NHS
Hampshire and Isle of Wight

Terms of Reference

Hampshire and Isle of Wight Integrated Care Board
Priorities Committee

1. Constitution

1.1 The Hampshire and Isle of Wight Priorities Committee is an advisory group for the Integrated Care Board (ICB).

1.2 This group of commissioning organisations fund the infrastructure, provide operational support to, and are core members of the Priorities Committee.

1.3 The members of the Committee will collectively review these terms of reference at least every three years to ensure they remain appropriate. Review can be undertaken earlier than this in response to national requirements or if two or more party agree this is appropriate. Any such review will be signed off by the Clinical Leaders of the ICB.

2. Purpose

2.1 Commission evidence reviews of selected clinical treatments/ services/ interventions.

2.2 Make recommendations on the appropriateness of the use of NHS resources in these healthcare interventions to include specific treatments, diagnostics and procedures and care pathways

3. Responsibilities

3.1 In order to fulfil its purpose, the group will:

- Receive evidence appraisals and service reviews specifically commissioned by the committee members
- Take account of published evidence relevant expert, stakeholder and patient/ lay perspective in formulating its recommendations
- Consider the information they receive, in accordance with the Ethical Framework (see Appendix 1)
- Develop recommendations on commissioning policy, with regards to the topics presented to the Committee, to be considered and if accepted, adopted by the constituent commissioning organisations.
- Establish a Clinical Policy Operational Group (CPOG) to set the committee's work programme and prepare final version of draft policy statement taking account of comments received during its development (see separate Terms of Reference)

4. Scope of Authority

4.1 The Priorities Committee makes recommendations to the ICB Governing Body via the ICB Integrated Assurance Committee.
The Committee has the ability to request input / attendance by subject matter experts as appropriate.

5. Membership, Quorum and Attendance

5.1 The Priorities Committee will draw its membership from the following sources:

- Up to two members per Local Delivery System - LDS (Isle of Wight, North and Mid Hampshire, Southampton and South West Hampshire, and South East Hampshire)

  These members will supply specialist knowledge from one or more of the following areas:
  - ICB Executive with commissioning responsibility
  - ICB Executive with finance responsibility
  - Clinical background in practice
  - Lay members
  - Medicines Management
- A Specialist in Public Health
- A Medical Director / Consultant of an NHS provider organisation
- A Legal / ethics advisor
- A Contracting/IFR Advisor
- Healthwatch
- Corporate Governance

Other colleagues may be invited with the agreement of the Chair

5.2 Individual members representing local NHS commissioning organisations should have sufficient authority and standing to ensure fully informed recommendations are developed that command the confidence of their organisations. They are expected to champion best practice and value in the local health care system. These members are responsible for ensuring the outputs of the Priorities Committee are taken through their organisations own internal governance processes.

5.3 Where members are employed by the organisation they represent, this role should be included in their job description/ job plan.

5.4 Deputies will be permitted and should be of similar standing to the member they are representing. Consideration should be given by the committee as to the acceptable attendance level of deputies.

5.5 Training events relating to the work of the Priorities Committee may be offered to Committee members where appropriate.

5.6 The Chair of the committee will be agreed by the clinical leaders of the relevant commissioning organisations. The Deputy Chair will be a Priorities Committee member, elected by the Committee members.

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

- representation from at least three of the four Local Delivery Systems
- at least one senior clinician
- one lay member

5.8 Should a meeting not be quorate the “draft recommendations” produced by the committee will be circulated via e-mail to all Committee members, seeking approval.

If no consensus can be reached in this manner, then that item will be re-considered at the next Priorities Committee meeting. This may include inviting subject matter experts to support the development of a recommendation.

6. Recommendations of the Committee

6.1 The Committee's recommendations are made by a consensus of members, either at the meeting or as described in paragraph 5.8.

6.2 Members have a responsibility to try and reach a consensus, recognising that the impact of a recommendation may differ between Local Delivery System potentially affecting implementation. However the decision to adopt these recommendations remains with the ICB governing body.

7. Frequency

7.1 The Priorities Committee will meet bi-monthly. Additional meetings can be called by the Chair of the Committee if it is deemed necessary. The meeting will be held in a place agreed by members

8. Meeting Arrangements

8.1 The HIOW Priorities Committee shall operate in line with the requirements of the NHS Codes of Conduct and Accountability, the NHS Constitution and the ICB Constitution, reflecting the Nolan Principles.

8.2 The Committee will operate in accordance with standards of business conduct including conflicts of interest. It will hold a Register of Interests for its members and declarations of potential conflicts will be a standing agenda items in accordance with good governance.

8.3 Where a member has a potential conflict of interest then the Chair of the meeting will determine whether the person concerned can remain in the meeting and whether the persons must be excluded from discussions and the development of subsequent recommendations

8.4 The service provider South Central and West Clinical Effectiveness Team will manage and administer the Priorities Committee and will liaise with Committee Chair, ahead of each meeting to establish meeting quoracy. It is each member Local Delivery System/ICB responsibility to ensure they are appropriately represented at Priorities Committee meetings. Committee member 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.

8.5 The agenda for each meeting will be agreed by the Committee, in liaison with the Committee Chair and as per CPOG agreement. 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.

8.6 Minutes of the Committee will be drafted by SCW Clinical Effectiveness Team and circulated within ten working days of the meeting. As a minimum and in order to support points of clarity and transparency it is expected that these will contain

- General points of discussion
- Questions and responses
- Input of relevant experts and
- Any potential, real or perceived conflict of interest

8.7 The recommendations of the Committee will be formulated into a draft policy statement by SCW Clinical Effectiveness team and circulated for comment within ten working days of the meeting. Suggested amendments should be made by email within a further ten working days.

The SCW Clinical Effectiveness team will prepare the final version of draft policy statement taking account of comments received during their development.

8.8 Final Policy statements may require sign off by the Committee before being sent to for approval.

Updated May 2022
Last updated August 2022 to reflect organisational change only.

Appendix 1.

HAMPSHIRE and ISLE OF WIGHT ICB PRIORITIES COMMITTEE

ETHICAL FRAMEWORK

BACKGROUND

The Priorities Committee is a committee of Hampshire and Isle of Wight Integrated Care Board (ICB).

It includes the above ICB as well as lay members, clinicians, and managers. The purpose of the Priorities Committee is to advise the member ICB about the health care interventions and recommended commissioning policies that should be considered.

ICB is under a statutory duty to promote the health of the local community. They are also under a duty not to exceed their annual financial allocation. These legal requirements mean that, from time to time, difficult choices have to be made. The Priorities Committee will help the ICB to choose how to allocate their resources to promote the health of the local community. Individual cases are considered by each respective.

This Ethical Framework is based upon the South Central wide ethical framework and its preceding versions. Its purpose is to support decision making process of the Priorities Committee and to offer a decision framework for constituent commissioning bodies.

PURPOSE OF THE ETHICAL FRAMEWORK

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

- Providing a coherent structure for discussion, ensuring all important aspects of each issue are considered;
- 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***[1] the ***Public Sector Equality Duty***[2] and the requirement to involve the public when making significant changes to the provision of NHS healthcare[3] are adhered to.
- Providing a means of expressing the reasons behind the decisions made;
- Reducing risk of judicial review by implementation of robust decision-making processes that are based on evidence of clinical and cost effectiveness and an ethical and lawful framework;
- Supporting and integrating with the development of commissioning policies.

[1] The NHS Constitution http://www.nhs.uk/choiceintheNHS/Rightsandpledges/NHSConstitution/Pages/Overview.aspx

[2] Equality Act 2010: guidance (June 2015 update) https://www.gov.uk/guidance/equality-act-2010-guidance

[3] Patient and public participation in commissioning health and care: statutory guidance for clinical commissioning groups and NHS England (2017) https://www.england.nhs.uk/participation/involvementguidance/ccg-iaf/

Formulating policy recommendations regarding health care priorities involves the exercise of judgment 1. and discretion and there will be room for disagreement both within and out with the Committees. Although there is no objective or infallible 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 Committee recognises that its discretion may be affected by national policy and by National Institute for Health and Clinical Excellence (NICE) guidance and Secretary of State Directions to the NHS.

The Ethical Framework is especially concerned with the following:

1. Evidence of Clinical and Cost Effectiveness

The Committee will seek to obtain the best available evidence of clinical and cost 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 Committees. Choice of appropriate clinically and patient-defined outcomes needs to be given careful consideration, and where possible quality of life measures and cost utility analysis should be considered.

The Committee will promote treatments for which there is good evidence of clinical effectiveness in improving the health status of patients and will not normally recommend treatment that is shown to be ineffective. Issues such as safety and drug licensing will also be carefully considered. 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 decent 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 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. They will consider technical cost-benefit calculations where these can be accessed (e.g. quality adjusted life years), but these will not by themselves be decisive. The Priorities Committee may use the ethical framework to guide context-specific judgements about the relative priority that should be given to each intervention.

2. 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 Committees will not discriminate on grounds of personal characteristics, such as age, gender, sexual orientation, gender identity, race, religion, lifestyle, social position, family or financial status, 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. The committee will always make decisions and recommendations consistent with legislation such as the equality act and will consider the impact of all recommendations.

3. Health Care Need and Capacity to Benefit

Health care should be allocated justly and fairly according to need and capacity to benefit, such that the health of the population is maximised within the resources available. 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.

4. Cost Of Treatment and Opportunity Costs.

Because each commissioning body is duty-bound not to exceed its budget, the cost of treatment must be considered. The cost of treatment is significant because investing in one area of health care inevitably diverts resources from other uses. This is known as opportunity costs and is defined as benefit foregone, or value of opportunities lost, that would accrue by investing the same resources in the best alternative way. The concept derives from the notion of scarcity of resources. A single episode of treatment may be expensive, or the cost of treating a whole community may be high.

5. Needs of the Community

Public health is an important concern of the Committee and it 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). 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 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 relatively low priority and cannot generally be supported, a patient’s doctor may still seek to persuade the ICB that there are exceptional circumstances which mean that the patient should receive the treatment.

6. National Policy Drivers

The Department of Health issues guidance and directions to NHS organisations, including the NHS Constitution and NHS Mandate, 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 ICBs. The Committee will operate with these factors in mind and recognise that its discretion may be affected by national policy, NICE publications, 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 local delivery system.

7. Exceptional Need

There will be no blanket bans on treatment since there may be cases in which a patient has exceptional circumstances which present an exceptional need for treatment. Each case of this sort will be considered on its own merits in light of the clinical evidence. ICB has procedures in place to consider such exceptional cases on their merits.

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