South, Central and West
Commissioning Support Unit

Thames Valley Priorities Committee
Annual Report
2020-2021

Thames Valley Clinical Commissioning Groups (at March 2021):

Berkshire West Clinical Commissioning Group

Buckinghamshire Clinical Commissioning Group

East Berkshire Clinical Commissioning Group

Oxfordshire Clinical Commissioning Group

Date of Publication: May 2021

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 and Standing Invitees (at March 31st 2021)

Chair
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CCG Membership
Dr Jacky Payne, GP, Berkshire West CCG
Shairoz Claridge, Operations Director, Newbury Locality & Planned Care and Long Term Conditions Lead
Dr Raju Reddy, Secondary Care Consultant, Berkshire West CCG
Edward Haxton, Deputy Finance Director, Berkshire West CCG
David Pollock, Interface Lead Pharmacist, Berkshire West CCG
Eleanor Mitchell, Operations Director, Berkshire West CCG
Dr Megan John, GP, East Berkshire CCG Lead
Sangeeta Saran, Director of Operations, East Berkshire CCG
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Fiona Slevin-Brown, Managing Director - Bracknell Forest and Lead for Urgent and Emergency Care at Frimley Collaborative of CCGs
Catriona Khetyar, Head of Medicines Optimisation, East Berkshire CCG
Gill Manning, Lay Member, East Berkshire CCG
Jane Butterworth, Head of Medicines Management, Buckinghamshire CCG
Robert Majilton, Deputy Chief Officer, Buckinghamshire CCG
Dr Karen West, GP, Clinical Director Integration, Caldicott Guardian, Buckinghamshire CCG
Neil Flint, Head of Planned Care, Buckinghamshire CCG
Linda Collins, Clinical Effectiveness Manager (CCG), Oxfordshire CCG
Diane Hedges, Deputy Chief Executive and TVPC Strategic Lead, Oxfordshire CCG
Dr Andrew Brooks, Clinical Chief Officer, NHS Surrey Heath & NHS East Berkshire CCG, now Frimley Collaborative

Members with Specialist Knowledge
Professor Chris Newdick, Specialist Advisor, Health Law, University of Reading
Dr Mark Sheehan, Specialist Advisor – Ethics, University of Oxford
Tessa Lindfield, Strategic Director of Public Health for Berkshire, Public Health Services for Berkshire

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Dr Minoo Irani, Medical Director, Berkshire Healthcare NHS Foundation Trust
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Dr Tina Kenny, Medical Director, Buckinghamshire Health Care NHS Trust
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Andy Northeast, Consultant Surgeon (Vascular), Consultant Surgeon at Oxford University Hospitals & Buckinghamshire Healthcare NHS Trusts
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Professor Meghana Pandit, Medical Director, Oxfordshire University Hospitals NHS Trust
Dr Mark Hancock, Medical Director, Oxfordshire Health NHS Foundation Trust
John Reynolds, Associate Head of Medical Sciences Division, University of Oxford /Oxford University Hospital NHS Trust
Bhulesh Vadher, Clinical Director of Pharmacy and Medicines Management, Oxford University Hospital NHS Trust
Anny Sykes, Director of Clinical Improvement, Deputy CMO, Consultant in Respiratory Medicine and Lung, Oxford University Hospital NHS Trust
Louise Davies, Medicines Optimisation Pharmacist, Oxfordshire CCG and Oxford University Hospital

Matthew Covill, Director of Business Planning, Oxford University Hospitals NHS FT
Kate Stephen, Commisioning Manager, Oxford University Hospitals NHS FT

Other invitees
Tracey Marriott, Director of Innovation Adoption, Oxford Academic Health Science Network
Chandi Ratnatunga, Associate Medical Director, Clinical Networks and Partnerships
South, Central and West Commissioning Support Unit
Tiina Korhonen, Clinical Effectiveness Lead
Kathryn Markey, Clinical Effectiveness Manager
Kate Forbes, Clinical Effectiveness Manager
Rebecca Hodge, Clinical Effectiveness Manager
Kim Tie, Clinical Effectiveness Manager
Jenny Kovalaine-Kwan, Clinical Effectiveness Manager
Katie Newens, Clinical Effectiveness Manager
Rachel Finch, Clinical Effectiveness Administrator up until December 2020
Helen Hicks, Clinical Effectiveness Administrator
Funmi Fajesmisin, Clinical Services Programme Lead - Clinical Policy Implementation
Sarah Annetts, Head of IFR and Case Management
Aimee Ashby, Prior Approval and Audit Manager (Interim)
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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 within the allocated budget 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 seventh Annual Report, which summarises its key activities and achievements for 2020-2021 and looks at the year ahead.

The 2020-2021 work programme has been restricted due to the COVID-19 pandemic. Meetings continued but were held virtually via Microsoft Teams for a shorter duration and initially, from May to July inclusive, without the presence of NHS provider organisations due to the increased pressure of the COVID 19 pandemic. Acknowledging the lack of provider input the work programme over this time focused on progressing policy updates as opposed to review of new topics. Overall, 3 new topics and 8 priority policy updates have been discussed at eight Committee meetings this year (Section 2).

A literature review has been prepared for each topic, enabling an informed starting point for discussion. This review is widely circulated to local commissioners, medical directors of provider trusts and specialist 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.

Despite the COVID-19 pandemic, the Annual Report highlights that the Committee has had a productive year with some incredibly difficult discussions. Nevertheless, this highlights the importance in consistent decision making across Thames Valley CCGs and the significance of the role the Committee plays 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 2020-2021

2.1 Committee Membership

A key strength of the Priorities Committee is its range of expertise, which includes medical, pharmaceutical, finance, lay and specialised legal and ethical representation as well as provider organisations.

Despite the COVID 19 pandemic, committee meetings have been well attended with regular provider representation and engagement for clinical specialists where appropriate. The virtual meetings have enabled good clinician attendance and have been welcomed by provider trusts. This is essential to ensure the Committee achieves high quality and timely decision making. The Committee continues to benefit from regular specialised legal and ethical input. This year has also seen regular attendance from additional lay representatives.

The Committee programme continues to be managed and supported by the South, Central and West (SCW) Clinical Effectiveness team.

2.2 Topics considered

Eight meetings of the Priorities Committee were held during the 2020-2021 period. Due to the COVID-19 pandemic, these were shorter and held via 'Microsoft Teams'. 2021-2022 has seen the review of current policies in the main as it was considered inappropriate to address many new topics which would require secondary care specialist input.

Table 1 provides a summary of the new topics discussed and updates considered to require considerable review: 3 new topics and 8 priority topic reviews were addressed.

The Committee has also supported the scheduled review of 18 current policies reviews resulting in minor updates (Table 2). The Committee programme remains responsive to accommodate CCG in year requests or national policy directives. 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 a literature review including (where applicable and available) a summary of national guidance, appraisal of the evidence, local activity, costing information and any feedback received from local clinicians or other specialists. The literature reviews 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. Literature 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 (where applicable) and Governing Body summary paper for each policy recommendation to aid the ratification process. Once ratified, the SCW CSU Clinical Policy Implementation team (formerly the Individual Funding request (IFR) team) communicates new policies to the public and providers via the Clinical Policy Implementation Service website (formerly known as 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 the clinical policy implementation team (formerly known as the IFR team)

2.3 Current policies schedule for updates

Each CCG has adopted a number of policies over the years which are in need of regular updating to reflect current best practice. All TVPC policies are reviewed every three years. For each policy a literature search is conducted to identify evidence or national guidance published since the original policy review was undertaken. The Evidence-Based Interventions programme published list 1 in 2018 and list 2 in 2020. These guidelines are considered as part of the ongoing policy update programme and are also considered for development of new Thames Valley wide policy. 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 2020-21, within the remit of this programme, 11 policies were identified, reviewed and presented to the Committee. Of these, 5 have been updated with minor changes and/or new codes, and 1 has been recommended for withdrawal (included in table 2). Five policies have been scheduled for a full update, 3 of which has now been completed. (Table 3).

Table 1: New topics and priority updates that required considerable review by the Priorities Committee during 2020-2021 and resulted in a significant change in policy recommendation.

Thames Valley Priorities Committee Work programme: Topics considered 2020-21	
Evidence reviews of new topics and policy updates requiring substantial review identified for the work programme	**Recommended outcome of review**
1. RMOC Advisory Statement: Sequential Use of Biologic Medicines.	Updated policy recommendations for TVPC 46 psoriatic arthritis and TVPC 51 rheumatoid arthritis
2. Sodium oxybate for cataplexy and excessive daytime sleepiness in narcolepsy in adults	New policy
3. Defining activities of daily living (ADL)	A statement on the application of activities of daily living (ADL) to individ8ual funding requests (IFR) was developed.
4. Complementary and alternative therapies including homeopathy and acupuncture	New policy
5. TVPC10: Interventions for non-union fracture: Low intensity Pulsed Ultrasound and teriparatide	Policy update
6. Review of TVPC 43 Use of biologic therapies and Janus-associated tyrosine kinases (JAK) inhibitors for ulcerative colitis in adults (18 years and over)	Policy update
7. TVPC 59: Management of Female Pelvic Organ Prolapse	Policy update
8. TVPC 62 Functional Electrical Stimulation (FES) for Upper and Lower Limb Dysfunction of Central Neurological Origin	Policy update
9. TVPC 63 Circumcision and Preputioplasty	Policy update
10. TVPC81 Prescribing of cannabis-based products for medicinal use in particular THC:CBD spray (Sativex) for moderate to severe spasticity in adults with multiple sclerosis (MS)	Policy update
11. Review of Academy of Medical Royal Colleges Evidence Based Intervention list 2	Clarification of approach of TVPC to the 31 tests, treatments and procedures. Outcomes as of March 2021 include update to policies: TVPC21 Chronic rhinosinusitis (adults and children); TPC 48 Elective surgical hernia repair in adults; TVPC50 Subacromial decompression for shoulder impingement (imaging); TVPC52 Management of low back pain and sciatica (imaging); TVPC 74 Adhesive capsulitis; TVPC 75 Management of asymptomatic gallstones; TVPC76 Arthroscopic Knee Surgery for Meniscal Tears

Table 2 Review of current policies resulting in a minor update or withdrawal. This table includes policies identified within the policy update programme in 2020-2021

Review of current TVPC policies and old policies	Recommended outcome of review
1. Intravenous versus oral steroids for exacerbation of multiple sclerosis	Withdrawal of policy recommendation statement 67: Intravenous versus oral steroids for exacerbations of multiple sclerosis
2. Chronic fatigue syndrome	Minor update but new Thames Valley wide policy issued (TVPC98:Chronic Fatigue Syndrome/Myalgic Encephalomyelitis). Policy will be reviewed following publication of NICE guidance.
3. Short burst oxygen therapy (SBOT) for the relief of breathlessness	Withdrawal of policy
4. TVPC4: Vasectomy	Policy update
5. TVPC 19 Carpel Tunnel Syndrome	Policy update
6. TVPC 18 Dupuytren's contracture	Policy update
7. TVPC 15 Ganglion	Policy update
8. TVPC 49 and TVPC 8 Patients with OA against NICE guideline [NG157] joint replacement (primary): hip, knee and shoulder	Policy update
9. TVPC 56 Therapeutic use of facet joint injections and medial branch blocks for chronic neck pain	Policy update
10. TVPC 61: Snoring and Obstructive Sleep Apnoea / Hypopnoea Syndrome (OSAHS) in adults	Policy update
11. TVPC 67: NHSE Specialised Commissioning statement	Policy update
12. TVPC 68: Female sterilisation	Policy update
13. TVPC 69: Reversal of Female sterilisation and male sterilisation	Policy update
14. TVPC 70: Ectropion and Entropion - indications for surgery	Policy update
15. Donepezil, galantamine and rivastigmine for the treatment of dementia associated with Parkinson's	Withdrawal of policy
16. TVPC72 Management of Haemorrhoids	Policy update
17. TVPC 77: The diagnosis and treatment of Foetal Alcohol Spectrum Disorders (FASD) in children, adolescents and adults.	Policy update

In addition to the above, TVPC64 Real-time continuous glucose monitors for adults with type 1 diabetes and TVPC73 Flash Glucose Monitoring System (Freestyle Libre®) were reviewed and updated following new directives from NHS England and publication of updated NICE guidance.

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

- Some of the agreed policies offer financial savings or reduce the risk of significant financial impact to the CCGs by recommending the use of more cost-effective interventions as the first line treatment and by clarifying the place of treatment in a care pathway (for example TVPC 43 Use of biologic therapies and Janus-associated tyrosine kinases (JAK) inhibitors for ulcerative colitis in adults (18 years and over).
- Policies have also been developed to restrict procedures or interventions which are not supported by a robust evidence base and for which patients safety may be unknown (for example complementary and alternative therapies).
- Endorsing national best practice and high quality care for patients (for example review of TVPC policies in line with evidence based intervention lists 1 and 2).
- Direct savings and reduction in potential costs and support with system recovery and waiting lists associated with the recommendations may 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.

Table 3: Policy Update Programme – These policies have been reviewed and scheduled for a full review as a result of identifying new evidence and national guidance that requires further consideration by the TVPC.

Policy
1. TVPC50 Subacromial decompression for shoulder impingement
2. TVPC58: Hysterectomy – indications for surgery - completed
3. TVPC 59: Management of Female Pelvic Organ Prolapse - completed
4. TVPC 61: Snoring and Obstructive Sleep Apnoea / Hypopnoea Syndrome (OSAHS) in adults - completed
5. TVPC71: Treatment pathway for adults with ADHD

2.4 New topics for the 2021-2022 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. This year the Clinical Effectiveness team also corresponded with provider trusts for input to the workshop. A scoring system is used to help prioritise topics that will bring the greatest financial or quality benefit to their population. This year eight new topic submissions were received from the CCGs. The Priorities Committee topic working group convened in November 2020 to debate and score the new topics and those with the highest scores selected for inclusion (Table 4). Seven new topics were included in the work programme. Some

submissions were not scored due to further information being required or added to the policy updates programme.

Table 4: New topic submissions reviewed and scored in November 2020 for 2021-22 work programme

Topic No	Title	Topic Score
118	Cataract surgery for the second eye	35
119	Surgery for tear duct obstruction (lacrimal surgery)	12
120	In growing toenail	30
123	Hydrotherapy for people with special educational needs (18 to 25yrs)	16
124	Care plans for patients with very complex needs	45
127	Osteoporosis pathway	45
128	Sequential use of biologic drugs for Juvenile Idiopathic Arthritis	30
CCG topics submitted - agreed not to score.		
121	Mechanical Insufflation-Exsufflation devices/'Cough Assist' for patients with neuromuscular disease or cervical spinal cord injury	Not scored due to a low number of IFRs
122	Routine patient follow-ups following surgery	Not scored (already being addressed in trusts and CCGs)
125	Medication to delay menstruation	Not scored (added to work programme for consideration of a statement)
126	Novel/rare therapies for treatment resistant depression	Not scored, for Buckinghamshire CCG to provide more information regarding request
129	Acne vulgaris	Not scored (CE team to undertake further scoping exercise)
130	Tonsillectomy for tonsillitis (investigate opportunity to	Not scored (CE team to explore number of patients waiting surgery)
131	Benign prostate hyperplasia (BPH)	Review in line with Academy of Royal Medical Colleges Evidence based intervention list 2 guidance
132	Exercise ECG for screening asymptomatic and low risk patients for coronary heart disease (CHD)	Review in line with Academy of Royal Medical Colleges Evidence based intervention list 2 guidance
133	Imaging for orthopaedics (including low back pain)	Review in line with Academy of Royal Medical Colleges Evidence based intervention list 2 guidance

134	Endoscopy and colonoscopy investigations	Review in line with Academy of Royal Medical Colleges Evidence based intervention list 2 guidance
135	TV Oral Surgery referral criteria (NHS England)	Monitor with OCCG

2.5 Committee Operating Procedures and Annual Training Event

The ethical framework and standard operating procedure were reviewed. No training event was held in 2020-21.

2.6 COVID-19 recovery plan

A sub-group of the TVPC was set up and tasked with developing a set of ethical principles that could be used for prioritisation of resuming elective care. The specialist adviser in ethics facilitated this work. Proposals were shared with BOB ICS and East Berkshire representatives.

3. Future developments

The Committee has now been in operation for over eight 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, the development of Integrated Care Systems (ICS), priorities of the wider health and social care system, the recovery of elective care and patient services following COVID-19 and the Evidence-Based Intervention (EBI) programme. The Clinical Effectiveness team on behalf of the TVPC, promotes review of the EBI programme and participates in engagement events in order to gain the most benefit from the EBI programme. These areas of focus and development will ensure continuation of working 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 the Integrated Care Systems and their work streams and priorities. 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 and provider trusts to participate in work planning 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 four 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
- To take account of the NHS statutory requirements

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 of the Priorities Committee will be asked to declare any conflict of interest to the Committee secretariat annually. All members and attendees will also be asked to declare any conflict of interest at each meeting in relation to the agenda to the Committee Chair. The TVPC evidence review consultation will also include a request to disclose any conflicts of interest by the specialist feeding back on the topic under review. A judgement will be made by the Chair of the Committee as to materiality of any declaration to the Committee decision making.

2.2 Membership

TITLE	No. delegates	Voting rights
Independent Lay Member Chair	1	√
NHS Clinical Commissioning Groups*		
Oxfordshire 1 CCG	2	√
Buckinghamshire	2	√
Berkshire West	2	√
East Berkshire	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. Public Health representation is specifically sought for selected topics.

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
- 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 annually.

February 2014
Updated July 2017
Updated November 2018
Updated July 2019 and November 2019

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

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 four 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:

[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/

- 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.

- 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.

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

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 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. SIGNIFICANT 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

[6] https://www.gov.uk/government/collections/health-and-social-care-outcomes-frameworks

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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[7] Local commissioning policies include drug formularies