South, Central and West
Commissioning Support Unit

BOB ICB and Frimley ICB Priorities Committee Annual Report 2022-2023

Buckinghamshire, Oxfordshire and Berkshire West, and Frimley Integrated Care Boards (at March 2023)

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

BOB ICB and Frimley ICB Priorities Committee Membership and Standing Invitees (at March 31st 2023)

Chair

David Clayton-Smith, Chair – Priority Committees and IFR process Development, NHS England and NHS Improvement – South East

ICB Membership

Dr Rachael De Caux, Chief Medical Offier, BOB ICB
Abid Irfan, GP and Deputy Chief Medical Officer, BOB ICB
Alan Cadman, Senior Financial Accountant, BOB ICB
Dr Lalitha Iyer, Chief Medical Officer, Frimley ICB
John Seymour, Deputy Medical Director, Frimley Health Foundation Trust
Sue Carter, Clinical Effectiveness Lead, BOB ICB
Raju Reddy, Secondary Care Consultant, BOB ICB
Megan John, GP, Frimley ICB
John Fraser, GP, Frimley ICB
Jenn Sula-Minns, Clinical Effectiveness Manager, BOB ICB
Gill Manning, Lay Member, Frimley ICB
Ian Murdock, Finance Manager, Frimley ICB

Members with Specialist Knowledge

Emeritus Professor Chris Newdick, Specialist Advisor - Health Law, University of Reading
Dr Mark Sheehan, Specialist Advisor – Ethics, University of Oxford
David Locke, Commissioning Pharmacist, BOB ICB
Mohammed Asghar, Prescribing Governance Lead, Frimley Health and Care ICS
Yousaf Ahmad, Director of Pharmacy and Medicines Optimisation, Frimley ICB
Stuart Line, Public Health Consultant, BOB ICB area

NHS Provider Organisations

Dr Anny Sykes, Interim Chief Medical Officer, Oxford University Hospital NHS Trust
Dr Andrew Brent Director of Clinical Improvement Oxfordshire University Hospitals NHS Trust
Dr Will Orr, Acting Chief medical Officer, Royal Berkshire NHS Foundation Trust
Andrew McLaren, Deputy Medical Director, Buckinghamshire Health Care NHS Trust
Dr Karl Marlowe, Medical Director, Oxford Health NHS Trust
Dr Tim Ho, Medical Director, Frimley Health Foundation Trust
Faiza Khan, Chief Pharmacist, Frimley Health Foundation Trust
Dr Minoo Irani, Medical Director, Berkshire Healthcare NHS Foundation Trust
Kirsty Habibi-Parker, Associate Director of Pharmacy, Buckinghamshire Healthcare Trust
Bhulesh Vadher, Clinical Director of Pharmacy & Meds Management, Oxford University Hospital NHS Trust

Other invitees

Rosalind Pearce, Healthwatch, BOB ICB area
Claire Woolcock, Chief Medical Officer, Sussex Partnership Foundation Trust
Alison Wallis, Clinical Director for DAMHS Service, Sussex Partnership Foundation Trust
Tracey Marriot, Director of Innovation Adoption, Oxford Academic Health Science Network

South, Central and West Commissioning Support Unit

Tiina Korhonen, Clinical Services Programme Lead - Clinical Effectiveness
Naomi Scott, Clinical Effectiveness Manager
Kathryn Markey, Clinical Effectiveness Manager
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Sarah Annetts, Head of IFR and Case Management – Clinical Policy Implementation
Aimee Ashby, Interim Prior Approval and Audit Manager – Clinical Policy Implementation
Marion Mason, Interim Head of Prior Approval and Assurance – Clinical Policy Implementation
Karen Blogg, Clinical Services Administrator – Clinical Effectiveness

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1. Introduction

In 2022-2023 BOB Integrated Care Board (ICB) and Frimley ICB Priorities Committee (BOBFPC) (previously Thames Valley Priorities Committee) has acted as an advisory body for priority setting and clinical policy development to the four historical Clinical Commissioning Groups (CCGs, now two ICBs) across the Thames Valley Region in order 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 ICBs 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 ninth Annual Report, which summarises its key activities and achievements for 2022-2023 and looks at the year ahead. Meetings have been held virtually via Microsoft Teams.

The April 2022 to March 2023 work programme has continued to be affected by the COVID-19 pandemic and prioritisation of elective care recovery. This has been compounded by the establishment of the Integrated Care Boards in July 2022 and the associated restructuring of commissioning staff. At the end of the year NHS England South East Region proposal to develop a single regional Priorities Committee and this process has also affected the Committee workprogramme.

Existing CCG mergers and the establishment of the Integrated Care Boards saw the four historical Clinical Commissioning Groups (CCGs) of the committee, East Berkshire, Berkshire West, Buckinghamshire and Oxfordshire, evolve into two new Integrated Care Boards. Berkshire, Oxfordshire and Buckinghamshire (BOB) and Frimley ICB(North East Hampshire and Farnham, East Berkshire and Surrey Heath CCGs). The Committee's Terms of Reference was updated this year to reflect the change in commissioning structures. This year also saw the retirement of the committee's long-term Lay chair member. The TVPC expressed its gratitude to Alan Penn for his knowledge, tact and skill as chair of the Committee over the past eight years.

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 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 ongoing pressures in elective recovery and administrative changes to reflect the ICB formation, the Annual Report highlights that the Committee has had an active year and made a number of policy recommendations and made some difficult discussions. This highlights the importance in consistent decision making across BOB and Frimley ICBs and the significance of the role the Committee plays in supporting commissioners with high quality priority setting. With the push for consistency in commissioning policy positions across the South East and the national drive to reduce health inequalities the committee will need to review its ways of working to ensure it continues to support the ICBs to deliver to their objectives.

2. Key Activities 2022-2023

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.

The Terms of Reference were reviewed this year to ensure that terminology included was reflective of the change in commissioning responsibilities. As part of this the committee considered that the name of "Thames Valley Priorities Committee" was not representative of the wider geographical area the committee now serves. It was agreed that the committee's name should be updated to "Buckinghamshire, Oxfordshire and Berkshire West ICB and Frimley ICB Priorities Committee", which may be abbreviated to BOBFPC. Alongside this the committee membership and quoracy agreements were updated to ensure appropriate representation from the two ICBs.

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.

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

2.2 Topics considered

Four meetings of the Priorities committee were held during the 2022-2023 period. This year saw fewer meetings of the committee due to a request that the Clinical Effectiveness team's capacity be diverted to support the work on alignment of commissioning policies across the South-East of England.

The committee programme remains responsive wherever possible to accommodate in year requests from ICBs or national policy directives such as Evidence Based Intervention guidance. An example of an in year request received in 2022-2023 was for clarity over the use of hysterectomy to treat dysplasia. Here, a high level literature review was conducted alongside analysis of activity data, allowing the committee to clarify the scope of the policy and negating the need for an in-depth review.

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. Given the drive to address inequalities in healthcare access and outcomes this year saw the introduction of analysis to identify if there is inequality in treatment activity. This provided an insight into whether there are differences in the proportion of patients receiving treatment in each of the indices of deprivation compared to that of the ICB population.

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. ICBs 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 ICBs regarding the need for public engagement or public consultation for each policy proposal.

Draft policy recommendations are submitted to individual ICB 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 Frimley and Berkshire and Buckinghamshire areas of BOB ICB. The minutes of the committee meetings and committee core documents are available to the public on the ICB's website maintained by the clinical policy implementation team.

2.3 Topics considered by the committee this year

Historically the Clinical Effectiveness team has invited CCGs to submit proposals for new topics, after consultation with their stakeholders, for possible inclusion in the following year's work programme. This year it was considered that it would not be appropriate to request proposals from the CCGs ahead of the development of the ICBs as priorities were likely to change following the move. As such, whist a small number of priority topics were agreed for a policy review, the focus of the planning meeting in January 2022 was on developing a work programme for 2022/23 which ensured that the committee was able to fulfil its role in supporting the ICBs duties. The following topics were discussed:

- TVPC needs to explore how to support the ICS with the elective care recovery work programme within the remit of the TVPC. This may include a benchmarking exercise of variation in activity across the challenge specialties.

- Proactive work is required to plan how to use the available resources/finances to help with decision making.
- Preventative health care interventions may be considered rather than single treatments; to include prehab and rehab services and joint working to produce integrated patient pathways.
- Inequalities in access to care/services and outcomes achieved should be addressed.
- Review how best to manage ongoing updates to current TVPC policies. Policies could be aligned to challenge specialties.
- Explore co-working with medicines optimisation (MO) teams
- Review the TVPC membership to ensure adequate representation across the system.
- The publication of the 3rd list of the Evidence Based Interventions Programme
- Ingrown toenails
- Hydrotherapy for people with special educational needs (18 to 25 years)

As shown in Table 1, reviews of three interventions identified as priorities by the CCGs were presented to the committee to consider the publication of new policies. Two new policies were recommended and a policy was not considered to be required for the third topic.

Table 1: Reviews for the consideration of new policies undertaken by the priorities committee during 2022 - 2023

Evidence reviews of new topics and policy updates requiring substantial review identified for the work programme	Recommended outcome of review
Ingrown toenails	New policy developed including recommendations for conservative management and when to refer to the community podiatry team.
Surgery for tear duct obstruction (lacrimal surgery)	No policy required
Treatment with Anti-VEGF agents for Neovascular (Wet) Age-Related Macular Degeneration in patients with one seeing eye	New policy developed detailing treatment thresholds for patients with a severely sight impaired fellow eye

Historically policies developed by the committee have been reviewed every 3 years, identifying any new national guidance and high level clinical evidence which may impact on the policy recommendations. This year, in reflection of ensuring the best use of the committee time and resources, a new policy surveillance process was adopted. This involves the Clinical Effectiveness team conducting monthly surveillance of a range of information sources which publish clinical evidence and commissioning recommendations. If new, pertinent, information is identified this is reviewed and presented to the committee for consideration. The committee is then able to make an informed decision as to whether the policy should undergo an in-depth review.

As part of the consideration of the adoption of this new approach, the Clinical Effectiveness team identified all policies that would have been published more than 3 years ago in March 2023. Each of these policies were reviewed to ascertain if there had been a pertinent update to the clinical guidelines they were based upon. Any policies identified where national guidance had been updated in a way that impacted the policies were scheduled for review.

Table 2. Policies discussed as part of the 3 yearly policy update programme

Policies reviewed as part of the 3 yearly policy update programme	Recommended outcome of policy update review
Trigger finger	Policy update – No change
Corticosteroid injections for patella, elbow and Achilles tendinopathy	Policy update – No change
Corticosteroid injections for pre patella and olecranon bursitis	Policy update – No change
Subacromial decompression for shoulder impingement	Policy reviewed but paused to await national guidance due for publication in “early 2023”
Management of low back pain and sciatica	Policy updated with recommendations on supervised exercise, the length of time for non-surgical treatment before spinal decompression and the inclusion of ‘red flags’ for referral
Anti-VEGF treatments and dexamethasone implants for macular oedema caused by central and branch retinal vein occlusion	Policy update – No change
Surgical management of glue ear in children (under the age of 18)	Policy re-ordered for ease of reading and coding updated
Cataract removal in adults - thresholds for surgery	Policy updated to reflect new proposed national guidelines
Tonsillectomy for surgical management of recurrent tonsillitis and obstructive sleep apnoea in children and adults	Policy updated to reflect updates in national guidance
Snoring and obstructive sleep apnoea / hypopnea syndrome (OSAHS) in adults	Policy updated to reflect updates in national guidance
Chronic fatigue syndrome/ myalgic encephalomyelitis	Policy updated to reflect new national guidance
Melatonin treatment in children	Policy recommendations in relation to chronic fatigue updated to reflect new national guidance

Two policies were discussed as part of the policy surveillance process adopted during this year. Both policies (Patients with osteoarthritis; primary hip and knee replacement and arthroscopic lavage and debridement for patients with osteoarthritis of the knee) were identified following updates to NICE guidance on the treatment of osteoarthritis. These were received by the committee, who decided that a full review was not required at this time, and the policies should be maintained.

The National Evidence Based Interventions (EBI) programme published list 1 in 2018 and list 2 in 2020. The EBI programme consulted on list 3 during 2022 and it is due to be published in 2023. The Clinical Effectiveness team on behalf of BOBFPC, promotes review of the EBI programme, participates in engagement events and is part of an ongoing working group in order to gain the most benefit from the EBI programme. These guidelines are considered as part of the ongoing policy update programme. . Review of policies also includes the addition of clinical coding i.e diagnostic codes and intervention and procedure OPCS codes where applicable.

Significant committee time was spent in 2022-2023 discussing a review of the current policy for Assisted conception Services for Infertile Patients. A working group was also held to support this review. This review is currently awaiting final recommendation.

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

- Policies have been developed to ensure appropriate referral pathways are implemented across the region (for example the ingrown toenails policy)
- Policies have been developed to make progress in tackling health inequalities (for example the treatment with Anti-VEGF agents for neovascular age-related macular degeneration in patients with one seeing eye)
- Some of the agreed policies offer financial savings or reduce the risk of significant financial impact to the ICBs 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 treatments for non-specific low back pain)
- Endorsing national best practice and high quality care for patients (for example review of policies in line with NICE guidance for obstructive sleep apnoea)
- 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.

2.5 Committee Operating Procedures and Annual Training Event

The Terms of Reference and Standard Operating Procedure were reviewed to appropriately reflect the footprint of the ICBs the committee represents. Consideration was given to updating the ethical framework given the national drive to tackle health inequalities. It was agreed to discuss these further in detail when there has been more progress in the South East policy alignment project. No training event was held in 2022-23.

3. Future developments

The committee has now been in operation for over ten years. It has seen a change in membership over the last 12 months with the formation of the ICBs and the corresponding increase in the geographical area the committee the serves. Continual review and development are key to ensuring that the priorities committee is used effectively. The recent update to the terms of reference and the Ethical Framework aimed to ensure the committee is able to continue to meet the needs of the ICB functions and governance within its 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 (Specialised Commissioning), support the continued recovery of elective care and patient services following COVID-19 and review the local impact of the EBI programme.

In recent months there has been a nationally directed drive to reduce unwarranted variation across the NHS in the South East of England. The Clinical Effectiveness team has been supporting the initial stages of this project, utilising the knowledge and experience built up whilst working with the BOBFPC. At the request of the committee there have been fewer meetings and reviews conducted specifically for BOBFPC to allow for the Clinical Effectiveness team to divert capacity for this work. The committee has agreed that priority 'business as usual' will continue for the committee including:

- Policy surveillance for new evidence impacting on local clinical policies.
- Policy surveillance for EBI programme updates.
- Support to respond to enquiries, FOI/MP letters/complaints related to priority setting and implementation of clinical policies.
- Dissemination of monthly NICE updates to include NICE horizon scanning and overall impact assessment of new guidance.
- Production of finalised policies and minutes of the Priorities committee for publication (e.g. follow through the current assisted conception policy review, legal advice and associated Primary Care Pathway review.
- Liaison with the CPI team on implementation of policies.

At this time, it is considered that the committee needs to have an open approach to key priorities for the year ahead to ensure it remains responsive to local ICB priorities in conjunction with the developments in the ongoing regional project.

Appendix 1:
BOB ICB and Frimley ICB Priorities Committee Terms of Reference

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board
Frimley Integrated Care Board

TERMS OF REFERENCE

BOB ICB and Frimley ICB Priorities Committee

The BOB ICB and Frimley ICB Priorities Committee (BOBFPC) operates as an advisory body to the two Integrated Care Boards (ICBs). Its role is to provide evidence based recommendations and commissioning policies for consideration and adoption by ICBs.

1. FUNCTIONS of the BOB ICB and Frimley ICB Priorities Committee

Aim: To make recommendations to ICBs 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 ICBs.
- To identify potential healthcare interventions to be considered by the Committee
- To review progress against the agreed work programme
- To receive data and other reports, for example 'individual funding requests' (IFR) activity, to inform the work of the Committee and support the ICBs' duty to address health inequalities
- 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 where agreed 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 ICBs. 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. They should have background or expertise in a particular area; for example, ethics, law, clinical, public health, finance, contracting, pharmaceutical or lay representatives.

(c) Members representing 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, which 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 in relation to the agenda to the Committee Chair using the Declaration of Interest form circulated with meeting papers prior to each meeting. The BOBFPC 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

	Role	ICB	No. of members	Voting rights
Core members	Member Chair	N/A	1	✓
	NHS Integrated Care Board Representatives	BOB	2	✓
				✓
		Frimley	2	✓
				✓
	ICB executive members	BOB	1	✓
		Frimley	1	✓
	ICB finance manager	BOB	1	✓
		Frimley	1	✓
Members with specialist knowledge	Public Health Consultant	BOB	1	✓
		Frimley	1	✓
	Medicines Optimisation Commissioner	BOB	1	✓
		Frimley	1	✓
	Special advisor – Ethics	N/A	1	✓
	Special advisor – Health Law	N/A	1	✓
	Lay members	BOB	1	✓
		Frimley	1	✓
	Healthwatch	BOB	1	×
	Individual Funding Request Manager	BOB	1	×
		Frimley	1	×
	Academic Health Science Network	N/A	1	×
Provider members	Oxford University Hospitals NHS Foundation Trust	BOB	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	Frimley	1	×
	Surrey and Borders NHS Foundation Trust		1	×
	Sussex Partnership NHS Foundation Trust		1	×

2.3 Chairing of Committee

The Priorities Committee will have an independent Chair and a named deputy lay Chair (who will also be a member of the Priorities Committee). The Chair will be agreed by the members of the ICB executive team or personnel with delegated responsibility. The Chair 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)
- One ICB executive member (or designated deputy))
- at least one member representing each ICB.
- at least one lay member
- at least two clinicians (one medical for example GP or secondary care consultant)

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

2.5 Recommendations to ICBs

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 BOB ICB and Frimley ICB Priorities Committee will meet on a bi-monthly basis. The service provider South Central and West (SCW) clinical effectiveness team will manage and administer the Priorities Committee and will liaise with ICBs, ahead of each meeting to establish meeting quoracy. It is each member ICB's responsibility to ensure they are appropriately represented at Priorities Committee meetings. ICBs 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 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 Executive member (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 ICBs 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 ICB 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 ICBs on their websites. With supporting information from SCW, Lead Commissioners will communicate the clinical policies to provider organisations.

SCW 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 member of each ICB.

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 ICBs' priorities as identified in their annual/strategic plans. The Working Group meeting will take the format of a workshop aimed at all committee members. 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, ICBs 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
Updated November 2022 (V4)

Appendix 2:
BOB ICB and Frimley ICB Priorities Committee Ethical Framework

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board
Frimley Integrated Care Board

BOB ICB and Frimley ICB 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]. 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 two Integrated Care Boards (ICBs) 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 ICBs 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 Buckinghamshire, Oxfordshire, Berkshire West and Frimley regions 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]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***[2] the ***Public Sector Equality Duty***[3] and the requirement to involve the public when making significant changes to the provision of NHS healthcare[4] 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 ICB 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 outside of 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.

[2] The NHS Constitution http://www.nhs.uk/choiceintheNHS/Rightsandpledges/NHSConstitution/Pages/Overview.aspx
[3] Equality Act 2010: guidance (June 2015 update) https://www.gov.uk/guidance/equality-act-2010-guidance
[4] Working in partnership with people and communities: Statutory guidance July 2022 B1762-guidance-on-working-in-partnership-with-people-and-communities.pdf (england.nhs.uk)

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 both as to the ability to access services, and the outcomes achieved by providing them.

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. In some circumstances, these factors may be relevant to the clinical effectiveness of an intervention and the capacity of an individual to benefit from the treatment.

2. HEALTH CARE NEED AND CAPACITY TO BENEFIT

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

This approach leads to three important principles:

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

3. EVIDENCE OF CLINICAL EFFECTIVENESS

The Committee 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 Committee 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 where possible, both to the individual and the population. 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 ICB 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 Committee 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 Committee will consider the numbers of people in their designation populations who might be treated.

6. NEEDS OF THE COMMUNITY

Population health aims to improve the health of an entire population. Reducing inequalities in health as well as improving health overall is core to addressing population health. The Committee will seek to promote the health of the entire community by promoting equality of access to services and the outcomes achieved by providing them.

Public health is an important concern and the Committee 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 supports effective policies to promote health equality and delivery of integrated care that better meets the needs of patients.

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 ICBs. The Committee operates with these factors in mind and recognises that their discretion may be affected by 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 ICB and these will be described in their Local Delivery Plan.

8. SIGNIFICANT CLINICAL BENEFIT

Sometimes the needs of the community may conflict with the needs of individuals. Decisions are difficult when there is little evidence that expensive treatment produces substantial 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 will not normally be

funded 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.

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. ICBs will consider such cases according to the following general procedures:

The ICB 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[5] 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.

BOB ICB and Frimley ICB Priorities Committee
Date of issue: 7th February 2014
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Updated July 2021
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[5] Local commissioning policies include local drug formularies