South, Central and West
Commissioning Support Unit

Thames Valley Priorities Committee
Annual Report
2021-2022

Thames Valley Clinical Commissioning Groups (at March 2022):

Berkshire West Clinical Commissioning Group

Buckinghamshire Clinical Commissioning Group

East Berkshire Clinical Commissioning Group

Oxfordshire Clinical Commissioning Group

Date of Publication: July 2022

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 2022)

Chair

Dr Alan Penn, Independent Lay Member

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
Robert Majilton, Deputy Chief Officer, Buckinghamshire CCG
Dr Karen West, GP, Clinical Director Integration, Caldicott Guardian, Buckinghamshire CCG
Neil Flint, Head of Commissioning for Planned Care, Buckinghamshire CCG
Dr Megan John, GP, East Berkshire CCG Lead
Sangeeta Saran, Director of Operations, East Berkshire CCG
Lalitha Iyer, Medical Director, East Berkshire CCG
Gill Manning, Lay Member, East Berkshire CCG
John Fraser, Clinical lead Surrey Heath
Sue Carter, Clinical Effectiveness Manager, Oxfordshire CCG
Jenn Sula-Minns, Prior Approvals Manager, Oxfordshire CCG
Diane Hedges, Deputy Chief Executive and TVPC Strategic Lead, Oxfordshire CCG

Members with Specialist Knowledge

Emeritus Professor Chris Newdick, Specialist Advisor - Health Law, University of Reading
Dr Mark Sheehan, Specialist Advisor – Ethics, University of Oxford

NHS Provider Organisations

Dr Minoo Irani, Medical Director, Berkshire Healthcare NHS Foundation Trust
Dr Tina Kenny, Medical Director, Buckinghamshire Health Care NHS Trust
Andrew McLaren, Deputy Medical Director, Buckinghamshire Health Care NHS Trust
Maire Stapleton**,** Formulary Manager, Medicines Resource Centre Buckinghamshire Integrated Care Partnership
Dr Tim Ho, Medical Director, Frimley Health Care NHS Foundation Trust
Mohammed Asghar, Prescribing Governance Manager, Frimley Health NHS Foundation Trust
Professor Meghana Pandit, Medical Director, Oxfordshire University Hospitals NHS Trust
Dr Andrew Brent Director of Clinical Improvement Oxfordshire University Hospitals NHS Trust
Bhulesh Vadher, Clinical Director of Pharmacy and Medicines Management, Oxford University Hospital NHS Trust
Kate Stephen, Commissioning Manager, Oxford University Hospitals NHS FT
Dr Mark Hancock, Medical Director, Oxfordshire Health NHS Foundation Trust
Dr Janet Lippett, Medical Director, Royal Berkshire NHS Foundation Trust

Other invitees

South, Central and West Commissioning Support Unit

Tiina Korhonen, Clinical Services Programme Lead - Clinical Effectiveness
Kathryn Markey, Clinical Effectiveness Manager
Kate Forbes, Clinical Effectiveness Manager
Jenny Kovalaine-Kwan, Clinical Effectiveness Manager
Katie Newens, Clinical Effectiveness Manager
Naomi Scott, Clinical Effectiveness Manager
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)
Marion Mason, Head of Prior Approval and Assurance (Interim)

Contents

1. Introduction

In 2021-2022 Thames Valley Priorities Committee (TVPC) acted as an advisory body for priority setting and clinical policy development to the four historical Clinical Commissioning Groups (CCG) across the Thames Valley Region, and has supported 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
- provide a transparent process expressing the reasons behind the decisions made to patients, families, carers, clinicians and the public.

This is the Priorities Committee's eighth Annual Report, which summarises its key activities and achievements for 2021-2022 and looks at the year ahead.

The 2021-2022 work programme has continued to be restricted due to the COVID-19 pandemic and prioritisation of elective care recovery. Meetings continued virtually via Microsoft Teams but with January's meeting being used to review priorities and discuss further the work plan, due to CCG staff deployment.

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 (appendix 2) 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 commissioners 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 continued effect of the COVID-19 pandemic, the Annual Report highlights that the Committee has had an active year with some incredibly difficult discussions. This highlights the importance in consistent decision making across Thames Valley CCGs and the significance of the role the Committee plays in supporting commissioners with high quality priority setting. With the implementation of the Health and Care Act 2022 and the significant reforms to the organisation and delivery of health and care services in England, the Committee will need to review its ways of working to ensure it supports the priorities of the Integrated Care Systems (ICS) and Integrated Care Boards (ICB).

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 until March 2022
Thames Valley Priorities Committee

2. Key Activities 2021-2022

The authors of this report note that CCGs are no longer in existence, but the term CCGs is referred to here to reflect the year ending 2021 for which this report is relevant.

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.

Committee meetings have been well attended with regular provider representation and engagement of clinical specialists where appropriate. The continuation of virtual meetings has enabled good clinician attendance and has been welcomed by provider trusts. The Committee continues to benefit from regular specialised legal and ethical input. This year has also seen regular attendance by 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

Six meetings of the Priorities Committee were held during the 2021-2022 period. 2021-2022 has seen the review of current policies in the main as fewer topics were proposed for review by CCGs.

The Committee programme remains responsive wherever possible to accommodate CCG in year requests or national policy directives such as Evidence Based Intervention guidance.

For each topic and policy review, 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 policy updates

Each CCG has adopted a number of policies over the years which are in need of regular updating to reflect current best practice. TVPC policies are currently 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 (EBI) 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. Review of policies also includes the addition of clinical coding i.e diagnostic codes and intervention and procedure OPCS codes where applicable. It is noted that this year, many policy reviews resulted in no change to the current policy.

Table 1 provides a summary of the topics discussed and updates considered

Table 1: New topics and policy updates that required review by the Priorities Committee during 2021-2022

Thames Valley Priorities Committee Work programme: Topics considered 2021-22	
Evidence reviews of new topics and policy updates requiring substantial review identified for the work programme	**Recommended outcome of review**
1. Review of Posterior tibial nerve stimulation for urinary incontinence in children	New policy with a not normally funded position
2. Review of the use of biological and immunomodulatory therapies in moderate Rheumatoid Arthritis	New interim statement to support cost effective prescribing and NICE Technology appraisals
3. Review of Benign prostate hyperplasia (BPH) pathway to include review of Evidence Based Intervention 2I — Surgical intervention for benign prostatic hyperplasia	New policies developed in line with EBI and MedTech Funding Mandate policy 2022/23 TVPC104 prostate specific antigen testing. TVPC109 treatment of voiding LUTS due to BPH.
4. Review of Evidence based intervention list 2: 2M Endoscopy; 2N Colonoscopy; 2O Repeat colonoscopy	New policies developed: TVPC106 Surveillance colonoscopy post-polypectomy and post-colorectal cancer resection; TVPC 107 Colonoscopy in the management of hereditary colorectal cancer; TVPC 108 Upper gastrointestinal endoscopy in adults
5. Review of Evidence based intervention list 2: Surgical removal of kidney stones	New policy
6. Policy review: TVPC 1 Interventional Procedures for Varicose Veins	RCT identified and EBI phase 1 guidance supports NICE CG168. This requires further consideration by the Committee.
7. Policy review: TVPC20 Otitis Media with effusion in children under 12	Policy updated in line with EBI
8. Policy review: TVPC 14 Biological mesh and review of biological mesh for abdominal surgery	Policy update – no change
9. Policy review: TVPC 49 Patients with osteoarthritis (OA); primary hip and knee replacement	Policy reviewed and updated as initiated by clinicians
10. Policy review: TVPC83 Anterior Cruciate Ligament (ACL) reconstruction	Policy reviewed and updated as initiated by clinicians

11. Policy review: TVPC 76 Arthroscopic Knee Surgery for Meniscal Tears	Policy updated to include link to patient information
12. Policy review: TVPC 68 Female Sterilisation	Policy update – no change
13. Policy review: TVPC 11g Assisted reproduction services for infertile patients	Ongoing
14. Review of Care plans for patients with very complex needs	Detailed review of the cost, complexity and risks involved with provision of home care for patients eligible for Continuing Healthcare (CHC). Discussions established that there may be scope for a cost threshold for provision of home care, once equity and choice policies are in alignment across the ICS. This would provide consistency to decision making reducing variation in access and provision of care.
15. Policy review: TVPC2 Treatments for Gender Dysphoria	Policy updated to reflect the current NHS England Specification and maintain not normally funded position for non-core procedures
16. Policy review: Policy TVPC80 Primary Care Pathway for Subfertility	Policy update – no change
17. Policy review: TVPC 3 Arthroscopic lavage & debridement for patients with OA of the knee	Minor update to policy
18. Policy review: TVPC 29 Dilatation and curettage for abnormal uterine bleeding	Minor update to policy
19. Policy review: TVPC 33 Surgical treatment of femoro acetabular hip impingement surgery	Policy update – no change
20. Policy review: TVPC 32 Ultrasound guided injections for hip pain	Policy update – no change
21. Policy review: TVPC 78 Smoking cessation before planned surgery	Minor update to policy
22. Policy review: Anal Irrigation Systems for the Management of Faecal Incontinence/Constipation	Policy update – no change
23. Policy review: Severe and complex obesity	Policy updated to remove 5 year time period for obesity

24. Policy review: Non pharmacological services for dementia	Policy withdrawal

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 the use of biological and immunomodulatory therapies in moderate Rheumatoid Arthritis)
- 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 Posterior Tibial Nerve Stimulation for urinary incontinence in children)
- Endorsing national best practice and high quality care for patients (for example review of TVPC policies in line with EBI 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.

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. The Clinical Effectiveness team also corresponds 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. The Priorities Committee topic working group convened in December 2021 to debate and score potential new topics and discuss future ways of working to ensure TVPC remains fit for purpose. At the workshop the following were discussed:

- IFRs citing mental health issues as a reason for 'exceptionality' – it was proposed that there could be peer review across the IFR teams to allow bench marking and share learning
- Management of chronic neck pain – it was suggested that the Clinical Effectiveness team on behalf of TVPC should liaise with Elective Care Boards to ascertain the value of review.
- Review and benchmarking of variation in activity across "challenge specialities" (high volume/high clinical time/high theatre time specialties) – it was proposed that the Clinical Effectiveness team on behalf of TVPC should liaise with Elective Care Board to agree how to review and benchmark in order to identify how TVPC may support work addressing 'challenge specialities'.

- Review of inequalities in access to care and utilisation of services - The TVPC must ensure policies have a positive impact on equalities and access. It was suggested that IFR teams could review IFR decisions against deprivation scores by ward.

2.5 Committee Operating Procedures and Annual Training Event

The Ethical Framework and Standard Operating Procedure were reviewed. It was agreed to discuss these further in detail when ICBs become fully operational. These discussions are scheduled for September 2022. No training event was held in 2021-22.

3. Future developments

The Committee has now been in operation for over nine years. It has seen a change in membership particularly, over the last 12 months. Continual review and development are key to ensuring that the Priorities Committee is used effectively. The Committee will need to meet the needs of the ICB functions and governance in relation to the Committee remit. In addition, the Committee will need to continue to take account of the direction set out in the NHS Long Term Plan, consider the priorities of the wider health and social care system, review future changes in commissioning arrangements, support the continued recovery of elective care and patient services following COVID-19 and review the local impact of the 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.

It is noted that evidence and guidance has been reviewed for many current TVPC policies and resulted in no change to the policy position. The way in which current TVPC policies are best reviewed in the future should be addressed to ensure the most efficient use of resources.

Key priorities for the year ahead include:

- Ensuring the Committee is adaptable in supporting the priorities of the ICB and ICS and their work streams. This may require greater engagement between the TVPC and ICS stakeholders.
- Review the Committee's Terms of Reference including the Committee membership and Ethical Framework.
- Encouraging continued engagement, feedback and ownership of clinicians and stakeholders within the ICSs and ICBs of the process and the evidence reviews prepared for the Committee.

- Review of the current TVPC policies in the most efficient way whilst ensuring they reflect best practice. A Standard Operating Procedure is being developed to propose a move to a policy surveillance approach for maintaining current clinical policies as opposed to 3 yearly updates.
- Elicit lay/public involvement and insight to inform decision-making in support of accountability and transparency of the decision making process.
- In terms of the future work plan, the Committee may wish to enhance its work in:
    - Utilisation of cross-system intelligence and analytical functions to support improving decision-making.
    - Addressing inequalities in outcomes, experience and access to care.
    - The use of shared decision-making tools and resources to ensure progress towards personalised care across the system.
    - Review of innovation, new high impact service models and pathway redesign to support effective use of NHS capacity and resources.
    - Policy topic content to facilitate move away from commissioner focused committee to collaboration across the ICS e.g., more integrated pathways.
    - Bring to fore preventative healthcare interventions (prehab and rehab).

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

Buckinghamshire Clinical Commissioning Group
Frimley 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	2	√
Buckinghamshire	2	√
Berkshire West	2	√
Frimley	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
Updated July 2021

Buckinghamshire Clinical Commissioning Group
Berkshire West Clinical Commissioning Group
Frimley 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.

[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/

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.

- 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:

[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] 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/

- 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 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:

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

(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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