SOUTHAMPTON, HAMPSHIRE, ISLE OF WIGHT AND PORTSMOUTH CLINICAL COMMISSIONING GROUPS

ETHICAL FRAMEWORK

1. BACKGROUND

1.1. The Priorities Committee is a committee of representatives of the following organisations:

- Fareham and Gosport CCG
- North East Hampshire and Farnham CCG
- North Hampshire CCG
- Portsmouth CCG
- Southampton City CCG
- South Eastern Hampshire CCG
- West Hampshire CCG
- Isle of Wight CCG

1.2. It includes the eight Clinical Commissioning Groups (CCGs) as well as lay members, clinicians and managers. The purpose of the Priorities Committee is to advise the member Clinical Commissioning Groups about the health care interventions and recommended commissioning policies that should be considered.

1.3. CCGs are 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 SHIP8 CCGs to choose how to allocate their resources to promote the health of the local community. Individual cases are considered by each respective PCT.

1.4. This Ethical Framework is based upon the South Central wide ethical framework, updated in September 2010, and its preceding versions. Its purpose is to support decision making process of the Priorities Committee and to offer a decision framework for constituent CCGs.

2. PURPOSE OF THE ETHICAL FRAMEWORK

2.1. 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;

- 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 framework;

- supporting and integrating with the development of CCG commissioning policies.

2.2. 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 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.

2.3. The Ethical Framework is especially concerned with the following:

A: Evidence o**f Clinical and Cost Effectiveness**

2.4. 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.

2.5. 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 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.

2.6. 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.

B: Equity

2.7. 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.

C: Health Care Need and Capacity To Benefit

2.8. 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. So 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.

2.9. 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.

D: Cost Of Treatment and Opportunity Costs.

2.10. Because each CCG 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 very expensive, or the cost of treating a whole community may be high.

E. Needs of the Community

2.11. 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.

2.12. 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 relatively 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.

3. POLICY DRIVERS

3.1. 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 CCGs. 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.

3.2. Locally, choices about the funding of health care treatments will be informed by the needs of each individual CCG.

4. EXCEPTIONAL NEED

4.1. There will be no blanket bans on treatment since there may be cases in which a patient has special 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. CCGs have procedures in place to consider such exceptional cases on their merits.

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