South, Central and West
Commissioning Support Unit

Thames Valley Priorities Committee
Annual Report
2018-2019

Thames Valley Clinical Commissioning Groups (at March 2019):

Berkshire West Clinical Commissioning Group

Buckinghamshire Clinical Commissioning Group

East Berkshire Clinical Commissioning Group

Oxfordshire Clinical Commissioning Group

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

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Contents

1. Introduction

Thames Valley Priorities Committee acts as an advisory body for priority setting to the four Clinical Commissioning Groups (CCG) across the Thames Valley Region, and supports the CCGs to:

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

This is the Priorities Committee's sixth Annual Report, which summarises its key activities and achievements for 2018-2019 and looks at the year ahead.

The 2018-2019 programmes has been varied and full with 15 new topics and 6 priority policy updates have been 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 continued 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 2018-2019

2.1 Committee Membership

A key strength of the Priorities Committee is its range of expertise, which includes medical, pharmaceutical, public health, finance, lay and specialised legal and ethical representation as well as provider organisations. The Committee meetings have been well attended, with regular attendance from senior representatives for each CCG. 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.

Local HealthWatch has been a member of the Committee for several years, however, unfortunately in January 2019, it was confirmed that they would no longer attend the meetings. Fortunately, a new lay member has come forward from Buckinghamshire and will join the committee for the future meetings.

The Committee programme continues to be managed and supported by the South, Central and West (SCW) Clinical Effectiveness team. From April 2018 a new contract and SCW Clinical Policy Management service specification came into effect.

2.2 Topics considered

Six meetings of the Priorities Committee were held during the 2018-2019 period and 21 clinical topics have been considered (Table 1); 15 new topics and 6 priority policy reviews. The Committee has also supported the scheduled review of 40 current policies reviews (Table 2). The Committee programme remains responsive to accommodate CCG in year requests or national policy directives. Fertility preservation policy review was prioritised due to identified risk in relation to the Equality Act 2010; NHS England evidence based interventions (EBI) programme consultation and assessment of impact was also considered by the Committee as a priority due to its impact on National Standard Contract. Similarly priority update was necessary for Flash Glucose Monitoring Systems due to national directive for funding from April 2019. The majority of the reviews have led to a new policy development or to a policy update.

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. 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.

Table 1: New topics and priority updates considered by the Priorities Committee during 2018-2019

Thames Valley Priorities Committee Work programme: Topics considered 2018-19	
Evidence reviews of new topics identified for the work programme	**Outcome of review**
1. Smoking cessation before elective surgery	New policy recommendation
2. Referral to a weight loss programme before surgery	No policy recommendation
3. Sequential use and dose escalation of biologics in Crohn's disease	Policy recommendation and pathway in development
4. Negative pressure wound therapy	New policy recommendation
5. Iron chelation for myelodysplastic syndromes	New policy recommendation
6. Primary Care pathway for subfertility	New policy recommendation
7. Unicompartmental knee replacement compared to total knee replacement	Review and addition to 'Patients with osteoarthritis; primary hip & knee replacement' policy
8. Arthroscopic surgery for anterior cruciate ligament (ACL) rupture	New policy recommendation
9. Cannabis based product for medicinal use	New interim holding statement
10. Corticosteroid injections for patella, elbow and Achilles tendinopathy	Amalgamation of separate CCG documents into a new policy recommendation
11. Corticosteroid injections for pre patella and olecranon Bursitis	New policy recommendation
12. Clinical threshold for audiology services	New policy recommendation
13. Continuous Glucose Monitoring: Paediatrics	New policy recommendation
14. Management of ear wax	New policy recommendation
15. Lignocaine infusions for chronic pain	New policy recommendation
Scheduled policy review of existing policies with identified issues	**Outcome of review**
1. Preservation of Fertility	Priority update due to national legal challenges

2. Aesthetic treatments for adults and Children policy	Breast surgery section updated to include removal of breast prostheses
3. NICE 'do not do' policy	Policy withdrawn as NICE no longer supports the database
4. Follow-up appointments after primary hip and knee joint replacement surgery	Policy update to clarify the IFR/PA requirement
5. Primary hip and knee replacement revision surgery	Policy update to clarify IFR/PA requirement
6. Flash Glucose Monitoring System - FGS (Freestyle Libre®) policy	Policy update following national directive

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 (for example the policy for arthroscopic surgery for anterior cruciate ligament rupture).
- Policies have also been developed to restrict procedures or interventions which are not supported by a robust evidence base (for example Lignocaine infusions for chronic pain).
- Endorsing national best practice and high quality care for patients (for example clinical threshold for audiology services and management of earwax).

Direct savings associated with the recommendations arise from agreeing appropriate clinical thresholds or adopting a not normally funded policy position. The impact of new threshold policies will be realised over time via the contract challenge process.

2.3 Current policies schedule for updates

Each CCG has developed or inherited a number of policies over the years which are in need of updating to reflect current best practice. A schedule for updating the existing joint Thames Valley clinical policies was developed in 2018-19 to ensure policies are relevant, take into account the latest guidance and reflect up to date clinical and cost effectiveness research, all the policies are to be reviewed every two years. For each policy a literature search is conducted to identify evidence or national guidance published since the original policy review was undertaken. On the basis of the findings, policies are either updated with minor changes or scheduled for further discussion as appropriate. This may include the need for specialist clinical expertise. As part of the policy update programme, relevant diagnostic codes and intervention and procedure OPCS codes are added where applicable in line with current practice.

During 2018-19, 40 policies were reviewed and presented to the Committee. Of these, 27 have been updated with minor changes and/or new codes, and 1 has been recommended for withdrawal as the procedure is now commissioned by NHS England. 13 policies were scheduled for a full update, 1 of which has now been completed (Table 2).

Table 2: Policy Update Programme - policies scheduled for a full update

Policy
1. Retinal vein occlusion; Policy updated with new clinical criteria
2. Treatment of chalazia
3. Tonsillectomy
4. Trigger finger
5. Verteporfin and photodynamic therapy in Chronic Central Serous Chorioretinopathy and Idiopathic Polypoidal Choroidal Vasculopathy
6. Botulinum toxin A for management of chronic medical conditions
7. Biological mesh for breast reconstruction
8. Severe and complex obesity (interim policy)
9. Use of biological therapies in ulcerative colitis
10. Ketone testing for patients with diabetes
11. Erectile dysfunction
12. Therapeutic use of facet joint injections and medial branch blocks for chronic neck pain
13. Exogen therapy for non-union of long bones

Alongside the updates of the TVPC clinical policies, a review of the remaining medicines policies held by Thames Valley CCGs is underway. This has identified a number of policies that can be recommended for removal or for further discussion.

2.4 New topics for the 2019-2020 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 18 new topic submissions were received from the CCGs. The Priorities Committee topic working group convened in November 2018 to debate and score the new topics and those with the highest scores selected for inclusion (Table 3). 6 new topics were included in the work programme. Some submissions were withdrawn or not scored due to low activity, or agreed for data monitoring.

Table 3: New topic submissions reviewed and scored in November 2018 for 2019-20 work programme

Topic No	Title	Topic Score
092	IgE blood testing (confirming allergen triggers) to prevent asthma exacerbations	23
093	Intravesical medication in the treatment of painful bladder syndrome (interstitial cystitis)	14
094	Repair of divarication recti in women	19
095	Clinical referral thresholds for surgery for those with frailty	Withdrawn
096	Clinical threshold for access to audiology services including severity of hearing loss and Management of earwax	36 & 22 For review in 2018-19

097	Use of bevacizumab (Avastin®) in the management of wet AMD	For interim statement
098	Anti-VEGFs for a range of rare eye conditions	24
099	Posterior tibial nerve stimulation for urinary incontinence in children	19
100	Use of medicinal cannabis	For interim statement
101	Use of P1NP and other bone-turnover marker testing in the management of osteoporosis	Add to policy updates
102	Commissioning statement for drugs other than biologics	Add to policy updates
103	Extracorporeal shockwave therapy – MSK conditions	Low activity, not scored
104	Surrogacy and possible consolidation of the 3 fertility policies into one TVPC11g Assisted conception services policy – potential threshold review	Surrogacy – 27 and Assisted conception policy
CCG topics submitted - agreed not to score but to monitor local activity for an update of scope		
105	Infrared A induced whole body hyperthermia treatment	No IFR requests
106	Plagiocephaly (flat head syndrome), referral and treatment criteria	No IFR requests
107	Temperature-controlled laminar airflow device for the treatment of chronic allergic asthma	No IFR requests
108	Video capsule endoscopy and balloon enteroscopy	17
109	Scotopic sensitivity syndrome (Mears Irlen syndrome) and coloured lenses	No IFR requests

2.5 Committee Operating Procedures and Annual Training Event

This year's training event took place in November 2018 and was hosted by University of Reading. The event was to offer the new and current members of the Committee an opportunity to explore the core principles and processes of the Committee and offer an opportunity for on-going development of the Committee process.

Presentations at the event included:

- NICE implementation - Chris Connell, Associate Director, NICE Field Team (South)
- Lifestyle and ill health - Dr Mark Sheehan, Special Advisor – Ethics, University of Oxford
- IT systems to assist Individual Patient Funding Requests (IFRs) - James Coulson, NHS Wales
- Review of TVPC Ethical Framework and guidance for considering 'exceptions' in Individual Funding Requests

At heart of the Committee decision making is the Ethical Framework. Post November training event the Ethical Framework was updated in March 2019, following a workshop led by Professor Chris Newdick, to consider the issue of exceptionality and the exceptional capacity benefit from interventions in support of the Individual Funding Request in cases. The refreshed wording focuses on the demonstration of exceptional clinical benefit in two distinct cases; when NICE technology appraisal or local clinical

commissioning policies do not recommend use of the intervention or in cases in which the intervention has not been subject to NICE technology appraisal or local clinical commissioning policy.

The Committee has also agreed updates to the Standard Operating Procedures and the Terms of Reference. 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 five years and has grown in strength. However, continual assessment and development is a key to ensuring that the Priorities Committee is used effectively and new strategic opportunities are realised going forward. There are several areas where the TVPC can contribute to practical steps to deliver better, more joined-up and more responsive NHS care. In particular, the Committee will need to take account of the direction set out in the NHS Long Term Plan to work towards reducing unwarranted variation across the NHS, support the improvement of providers' operational and financial performance as well as clinical practice and to narrow variation in health outcomes and reduce inequalities.

Key priorities for the year ahead include:

- Ensure the Committee is adaptable to supporting the development of STPs and the Integrated Care Systems and their work streams. In particular reducing clinical variation, improving consistency in care pathways and access criteria and increasing involvement, trust and partnership with clinicians.
- 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.
- Encourage CCG stakeholders to submit topics in priority, high impact areas for consideration by November each year.

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

Buckinghamshire Clinical Commissioning Group
East Berkshire Clinical Commissioning Group
Oxfordshire Clinical Commissioning Group
Berkshire West Clinical Commissioning Group

TERMS OF REFERENCE

Thames Valley Priorities Committee

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 group 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	√
East Berkshire 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	√
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 service provider South Central and West clinical effectiveness team will manage and administer the Priorities Committee and will liaise with CCGs, 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 is able to attend, they should inform the SCW 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, as per the annual work programme. 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 South, Central and West CSU, Lead Commissioners will communicate the clinical policies to provider organisations.

South, Central and West 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 July 2017
Updated November 2018

Appendix 2: Thames Valley Priorities Committee Ethical Framework

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 treatment[1,2]. 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***[3] the ***Public Sector Equality Duty***[4] and the requirement to involve the public when making significant changes to the provision of NHS healthcare[5] are adhered to.

[1]Five year forward view (2014) https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf
[2]NHS long term plan (2019) https://www.longtermplan.nhs.uk/
[3] The NHS Constitution
http://www.nhs.uk/choiceintheNHS/Rightsandpledges/NHSConstitution/Pages/Overview.aspx
[4] Equality Act 2010: guidance (June 2015 update) https://www.gov.uk/guidance/equality-act-2010-guidance

- 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.

[5] NHS England - Involving people in health and care guidance
https://www.england.nhs.uk/participation/involvementguidance/

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 Frameworks[6], 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 CLINICAL BENEFIT

There will be no blanket bans on treatments since there may be cases in which the clinician providing the care can demonstrate why an individual patient is likely to obtain significant clinical benefit at reasonable cost from an intervention which is not normally funded. CCGs will consider such cases according to the following general procedures:

The CCG through its Individual Funding Request (IFR) panel will consider whether the criteria in (1) or (2) have been satisfied;

(1) **In cases in which NICE technology appraisal or local clinical commissioning policies[7] do not recommend use of the intervention**, treatment may be funded if:

(a) the clinician can demonstrate persuasive evidence why the patient's clinical circumstances are significantly different to those of the population of patients for whom the recommendation has been made not to use the intervention, **and**
(b) the clinician can demonstrate why the patient is likely to gain significantly more clinical benefit from the intervention than would normally be expected from patients for whom the recommendation is not to fund it, **and**
(c) the IFR panel are satisfied as to the reasonableness of the cost of funding the intervention.

(2) **In cases in which the intervention has not been subject to NICE technology appraisal or local clinical commissioning policies**, treatment may be funded if:

(a) the clinician can demonstrate why the patient is likely to gain EITHER significantly more clinical benefit from the intervention than other similar patients OR for patients with rare conditions, an equivalent benefit to patients with comparable symptoms **and**
(b) the IFR panel are satisfied as to the reasonableness of the cost of funding the intervention.

Thames Valley Priorities Committee
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[6] https://www.gov.uk/government/collections/health-and-social-care-outcomes-frameworks
[7] Local commissioning policies include local drug formularies