative on an occasion where NICE has previously issued guidance.

4. A decision framework: Workshop 5

Workshop 5: Discussion Guide

Section and aim	Key questions and probes	Time
Introduction	Lead facilitator in plenary (in locations) Welcome back to our final session together. Today, we'll do the following: • Recap on what we've heard from you so far • Remind you of your objectives and how we will work together • Why we are here + What NICE's role is (to include clarification on remit/ scope) • Ask you to tell us which areas are most / least important and help us understand why • Test out where your views might change with some "what if?" cases • Film some videos – will be asking for volunteers! • Wrap up and bring our time together to a close	5 min 1:00-1:05pm
Getting reacquainted and recapping the online sessions Aim: cross-pollination between groups, refresh of key content, check in on areas of consensus and disagreement, surface emerging priorities among participants	Breakout groups – returning to the original groups from the first face to face event to give a sense of reconnection after the online **To get us started, let's go round the table and re-introduce yourself by sharing your first name, and one interesting that you've done since we last met.** All participants to re-introduce themselves **During the online sessions you were all in different groups, working with people from other locations. To help recap what was discussed and understand where discussions varied across groups, we're going to create a quick summary together.** Facilitator read through definitions of the domain to help participants remember. Stick these definitions up on the flipchart.	30 min 1:05-1:35pm

Section and aim	Key questions and probes	Time

	• **Please take a few minutes to note down on your post-it notes the key points you remember from your discussions**
	• **We'll split up the key areas we focused on during the online sessions around the table [facilitator to allocate one or two participants to each domain]**
	
	Facilitator to lead a brief debrief/recap of each of the domains, focusing on what was different across the groups, any immediate areas of disagreement/ different focus [spending around 5 mins per domain].
	
	• **Are there any other key areas that are important for NICE to consider as they prioritise their work?**
	  ○ Facilitator to add to flipchart and probe on what these are and **why** are they important to include
	  ○ Support conversation if needed by providing examples raised throughout the dialogue e.g. prevention, patient experience
	
	Note to facilitator: If participants continue to voice / become fixed on the view that areas such as health inequalities and sustainability are not part of NICE's remit, challenge by referring back to introduction re-cap of NICE's role (which stated that they are within NICE's remit).	

Exploring health and care need To explore this area in more detail before spending further time ranking the other domains	Breakout groups **We know from the discussions so far that there is no easy answer to the question of what's important for NICE to consider.** **Many of the participants from across all our locations felt that health and care need is really important for NICE to consider.** **When we returned to the ranking diagram at the end of the online workshops, many people consistently felt that health and care need was**	10 min 1:35-1:45pm

Section and aim	Key questions and probes	Time

	the most <u>important</u> area for NICE to take into account when prioritising.
	
	Facilitator to check whether this was a point of agreement across all participants' online groups and make note of any differences.
	
	I want to talk about health and care need in more detail before we go on to the other key areas NICE could consider.
	
	Take a moment to write down on your post-it notes, which aspects within health and care need you feel are most important for NICE to consider when prioritising.
	
	Facilitator to ask participants to share their thoughts:
	• Why are these important to look at?
	• Are there any circumstances under which you might want to prioritise one of these aspects over another? Why?
	• Probe on:
	  ○ Number of people affected
	  ○ Severity of impact
	  ○ Quality of life
	  ○ Wider impact (e.g. on society, families and friends, economy)	

Comparing the areas Aim: Different way of considering trade-offs between areas, developing an in-depth understanding of the trade-offs	Lead facilitator in plenary to present a recap of NICE's prioritisation challenge. Introduce the pairwise comparison task for ranking the key areas **We're going to use a few different ways of looking at the question to try and understand how and why you think particular areas are important – and if there are situations where you aren't able to place more importance on one area compared to the other.** • The first way of looking at this is to compare each of the areas in pairs, here's a quick example:	5 min 1:45-1:50pm

Section and aim	Key questions and probes	Time
	○ Imagine there are two candidates in a presidential election – it's probably fairly easy to identify your favourite. ○ But what if there are more candidates? Or a situation where you like some things about candidate A, but prefer other things about candidate B? It quickly becomes complicated. ○ Looking at the candidates in pairs can help you sort through your preferences – and the **reasons** for them – and sometimes the answer will surprise you. Click through example ranking table on slides to explain	
Comparing the areas Aim: Different way of considering trade-offs between areas, developing an in-depth understanding of the trade-offs	**We've already talked about health and care need, and we will come back to this.** **But we're now going to use this approach to compare the other key areas that NICE could consider when prioritising – and discuss the circumstances where one area might take priority over another.** Breakout groups Table facilitators to hand out worksheets where participants can note down their own ranking. **Pairwise ranking – step-by-step instructions:** 1. Start by comparing the first two areas – write down the number in the box of the one that you think is more important for NICE to consider when prioritising 2. Then move down to compare each of the areas together in turn 3. In each box, write down the number of the area you think is more important between the two **Let's start with the first comparison. Take a moment to jot down on your worksheet which of these two areas you think is more important for NICE to consider.**	45 min 1:50-2:35pm

Section and aim	Key questions and probes	Time
	Allow 5 mins for participants to complete their worksheets, clarifying on process as needed. Encourage participants to push themselves to rank one area over the other, but allow them to note down where, if at all, they really cannot rank one area over the other and feel they are of equal importance. • **Now we're going to discuss why you think that's the case. Would somebody start us off by telling us what they wrote down and why?** Facilitator then to lead discussion exploring variation in choices, flexing the time spent on each comparison based on levels of consensus vs. disagreement. • **What did you have in mind when you were making this decision?** For each comparison, probe on: • Under what circumstances a particular area is more or less important – what is the "it depends" here? • Influences on their decisions – hearing from specialists, discussions with fellow participants, case studies, personal experiences • The ease (or not) of making decisions – why some areas are easier / harder to decide between **Now we've looked at all the comparisons you should be able to quickly add up the scores and see how the areas are ranked.** **To do this:** • **Count up the number of times each area appears in the grid.** • **For example, if Evidence availability (2) was written in as more important than the other area 3 times in the grid, then the score for this area would be 3**	

Section and aim	Key questions and probes	Time
	Facilitator to help participants with scoring on the worksheet. Once completed, ask participants to share their scores and write up participants' scores for each area on flipchart. • How do you feel about that this/these areas being prioritised over the others? • Are the rankings surprising to you or has it turned out as you expected? • Why did you rank the areas in this way? • Facilitator to probe on the implications of their rankings to prompt consideration of the impact of prioritising based on one area vs. another. For example: ○ Prioritising based on X area would mean giving less emphasis to Y area. How do you feel about this? Why? **Let's now look at how the other group ranked each area.** Two tables to swap over their flipcharts to reflect on how the other group ranked the areas. • How consistent is this with our table's rankings? • What are the similarities and differences? • Why do you think they might have ranked the areas in this way? Facilitator to allow group to discuss areas of similarity and difference, prompting to encourage them to reflect on **why** these might exist. **Let's go back to our earlier conversation about health and care need.** • Overall, how do these other areas compare if we reintroduce health and care need to the mix? • Based on what we've discussed, are there any situations where you feel these other areas	

Section and aim	Key questions and probes	Time
	would be more important for NICE to consider than health and care need? o When? Why? **Are there any other ways in which you would rank these areas?** E.g. do some of them underlie or cut across all the others?	
Edge cases Aim: Testing the boundaries and conditionalities of participants views on what's important, developing our understanding of what values underlie judgments	In plenary, lead facilitator to introduce next session **We want to spend time talking about some really difficult examples, where it can be hard for NICE to decide how to prioritise in a specific situation.** **We'd like to explore your views on these situations now that you've been able to explore the different areas in detail. For each of these scenarios, we're going to look at how a specific situation might change your view on what's most important.** Breakout groups Edge cases set up at tables and order they are explored is rotated, participants split into **new** breakout groups to hear different perspectives. Spend c.10 mins for first two edge cases, c.15 mins for third and fourth. Facilitator to read out definition and key considerations. **What's your immediate response to this case study?** • Why might NICE choose to produce – or not produce – guidance in this situation? • What factors do you think would inform NICE's decision? • What makes you say that? What areas do you think are important to consider? • To what extent has it made you think differently about any of the areas we've	50 min 2:50-3:40pm

Section and aim	Key questions and probes	Time
	discussed? Or surfaced any new areas for consideration? Facilitator to ask participants to refer to their workbooks for ranking generated in previous activity. **How does this influence your previous ranking?** • Probe on changes in ranking, and reasons for these • What do others think? • Why might it be important to produce guidance in this area? **See facilitator 'cheat sheet' for edge case specific probes.**	
Back to your tables – has anything changed? Aim: understanding of how edge cases have/ haven't influenced perceived importance of areas, confirming consensus and disagreement	Breakout groups – returning to the original 'home' groups **Having looked at those case studies, what impact did they have on how you think about the importance of any of these areas?** • What new information/ considerations came up? • Would anyone like to change their rankings which we talked about earlier? If so, why?	10 min 3:40-3:50pm
Bringing everything together – underlying principles and communication Aim: Stepping back from the	Breakout groups **We're nearly at the end of our deliberation. You've considered a huge range of information about NICE, and the health and care system broadly.** **We're now going to put you in charge of NICE.**	25 min 3:50-4:15pm

Section and aim	Key questions and probes	Time
domains to a more participant focused view of what's important to NICE and underlying principles that should guide prioritisation, understanding what has been most influential, thinking about communicating the framework to the wider public	**In pairs, imagine that you are the Heads of Prioritisation at NICE. You are writing a brief for your team on what they need to consider when prioritising where they focus their resources.** **You need to prepare a briefing for your team, based around one key question:** 1. **What 3 things should NICE colleagues always bear in mind when they are prioritising guidance – regardless of the specific circumstances of an individual topic. Why is this important?** Please try to think about overarching considerations that go beyond the key areas we have covered in detail. They might be about **how** NICE makes decisions, core values, or how they could communicate about this to the public. **You will then present back your brief to the rest of the table – who will be your team of NICE colleagues, who will be putting what you say into practice. They will ask you questions about why you think these areas should be considered.** Facilitator to hand out worksheets for pairs to write their briefing. Participants spend c.5 minutes preparing their answer. Facilitator then asks each pair to share their briefing with the rest of the table, who will be playing the role of 'NICE colleagues' in their team. **You will now present your briefing to your 'NICE colleagues' at this table, for discussion. Colleagues around the table should ask questions to their 'team leads' to challenge or introduce other areas to consider.** Facilitator to prompt discussion as needed to keep on track, and to encourage participants to think about **underlying principles** rather than solely the domains:	

Section and aim	Key questions and probes	Time
	• Why is this important for NICE colleagues to bear in mind at all times when prioritising? • What impact will considering this have? For NICE? For the health and care system? For the public? • What has been most influential in shaping your ideas? Why? • How far do you agree / disagree with these areas? • How would you explain or communicate this to people who might disagree with NICE's decisions on what to prioritise? Facilitator to capture key points on flipchart to feedback in wrap-up.	
Wrap-up and close Aim: Thank participants, let them know what happens next, finish on a positive note	First, in location plenary, led by lead facilitator. Brief summary of discussion from each breakout group. In cross-location Zoom plenary: Led by facilitator in London (c.4:20pm) Brief 1 minute summary of discussion from each breakout group facilitator across all four locations via video link. Closing thank you message from NICE representatives outlining what happens next. Back in each location, in plenary, lead facilitator to: • Hand out individual evaluation questionnaires • Explain that incentives will be paid via our payment platform, Ayda. • Thank everyone for their hard work and close.	15 min 4:15-4:30pm

Workshop 5 Stimulus

Edge Case: What if…there isn't much evidence yet?

Sometimes there are very few treatment options for a condition because the evidence is still developing. Despite the lack of evidence, decisions still need to be made, particularly if the issue is a national priority.

- To what extent should this influence which topics NICE chooses for its guidance?

For example:

- During the Covid-19 pandemic, the Government announced that millions of vulnerable people in England would receive free supplies of vitamin D for the winter.
- Due to a lack of evidence, NICE produced guidance that recommended healthcare professionals 'not to offer vitamin D supplements to people solely to [prevent or treat] Covid-19, expect as part of a 'clinical trial'.

Edge Case: What if…the evidence won't ever be "good"?

There are some situations where it is very difficult to get good quality evidence. Sometimes the numbers are small (rare diseases) and sometimes its unethical to run medical trials (maternity, babies and children, end of life). In these situations, the evidence is often poor or non-existent, so NICE will use expert opinion or look for similar areas to compare.

- To what extent should this influence which topics NICE chooses for its guidance?

For example:

- Motor neurone disease is an uncommon condition that significantly impacts people's quality of life. There are very rare varieties that affect very young children. Most people die within 2 to 3 years of developing symptoms. There is currently no cure.
- Guidance could improve care for people with MND from diagnosis, management monitoring, psychological support and preparation for end-of-life care.

Edge Case: What if…we put some people at a disadvantage?

NICE aims to improve the health and wellbeing of everyone. But not everyone has the same access to services. This can put some people at a disadvantage when NICE recommends a service or intervention that unintentionally excludes certain groups or is not available everywhere in the country.

- To what extent should this influence which topics NICE chooses for its guidance?

For example:

- Digital health tech (virtual appointments, remote monitoring devices, health apps) can free up staff and space for those that need in-person care most, as well as reducing delays and waiting lists. They can also reduce emissions by requiring fewer journeys, for example.
- But the benefits are not accessible for everyone. Around 7% of households still do not have home internet and approx. 1 million people cancelled their internet this year due to rising costs. Older people, more socio-economically disadvantaged groups, people living in rural areas, and people with disabilities are at risk of health inequalities.

Edge Case: What if…it's very hard to do?

Sometimes, the evidence will clearly show that something will benefit people and be a good use of public money. But when it comes to making the change in the real world, there are lots of barriers in the way to making it a success.

- To what extent should this influence which topics NICE chooses for its guidance?

For example:

- Physical inactivity is associated with 1 in 6 deaths in the UK and is estimated to cost the UK £7.4 billion annually. England is around 20% less active than in the 1960s. Physical activity can help people to prevent and manage over 20 chronic health conditions.
- Evidence clearly shows that our surroundings (natural and manmade) can influence our ability to be active. But making changes to neighbourhoods and public spaces is complex and costly, requiring joint working across public and private sectors. There are also conflicting priorities within transport and housing policy.

Edge Case: What if…there's a chance to make a difference?

Currently, it's hard to measure the carbon footprint of most individual treatments or actions. But in some areas the evidence is very clear that significant environmental damage is being caused. Switching to greener alternatives won't always make a difference to costs or patient health outcomes, but the system needs guidance to change.

- To what extent should this influence which topics NICE chooses for its guidance?

For example:

- Desflurane is a type of anaesthetic gas that's extremely damaging to the environment. One hour of surgery using desflurane has a global warming effect equivalent to driving from Preston to London.
- Evidence suggests that stopping the use of desflurane across the NHS, with use allowed only in exceptional clinical circumstances, will reduce harmful emissions by around 40 kilotonnes of carbon a year – the same as powering 11,000 homes each year.
- Other anaesthetic gases are significantly less damaging to the planet.

Edge Case: What if…some people get worse care than others?

Through no fault of their own, some groups in society receive worse care than others. This can create real differences in their health outcomes – sometimes in extreme ways.

- To what extent should this influence which topics NICE chooses for its guidance?

For example:

- Maternal mortality for black women is currently almost four times higher than for white women. Significant disparities also exist for women of Asian and mixed ethnicity. There are many possible reasons for this disparity in the frequency of deaths, including pre-existing conditions and co-morbidities; socio-economic factors including deprivation; and factors impacting on the care that women received, including ignorance, bias, microaggressions, and racism.
- NICE guidance could ensure that the training and continuing professional development for all maternity staff include evidence-based learning on maternal health disparities, the possible causes, and how to deliver culturally competent, personalised, and evidence-led care.

6. Analysis

Data Capture

Each discussion group and workshop were audio recorded. The audio was then transcribed by members of the Thinks team. Permission to record the sessions was requested in the consent form prior to the project beginning, as well as verbally at the beginning of each workshop.

The transcription of the participants' comments was typed into an analysis 'grid' using Excel.

Thinks moderators also took notes during the workshops and these were used as a starting point in analysis meetings.

Thematic Analysis Approach

Following each workshop, the Thinks moderators held analysis sessions to discuss key emerging findings, themes, and to compare findings across breakout groups.

Using these emerging themes, the Thinks project team developed a code-frame. This was used to systematically code and analyse the data gathered across the workshops. The coding process was conducted by the Thinks project team and captured in Excel. The team read through all the verbatim comments made by participants and labelled them with a set of codes to help identify common themes and difference among participants. The team met regularly to ensure the data was being coded consistently.

This analysis was used as the basis of the report. Themes were selected for the report outline based on prevalence (e.g. the common themes that were raised across participants and locations) and prominence (e.g. the strength of feeling and importance attributed to them by participants). The reflections of the Thinks project team also contributed to the selection of the themes, for example, where they noted particularly strong agreement or disagreement about an issue.

NICE and Sciencewise representatives observed the workshops. During the dialogue, regular meetings were held between them and the Thinks project team in which discussions centred around emerging key themes. They contributed to the analysis process by sharing their observations and notes from the workshops. These sessions helped to inform the subsequent workshops and reporting.

7. Glossary

Below is a glossary of terms used throughout the report.

Burden of care	The physical, emotional, social, and financial problems that can be experienced by family caregivers
Cannulation	The process of inserting a hollow tube made of plastic into a peripheral vein to enable the administration of drugs or fluids
Commissioner	Responsible for planning and purchasing healthcare services for their local population. Most NHS services are commissioned by integrated care boards, while publicly funded social care and most public health services are commissioned by local authorities.
Evidence	the available body of facts or information that can support NICE is producing guidance. Participants defined this as more than just randomised clinical trials, including expert opinion, people's experience, cross-system learnings and comparable research.
Environmental sustainability	Reducing the environmental impact of the health and care system through: • Preventing illnesses and diseases to reduce the need for more healthcare and its accompanying carbon footprint. • Encouraging patients to take a greater role in managing their own health, reducing carbon-intensive forms of care. • Streamlining care systems, reducing hospital attendances, and avoiding wasteful practices. • Considering low carbon alternatives to current treatments and technologies.
Fairness	Ensuring that the population at large has equal access to the same quality of care and avoiding creating guidance that has the potential to disrupt equal access.
Guidance	Evidence-based recommendations for health and care. They help health and social care professionals to prevent ill health,

	promote good health and improve the quality of care and services.
Health inequalities	The preventable, unfair and unjust differences in health status between groups, populations or individuals that arise from the unequal distribution of social, environmental and economic conditions within societies.
Health and care system	A system 'consisting of all organizations, people and actions whose primary intent is to promote, restore or maintain health'. This includes efforts to influence wider determinants of health, as well as more direct health-improving activities.
Maternal mortality	The death of a women during pregnancy related to, or aggravated, by pregnancy or its management during childbirth or within 42 days of termination of pregnancy.
Medical device	A medical device is an instrument, apparatus, implant, software or related device used to diagnose, prevent, or treat disease or other conditions.
Principle	A key area that participants think NICE should focus on when prioritising guidance, derived from analysis of the public dialogue.

Prioritisation framework	A framework that supports selecting topics for guidance. It is a two-step approach:
	• Step 1 – Should NICE do it?
	  ○ **NICE's role:** What is the unique value that NICE can add to the health and care system by producing this guidance? (that is, providing cost-effectiveness analysis, our robust methodology, and independence)
	  ○ **Health and care need:** How many people are affected by the problem, what impact does it have on their lives?
	  ○ **NICE's methods:** Does NICE have the methods and resources to produce guidance on this topic?
	  ○ **Availability:** Will the proposed interventions be available for use in England?
	• Step 2: When and how should NICE do it?
	  ○ **Budget impact:** What impact will the guidance have on health and care budgets?
	  ○ **System impact:** What will change in the health and care system if we produce this guidance?
	  ○ **Evidence availability:** is there evidence available to produce impactful guidance?

	○ **Health inequalities:** Would this guidance helped reduce differences in health outcomes for people with different background? ○ **Environmental Sustainability:** Could this guidance reduce the need for healthcare services through the prevention of ill-health, or support disinvestment and reinvestment plans?
Quality of life	The standard of health, comfort, and happiness experienced by an individual or group.
Scale of condition	How many people are affected by a disease or other condition.
Severity of condition	How much a disease, or other condition, affects people and threatens or limits life.
Value	Standards of behaviour, participants judgement on what is important in life.
Virtual ward	Using the systems and staffing of a hospital ward while enabling the patient to get the care they need where they live (including care homes) safely and conveniently, rather than being in hospital.