

Thames Valley Priorities Committee Annual Report 2016-2017

Thames Valley Clinical Commissioning Groups:

Aylesbury Vale Clinical Commissioning Group

Bracknell and Ascot Clinical Commissioning Group

Chiltern Clinical Commissioning Group

Newbury and District Clinical Commissioning Group

North and West Reading Clinical Commissioning Group

Oxfordshire Clinical Commissioning Group

Slough Clinical Commissioning Group

South Reading Clinical Commissioning Group

Windsor, Ascot and Maidenhead Clinical Commissioning Group

Wokingham Clinical Commissioning Group

Date of Publication: April 2017

Audience for the report: Thames Valley Priorities Committee and member CCGs.

Report author: Clinical Effectiveness Team; South, Central and West Commissioning Support Unit.

Thames Valley Priorities Committee Membership (at March 31st 2017)

CCG Membership / Specialists

Dr Alan Penn, Independent Lay Member Chair
Cathy Winfield , Chief Officer , Berkshire West Federation CCGs, TVPC Strategic Lead
Dr Jacky Payne, GP, Berkshire West Federation of CCGs
Dr Megan John, GP, Berkshire East CCGs
Fiona Slevin-Brown, Director of Strategy and Operations, Berkshire East CCGs
Catriona Khetyar, Head of Medicines Optimisation, Berkshire East CCGs
Jane Butterworth, Head of Medicines Management, Buckinghamshire CCGs
Dr Graham Jackson, Clinical Chair, Aylesbury Vale CCG
Gareth Kenworthy , Director of Finance, Oxford CCG
Linda Collins, NICE Lead, Oxfordshire CCG
Dr Miles Carter, West Oxfordshire Locality Clinical Director, Oxfordshire CCG
Jeremy Servian, Individual Funding Request Manager, Oxfordshire CCG
Professor Chris Newdick, Special Advisor, Health Law, University of Reading
Dr Mark Sheehan, Special Advisor - Ethics University of Oxford
Dr Anees Pari, Senior Public Health Registrar, Bracknell Forest Council
Rosalind Pearce, Executive Director, HealthWatch Oxfordshire

NHS Provider Organisations

Dr Lindsey Barker Royal Berkshire NHS Foundation Trust
Dr Tony Berendt Oxfordshire University Hospitals NHS Trust
Dr Mark Hancock, Oxfordshire Health NHS Foundation Trust
Dr Tim Ho, Frimley Health NHS Foundation Trust
Dr Tina Kenny Buckinghamshire Healthcare NHS Trust
Dr Minoo Irani Berkshire Healthcare NHS Foundation Trust

Other invitees

Frances Fairman, Associate Director Clinical Strategy, NHS England Thames Valley Area Team
Tracey Marriott, Director of Innovation Adoption, Oxford Academic Health Science Network

South, Central and West Commissioning Support Unit

Rachel Finch, Administrator
Tiina Korhonen, Clinical Effectiveness Team Lead
Laura Tully, Clinical Effectiveness Lead
Kathryn Markey, Clinical Effectiveness Manager
Kate Forbes, Clinical Effectiveness Manager
Sarah Robson, Head of IFR

Contents

	Page
Introduction	4
Key activities 2016-2017	5
Future developments	10
Appendix 1: Terms of Reference	11
Appendix 2: Ethical Framework	15

1. Introduction

The Thames Valley Priorities Committee (Priorities Committee) has now been re-established for over three years and is robust in terms of membership and governance. It acts as an advisory body for priority setting to the ten Clinical Commissioning Groups (CCG) across the Thames Valley Region, and supports to:

- ensure CCGs meet their statutory duties
- commission the best quality and effective health care services for their designated populations, support funding prioritisation
- reduce the potential for health inequity and
- optimise safeguarding against legal challenge.

This is the Priorities Committee's fourth Annual Report, which summarises its key activities and achievements for 2016-2017 and looks at the year ahead.

The 2016-2017 programme has been varied and full with 14 new topics and 13 current policy updates discussed at the six Committee meetings (Section 2). An evidence based review has been prepared for each topic, enabling an informed starting point for discussion. This review is widely circulated to local commissioners and clinicians prior to Committee meetings. It is evident that clinical and other specialists are increasingly feeding back informed responses that support the Committee work. Discussion of each topic by the Committee, with the advice from clinical and other specialists, has involved careful consideration of the evidence of clinical and cost effectiveness alongside the resource implications, within the context of the Ethical Framework and local population needs. Despite robust processes in place for making prioritisation decisions in fair and equitable ways, the debates continue to highlight the difficulties CCGs face in ensuring a balance between their duty to commission the best quality and effective health care services for their designated populations and also to reduce the potential for health inequity, against their duty not to exceed their annual financial allocations. The Committee has acknowledged the increasing importance of ensuring decisions and the rationale behind them are well captured, documented and available for scrutiny.

The Annual Report highlights that the Committee has had a productive year. It plays an important role in supporting CCGs with high quality priority setting. Section 3 outlines some key issues to be addressed continually in order to ensure that the Priorities Committee is used effectively and strategically going forward.



Dr Alan Penn, Chair
Thames Valley Priorities Committee

2. Key Activities 2016-2017

2.1 Committee Membership

A key strength of the Priorities Committee is its range of expertise, which includes medical, pharmaceutical, public health, finance, specialised legal and ethical representation as well as HealthWatch and provider organisations. The Committee meetings have been well attended, with high level CCG engagement and regular attendance from senior representatives including a Chief Operating Officer and Chief Finance Officer. The Committee has also enjoyed a strong provider representation with regular Medical Director support and engagement from clinical specialists. This has been essential to ensure the Committee achieves high quality and timely decision making and that CCGs are kept regularly informed of the Committee's work.

The Committee programme is managed and supported by the South, Central and West Commissioning Support Unit's (SCWCSU) Clinical Effectiveness team. Berkshire East CCGs have continued to host the priorities service on behalf of the Thames Valley CCGs and Cathy Winfield, Chief Officer for Berkshire West CCGs has provided strategic lead for the Committee offering valuable stability and leadership. Louise Patten, Chief Officer for Buckinghamshire CCGs has agreed to offer her support to the Committee as the Strategic Lead for 2017-18.

2.2 Topics considered

Six meetings of the Priorities Committee were held during the 2016-17 period and in total 27 clinical topics have been considered (Table 1). All 10 new topics submitted for review for 2016-17 were considered. In addition three new topics were added to the programme of reviews following a benchmarking exercise in March 2016 and one further in-year request was also considered.

In addition to these new topics, 13 current policies were also reviewed via the Committee, the majority of which were retained and updated to reflect current best practice and evidence. A small number were deemed to be no longer needed as clinical practice or national guidance has advanced and therefore recommendations were made for policy withdrawal.

For each topic, the Clinical Effectiveness Team prepared and presented an evidence appraisal including (where applicable and available) a summary of national guidance, local activity, costing information and any feedback received from local clinical or other specialists. The evidence appraisals were considered by the Priorities Committee in the context of the Ethical Framework, local population needs and any information from attending clinical experts, with the aim of reaching

a consensus decision around policy recommendation. Evidence reviews and policy recommendations are considered against the principles and legal requirements of the NHS Constitution and the Public Sector Equality Duty. CCGs are subject to a duty to involve the public when making significant changes to the provision of NHS healthcare and the Priorities Committee supports this by making recommendations to the Thames Valley CCGs regarding the need for public engagement or public consultation for each policy proposal.

Draft policy recommendations are submitted to individual CCG Governing Bodies for ratification. The Clinical Effectiveness Team prepares a Diversity Impact Assessment and Governing Body summary paper for each policy recommendation to aid the ratification process. Once ratified, the SCW CSU Individual Funding request (IFR) team communicates new policies to the public and providers via the [IFR website](#) and contract meetings for Berkshire and Buckinghamshire CCGs. The minutes of the Committee meetings and Committee core documents are available to the public on the CCGs website maintained by IFR team.

The impact of the agreed policies is achieved in variety of ways:

- Some of the agreed policies offer financial savings by recommending the use of equally effective but more cost-effective interventions as the first line treatment and by clarifying the place of treatment in a care pathway (eg sequential use of biologic drugs; high cost therapeutics).
- Policies have also been developed to restrict procedures or interventions which are not supported by a robust evidence base (eg radiofrequency denervation of the sacroiliac joint, autologous blood injections in the treatment of musculoskeletal conditions).
- Endorsing national best practice and high quality care for patients (eg low back pain and sciatica, use of melatonin in children to improve sleep and subsequent behaviour)

Direct savings associated with the recommendations arise from agreeing appropriate clinical thresholds or adopting a not normally funded policy position. Examples include adopting a not normally funded position for autologous blood injections which was associated with a local spend of £100k annually and lumbar spinal fusion for low back pain associated with an annual spend of £340K across TV. The impact of new threshold policies will be realised over time via the contract challenge process.

Table 1: Topics considered by the Priorities Committee during 2015-2016

Thames Valley Priorities Committee Work programme: Topics considered 2016-17	
Evidence reviews of new topics identified for the work programme	Outcome of review
1. Anti VEGFs/steroid implants sequential use for ophthalmology Diabetic Macular Oedema (DMO), Age-related Macular Degeneration (AMD), Retinal Vein Occlusion (RVO)	New policy recommendation
2. Adult specialised severe and complex obesity services. Commissioned by CCGs from April 2016.	Recommendation to retain interim policy developed in March 2016
3. Sequential use of a third or subsequent biologic drugs for psoriasis	New policy recommendation
4. Sequential use of biologic drugs for ulcerative colitis	New policy recommendation
5. Sequential use of biologic drugs for psoriatic arthritis	New policy recommendation
6. Sequential use of biologic drugs for rheumatoid arthritis	New policy recommendation
7. Treatments for painful shoulder; subacromial pain	New policy recommendation
8. MRI Scan - Open/Standing	New policy recommendation
9. Frenuloplasty in children	Recommendation not to develop local policy
10. Radiofrequency denervation of the sacroiliac joint	New policy recommendation
11. Use of melatonin in children to improve sleep and subsequent behaviour	New policy recommendation
12. Autologous Blood Injections and Platelet Rich Plasma Therapy in the treatment of musculoskeletal conditions	New policy recommendation
13. Female genital surgery for stress incontinence and prolapse	Pending final decision
14. Freestyle Libre and other Continuous Blood Glucose Monitoring systems for adults with diabetes	Pending final decision
Policy updates of existing policies	
1. Laparoscopic fundoplication for chronic reflux oesophagitis	Withdrawal recommendation
2. Laparoscopic gastro-oesophageal reflux surgery (LGORS) for patients	Withdrawal recommendation
3. Surgical techniques for the treatment of Oesophageal Stricture	Withdrawal recommendation
4. Surgery for painful big toe (bunions)	Update recommendation
5. Primary hip and knee replacement surgery	Update recommendation
6. Hernia (Inguinal and Umbilical) and other hernias	Update recommendation with a wider indication set included.
7. Low back pain <ul style="list-style-type: none"> • Facet joints injections diagnostic and therapeutic • Spinal Surgery • Epidural injections for sciatica, diagnostic and therapeutic • Acupuncture and manual therapies • Radiofrequency denervation (new topic) 	Policy update recommendation. Existing policies amalgamated into one over-arching policy for ease of use.
8. Primary Hip and Knee Revision	Update recommendation
9. Insulin pumps (adults, element not covered by NHSE)	Pending final decision

2.3 New topics for the 2017-2018 work programme

The identification of interventions or services for review is critical in order for the Priorities Committee to provide effective support to Thames Valley CCGs. Each year the Clinical Effectiveness Team invites CCGs to submit proposals for new topics after consultation with their stakeholders for possible inclusion in the following year's work programme. A scoring system is used to help prioritise topics that will bring the greatest financial or quality benefit to their population. This year 10 new topic submissions were received from the CCGs and 3 were put forward by the Clinical Effectiveness team. The Priorities Committee topic working group convened in November 2016 to debate and score the new topics and those with the highest scores selected for inclusion. Three further topics were raised as an in-year request and scored in March (Table 2).

Table 2: New topic submissions scored this year

Topic No	Title	Topic Score
066	Sleep apnoea and CPAP; stopping criteria for CPAP	36
055	Foot and ankle surgery; identify and prioritise procedures for consideration of threshold criteria	29
054	Eyelid ptosis – amendment to current aesthetic surgery policy	Agreed for inclusion within existing aesthetics policy
058	Prescribing of gluten free foods	23
060	Surgical and non-surgical treatment of ectropion and entropion	22
061	Functional electrical stimulation for drop foot and upper limbs – policy update	Agreed for inclusion
067	Threshold for referral for investigation of hypersomnia's and circadian rhythm sleep-wake disorders	19
062	Diagnosis of Foetal Alcohol Syndrome Disorder (FASD) and Alcohol Related Neurodevelopment Disorder (ARND) especially in older children, adolescents and adults and treatment of associated behavioural problems	18
052	Treatments for painful shoulder ; shoulder arthroscopy (topic continued from 2016-17)	Carried over from previous shoulder review, not re-scored
063	NICE 'Do Not Do List' - new statement	Agreed for inclusion
068	CCG statement clarifying that the CCGs will not fund treatments which are commissioned by NHS England Specialist Commissioning regardless of provider – new statement	Agreed for inclusion
057	Management of haemorrhoids	13
056	General policy statement on steroid injections to joints (patella tendinopathy/elbows) – expansion of current policy	Agreed for inclusion
Additional In-year requests scored in March 2017		
074	Iron chelation	28
071	Meniscal tears Outcome: Meniscal arthroscopy (tears) – Scope widened to include patients that go onto have a total knee replacement	26
072	Joint prosthesis other than hip and knee (shoulder, ankle, elbow)	23

2.4 Current policies schedule for updates

Each CCG has developed/inherited a number of policies over the years which are now in need of updating to reflect current best practice. These existing policy review updates are not within the remit of the Priorities Committee, however it has been agreed that updates of joint TV CCG policies could be agreed through the Committee to allow for joint policy development and ease of ratification. A schedule for updating existing joint Thames Valley clinical policies has therefore been developed for 2017-2018 to run alongside the new topics work programme, prioritising any policies that are not in line with national guidance and those which carry the greatest risk/benefits to patients or the CCGs.

2.5 Committee Operating Procedures

The Terms of Reference, Standard Operating Procedures and Ethical Framework that form the basis of the Committee operation are scheduled to be reviewed in July 2017 as part of the annual training event. The aim of the event is to offer the new and current members of the Committee an opportunity to explore the core principles and processes of the Committee and, in particular, to review the principles of the Ethical Framework, in order to ensure they remain robust to support the Committee decision making process. A copy of the current Terms of Reference can be found in Appendix 1. and Ethical Framework in Appendix 2.

3. Future developments

The Committee has now been in operation for over three years and has grown in strength. However, continual assessment and development is key to ensuring that the Priorities Committee is used effectively and new strategic opportunities are realised going forward. There are several areas in the [Next steps on the NHS Five Year Forward View](#) where the TVPC can contribute to practical steps to deliver better, more joined-up and more responsive NHS care. In particular, taking note of the plans for 'The NHS' 10 Point Efficiency Plan' of reducing avoidable demand and meeting demand more appropriately and reducing unwarranted variation in clinical quality and efficiency.

Key priorities for the year ahead include:

- Draw attention of the Committee to support the work of the CCGs towards achieving the ambitious plans as set out in the NHS Forward View.
- Ensure Committee is adaptable to supporting the development of STPs and their workstreams.
- Link Committee work with regional network programmes such as the South Regional Medicines Optimisation Committee (RMOC) and Academic Health Science Network

- Ensure the process from policy recommendation to ratification is optimised and efficient. The internal CCG processes to agree the TVPC policy recommendations vary greatly in their timing and extent of adoption of the recommendations, inevitably contributing to the variation in care and clinical referral thresholds across the local CCGs. Timely adoption and implementation of the policies is essential in maximising the associated savings.
- Encourage CCG stakeholders to submit topics in priority, high impact areas for consideration by November each year.
- Encourage continued engagement and feedback from both CCGs and Provider organisations on the evidence reviews prepared for the Committee, to ensure clinical feedback is captured and inputted during the consultation and decision phases.

The Clinical Effectiveness Team will continue to help ensure these challenges are addressed so that the Committee is used as effectively as possible.

Appendix 1: Thames Valley Priorities Committee Terms of Reference

The Thames Valley Priorities Committee operates as an advisory body to the ten Thames Valley Clinical Commissioning Groups. Its role is to provide evidence based recommendations and commissioning policies for consideration and adoption by Clinical Commissioning Groups.

1. FUNCTIONS of the Thames Valley Priorities Committee

Aim: To make recommendations to clinical commissioning groups on the appropriateness of commissioning and funding of healthcare interventions (e.g. specific treatments, procedures and care pathways), using the agreed Ethical Framework and taking into account clinical views.

Objectives:

- To receive evidence appraisals and service reviews as agreed by the Committee
- To take account of relevant expert advice and patient perspectives
- To consider the information received in accordance with the agreed Ethical Framework
- To develop recommendations on commissioning policy for consideration and adoption by clinical commissioning groups
- To identify potential topics to be considered by the Committee
- To review progress against the agreed work programme.
- To receive reports on 'individual funding requests' (IFR) activity to inform the work of the Committee

2. MEMBERSHIP and PROCESS

2.1 Roles and responsibilities of committee members

The overall role of all members is to actively contribute to the discussions and recommendations of the Committee. All members should have a named deputy of similar standing and expertise; all are expected to attend annual training and complete an induction relating to their Priorities Committee role. Employed members should have this role included in their job description/ job plan. The Committee members are recruited as:

- (a) Members representing clinical commissioning groups. They should have sufficient authority and standing to support the development of recommendations and provide a wider commissioning view.
- (b) Members performing specialist advisory roles, due to their background or expertise in a particular area; for example, ethics, law, clinical, public health, finance, contracting, pharmaceutical or lay representatives.
- (c) In attendance: representatives provider organisations. They should have sufficient authority and standing to contribute to the discussions on developing recommendations.
- (d) By invitation: relevant clinicians and patient representatives.

The **Term of Office** for members is three years, and can be renewed after that period.

All members and attendees attending a Priorities Committees will be asked to declare any conflict of interest to the Committee secretariat (annually and at each meeting in relation to the agenda) and to the Committee Chair, in a meeting.

2.2 Membership

TITLE	No. delegates	Voting rights
Independent Lay Member Chair	1	√
NHS Clinical Commissioning Groups*		
Oxfordshire 1 CCG	2	√
Buckinghamshire 2 CCG	2	√
Berkshire West 4 CCGs	2	√
Berkshire East 3 CCGs	2	√
Members with Specialist Knowledge		
Public Health Consultant	1	√
Medicines Management commissioner	1	√
Special advisor – Ethics	1	√
Special advisor – Health Law	1	√
HealthWatch/ Lay members	2	√
Head of Corporate Affairs (host CCG)	1	
Individual Funding Request Manager	2	
NHS provider organisations		
Oxford University Hospitals NHS Trust	1	
Royal Berkshire NHS Foundation Trust	1	
Buckinghamshire Healthcare NHS Trust	1	
Berkshire Healthcare NHS Foundation Trust	1	
Oxford Health NHS Foundation Trust	1	
Frimley Health NHS Foundation Trust	1	

*It is anticipated that the 8 CCG members will include at least one Chief Officer and at least one Chief Financial Officer.

Invitations to attend meetings will be extended to Clinical Senates and Networks and Academic Health Sciences on a topic basis, where their specialist input is required.

2.3 Chairing of Committee

The Priorities Committee will have an independent lay Chair and a named deputy lay Chair (who will also be a member of the Priorities Committee). The Chair will be agreed by the Accountable Officers of the Thames Valley CCGs and will have a role description.

2.4 Quoracy

The Priorities Committee meetings will be considered quorate if, as a minimum, the following members (or their deputies) are present:

- Chair of Committee (or deputy)
- Chief Officer or Chief Finance Officer (or designated deputy for CO / CFO)
- at least one member representing each Clinical Commissioning Group / CCG Federation
- a Public Health consultant (or designated deputy)
- at least one lay member
- at least two clinicians (one medical)

If members, and their named deputy, are absent from two consecutive meetings, the lack of representation of that function will be reported to the Accountable Officer or appropriate senior manager for resolution.

2.5 Recommendations to CCGs

The Committee's recommendations are made by a consensus of voting members, at a quorate meeting. On occasions, a vote is taken; a simple majority decides. In the event of no majority, the Chair has the casting vote.

3. MEETING LOGISTICS

The Thames Valley Priorities Committee will meet on a bi-monthly basis. The Federation of East Berkshire CCGs will manage and administer the Priorities Committee and will liaise with the service provider, Central Southern Commissioning Support Unit, ahead of each meeting to establish meeting quoracy. It is each member CCG's responsibility to ensure they are appropriately represented at Priorities Committee meetings. CCGs should send a deputy if the representative is unable to attend. If neither the representative nor the deputy are able to attend, they should inform the CSU clinical effectiveness team.

If a meeting is not quorate (as per point 2.4.) absent delegates will be required to confirm within two weeks their endorsement (or not) of the Committee's recommendations via the minutes of the meeting *post hoc*. If no response is received, requests will be escalated to the relevant Accountable Officer(s).

The location of meetings is to be agreed by the members.

The agenda for each meeting will be agreed by the Committee Chair and Chief Officer. The agenda and papers will be distributed to Committee members five working days in advance of each meeting. Meeting papers will be circulated to an agreed list of non-member recipients, for information. Draft Minutes will be circulated to the Committee and approved at the next meeting.

4. GOVERNANCE and relationship with commissioning organisations

The Committee's core function is to provide clinical commissioning groups with evidence-based recommendations on commissioning priorities and policies, using the agreed Ethical Framework.

The Committee will receive reports on Individual Funding Requests (IFR) activity and decisions as appropriate at the Priorities Committee meeting to identify trends, risks and issues that might inform the work of the Priorities Committee.

Each CCG will be responsible for taking the recommendations of the Priorities Committee through their internal governance committees including the Governing Body. Ratified policies will be published by CCGs on their websites. With supporting information from Central Southern CSU, Lead Commissioners will communicate the clinical policies to provider organisations.

Central Southern CSU will provide an annual summary report of the activity of the Priorities Committee (reviews undertaken, policies produced, impact and resources used) to the designated lead officer of each member CCG.

5. WORK PROGRAMME and WORKING GROUP

The Priorities Committee Working Group will set the work programme for the Priorities Committee by considering topics submitted to its annual meeting. The annual meeting of the Working Group must be scheduled to ensure the work programme topics are linked to the CCGs' priorities as identified in their annual/strategic plans. The Working Group meeting will take the format of a workshop primarily aimed at CCG representatives, but providers, clinical senates and networks, and Academic Health Science Network representatives may be invited to advise on specific issues as appropriate. The workshop will

- consider commissioning priorities for the next contracting/planning round

- agree which topics should be placed on the Priorities Committee work programme and
- agree the relative priority with which these topics should be presented to the Committee

Additional to the annual workshop, CCGs and other organisations represented on the Priorities Committee are encouraged to submit topics to the Priorities Committee via the Service Provider throughout the year, as issues or opportunities for clinical service improvements or efficiency savings arise.

6. REVIEW

The work of the Priorities Committee, SOP and ToR will be reviewed in March of each year.

February 2014
Updated March 2016

Appendix 2: Thames Valley Priorities Committee Ethical Framework

Background

A primary responsibility of the commissioners of NHS health care in England is to make decisions about which treatments and services should be funded for their designated populations. This includes making decisions about the continued funding of currently-commissioned treatments and services, as well as the introduction of new treatments and approaches to the delivery of care.

Commissioners are subject to a statutory duty not to exceed their annual financial allocation. Further, the NHS needs to make savings to narrow the substantial financial gap in order to continue to meet the demands for care and treatment¹. As the demand for NHS health care exceeds the financial resources available, commissioners are faced with difficult choices about which services to provide for their local populations.

The Priorities Committee has representatives of the NHS organisations across ten Thames Valley Clinical Commissioning Groups (CCGs) and includes lay members as well as clinicians and managers. The purpose of the Priorities Committee is to make recommendations, in the form of policies, to the local CCGs as to the services and health care interventions that should or should not be funded.

To help in this process, health care commissioners in the Thames Valley region have developed a decision-making tool - the 'Ethical Framework', to facilitate fairness and transparency in the priority-setting process.

The Ethical Framework was originally developed in 2004 by the NHS public health organisation *Priorities Support Unit* (now *Solutions for Public Health*) and the Berkshire PCTs. Since then, the Framework has been revised to take account of policy developments in the NHS and changes in the law, and has been adopted more widely.

The purpose of the Ethical Framework

The purpose of the ethical framework is to support and underpin the decision making processes of constituent organisations and the Priorities Committee to support consistent commissioning policy through:

- Providing a **coherent structure** for the consideration of health care treatments and services to ensure that all important aspects are discussed.
- Promoting **fairness and consistency** in decision making from meeting to meeting and with regard to different clinical topics, reducing the potential for inequity.
- Ensuring that the **principles and legal requirements of the NHS Constitution**² the **Public Sector Equality Duty**³ and the requirement to involve the public when making significant changes to the provision of NHS healthcare⁴ are adhered to.

¹ Five year forward view (2014) <https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf>

² The NHS Constitution <http://www.nhs.uk/choiceintheNHS/Rightsandpledges/NHSConstitution/Pages/Overview.aspx>

³ Equality Act 2010: guidance (June 2015 update) <https://www.gov.uk/guidance/equality-act-2010-guidance>

⁴ [Transforming Participation in Health and Care](#) NHS England (2013)

- Providing a transparent means of **expressing the reasons** behind the decisions made to patients, families, carers, clinicians and the public.
- Supporting and integrating with the development of CCG Commissioning Plans.

Formulating policy recommendations regarding health care priorities involves the exercise of judgment and discretion and there will be room for disagreement both within and outwith the Committee. Although there is no objective measure by which such decisions can be based, the Ethical Framework enables decisions to be made within a consistent setting which respects the needs of individuals and the community.

The following Ethical Framework consists of 8 principles or relevant considerations that will be taken into account in the development of each recommendation. It does not prejudge the weight that any one consideration is given nor does it require that all should be given equal weight.

1. EQUITY

The Committee believes that people should have access to health care on the basis of need. There may also be times when some categories of care are given priority in order to address health inequalities in the community.

However, the Committee will not discriminate, or limit access to NHS care, on grounds of personal characteristics including: age, race, religion, gender or gender identity, sex or sexual orientation, lifestyle, social position, family or financial status, pregnancy, intelligence, disability, physical or cognitive functioning. However, in some circumstances, these factors may be relevant to the clinical effectiveness of an intervention and the capacity of an individual to benefit from the treatment.

2. HEALTH CARE NEED AND CAPACITY TO BENEFIT

Health care should be allocated justly and fairly according to need and capacity to benefit. The Committee will consider the health needs of people and populations according to their capacity to benefit from health care interventions. As far as possible, it will respect the wishes of patients to choose between different clinically and cost effective treatment options, subject to the support of the clinical evidence.

This approach leads to three important principles:

- In the absence of evidence of health need, treatment will not generally be given solely because a patient requests it.
- A treatment of little benefit will not be provided simply because it is the only treatment available.
- Treatment which effectively treats “life time” or long term chronic conditions will be considered equally to urgent and life prolonging treatments.

3. EVIDENCE OF CLINICAL EFFECTIVENESS

The Committees will seek to obtain the best available evidence of clinical effectiveness using robust and reproducible methods. Methods to assess clinical and cost effectiveness are well established. The key success factors are the need to search effectively and systematically for relevant evidence, and then to extract, analyse, and present this in a consistent way to support the work of the Committee. Choice of appropriate clinically and patient-defined outcomes need to be given careful consideration, and where possible quality of life measures should be considered.

The Committees will promote treatments and services for which there is good evidence of clinical effectiveness in improving the health status of patients and will not normally recommend treatment and services that cannot be shown to be effective. For example, is the product likely to save lives or

significantly improve quality of life? How many patients are likely to benefit? How robust is the clinical evidence that the treatment or service is effective?

When assessing evidence of clinical effectiveness the outcome measures that will be given greatest importance are those considered important to patients' health status. Patient satisfaction will not necessarily be taken as evidence of clinical effectiveness. Trials of longer duration and clinically relevant outcomes data may be considered more reliable than those of shorter duration with surrogate outcomes. Reliable evidence will often be available from good quality, rigorously appraised studies. Evidence may be available from other sources and this will also be considered. Patients' evidence of significant clinical benefit is relevant.

The Committee will also take particular account of patient safety. It will consider the reported adverse impacts of treatments and the licence status of medicines and the authorisation of medical devices and diagnostic technologies for NHS use.

4. EVIDENCE OF COST EFFECTIVENESS

The Committees will seek information about cost effectiveness in order to assess whether interventions represent value for money for the NHS. The Committees will compare the cost of a new treatment to the existing care provided and will also compare the cost of the treatment to its overall benefit, both to the individual and the community. The Committee will consider studies that synthesise costs and effectiveness in the form of economic evaluations (e.g. quality adjusted life years, cost-utility, cost-benefit), as they enable the relationship between costs and outcomes of alternative healthcare interventions to be compared, however, these will not by themselves be decisive.

Evidence of cost effectiveness assists understanding whether the NHS can afford to pay for the treatment or service and includes evidence of the costs a new treatment or service may release.

5. COST OF TREATMENT AND OPPORTUNITY COSTS

Because each CCG is duty-bound not to exceed its budget, the cost of a treatment must be considered. A single episode of treatment may be very expensive, or the cost of treating a whole community may be high. This is important because of the overall proportion of the total budget: funds invested in these areas will not be available for other health care interventions.

The Committees will compare the cost of a new treatment to the existing care provided, and consider the cost of the treatment against its overall health benefit, both to the individual and the community. As well as cost information, the Committees will consider the numbers of people in their designation populations who might be treated.

6. NEEDS OF THE COMMUNITY

Public health is an important concern of the Committee and they will seek to make decisions which promote the health of the entire community. Some of these decisions are promoted by the Department of Health (such as the guidance from NICE and Health and Social Care Outcomes Framework). Others are produced locally. The Committee also supports effective policies to promote preventive medicine which help stop people becoming ill in the first place.

Sometimes the needs of the community may conflict with the needs of individuals. Decisions are difficult when expensive treatment produces very little clinical benefit. For example, it may do little to improve the patient's condition, or to stop, or slow the progression of disease. Where it has been decided that a treatment has a low priority and cannot generally be supported, a patient's doctor may still seek to persuade the CCG that there are exceptional circumstances which mean that the patient should receive the treatment.

7. NATIONAL POLICY DIRECTIVES AND GUIDANCE

The Department of Health issues guidance and directions to NHS organisations which may give priority to some categories of patient, or require treatment to be made available within a given period. These may affect the way in which health service resources are allocated by individual CCGs. The Committee operates with these factors in mind and recognise that their discretion may be affected by Health and Social Care Outcomes Frameworks⁵, NICE technology appraisal guidance, Secretary of State Directions to the NHS and performance and planning guidance.

Locally, choices about the funding of health care treatments will be informed by the needs of each individual CCG and these will be described in their Local Delivery Plan.

8. EXCEPTIONAL NEED

There will be no blanket bans on treatments since there may be cases in which a patient has special circumstances which present an exceptional need for treatment. Individual cases are considered by each respective CCG. Each case will be considered on its own merits in light of the clinical evidence. CCGs have procedures in place to consider such exceptional cases through their Individual Funding Request Process.

Thames Valley Priorities Committee

Date of issue: 7th February 2014

Updated: 23rd March 2016

⁵ <https://www.gov.uk/government/collections/health-and-social-care-outcomes-frameworks>