South, Central and West
Commissioning Support Unit

Thames Valley Priorities Committee
Annual Report
2017-2018

Thames Valley Clinical Commissioning Groups (at March 2018):

Aylesbury Vale Clinical Commissioning Group

Bracknell and Ascot Clinical Commissioning Group

Chiltern Clinical Commissioning Group

Newbury and District Clinical Commissioning Group

North and West Reading Clinical Commissioning Group

Oxfordshire Clinical Commissioning Group

Slough Clinical Commissioning Group

South Reading Clinical Commissioning Group

Windsor, Ascot and Maidenhead Clinical Commissioning Group

Wokingham Clinical Commissioning Group

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

Thames Valley Priorities Committee Membership (at March 31st 2018)

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Dr Alan Penn, Independent Lay Member

CCG Membership
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1. Introduction

The Thames Valley Priorities Committee is robust in terms of membership and governance. It acts as an advisory body for priority setting to ten Clinical Commissioning Groups (CCG) across the Thames Valley Region, and supports the CCGs to:

- commission the best quality and effective health care services for their designated populations, support funding prioritisation
- reduce the potential for health inequity
- ensure CCGs meet their statutory duties and
- optimise safeguarding against legal challenge.

This is the Priorities Committee's fifth Annual Report, which summarises its key activities and achievements for 2017-2018 and looks at the year ahead.

The 2017-2018 programme has been varied and full with 12 new topics and 18 current policy updates discussed at the six Committee meetings (Section 2). An evidence based review has been prepared for each topic, enabling an informed starting point for discussion. This review is widely circulated to local commissioners and clinicians prior to Committee meetings. It is evident that clinical and other specialists are increasingly feeding back informed responses that support the Committee work. Discussion of each topic by the Committee, with the advice from clinical and other specialists, has involved careful consideration of the evidence of clinical and cost effectiveness alongside the resource implications, within the context of the Ethical Framework and local population needs. Despite robust processes in place for making prioritisation decisions in fair and equitable ways, the debates continue to highlight the difficulties CCGs face in ensuring a balance between their duty to commission the best quality and effective health care services for their designated populations and also to reduce the potential for health inequity, against their duty not to exceed their annual financial allocations. The Committee has acknowledged the increasing importance of ensuring decisions and the rationale behind them are well captured, documented and available for scrutiny.

The Annual Report highlights that the Committee has had a productive year. It plays an important role in supporting CCGs with high quality priority setting. Section 3 outlines some key issues to be addressed continually in order to ensure that the Priorities Committee is used effectively and strategically going forward.

Dr Alan Penn, Chair
Thames Valley Priorities Committee

2. Key Activities 2017-2018

2.1 Committee Membership

A key strength of the Priorities Committee is its range of expertise, which includes medical, pharmaceutical, public health, finance, specialised legal and ethical representation as well as HealthWatch and provider organisations. The Committee meetings have been well attended, with high level CCG engagement and regular attendance from senior representatives for each CCG. The Committee has also enjoyed a strong provider representation with regular Medical Director support and engagement from clinical specialists. This has been essential to ensure the Committee achieves high quality and timely decision making and that CCGs are kept regularly informed of the Committee's work.

The Committee programme continues to be managed and supported by the South, Central and West (SCW) Clinical Effectiveness team. Berkshire East CCGs have hosted the priorities service on behalf of the Thames Valley CCGs until March 2018. From April 2018 a new contract and SCW Clinical Policy Management service specification comes into effect.

2.2 Topics considered

Six meetings of the Priorities Committee were held during the 2017-2018 period and in total 30 clinical topics have been considered (Table 1). 12 new topics and 18 current policies were reviewed via the Committee. The majority of new topics considered were planned in advance as per the agreed work programme and in addition, two topics were submitted as in-year requests. The majority of the reviews has led to a new policy development or to a policy update. Five current polices were deemed to be no longer needed as clinical practice or national guidance has advanced and therefore recommendations were made for policy withdrawal.

For each topic, the Clinical Effectiveness Team prepared and presented an evidence appraisal including (where applicable and available) a summary of national guidance, local activity, costing information and any feedback received from local clinical or other specialists. The evidence appraisals 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. Evidence 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 and Governing Body summary paper for each policy recommendation to aid the ratification process. Once ratified, the SCW CSU Individual Funding request (IFR) team communicates new policies to the public and providers via 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 IFR team.

Table 1: Topics considered by the Priorities Committee during 2017-2018

Thames Valley Priorities Committee Work programme: Topics considered 2017-18	
Evidence reviews of new topics identified for the work programme	**Outcome of review**
1. Snoring, Sleep Apnoea and CPAP use	New policy recommendation
2. Cataract Removal in Adults – second eye	New policy recommendation
3. NICE 'Do Not Do' Recommendations	New policy recommendation
4. NHS England Specialised Services Policy Statement	New policy recommendation
5. Ectropion and Entropion	New policy statement
6. Eyelid Ptosis	Review and addition to aesthetic procedures policy
7. Painful Shoulder – Arthroscopic Surgery for Adhesive Capsulitis (Frozen Shoulder)	New policy recommendation
8. Management of Haemorrhoids	New policy recommendation
9. Flash Glucose Monitoring/Freestyle Libre Policy and Patient Agreement Forms	New policy recommendation
10. Knee Arthroscopy for the Treatment of Meniscal Tears	New policy recommendation
11. Diagnosis of Foetal Alcohol Syndrome Disorder (FASD) and Alcohol Related Neurodevelopment Disorder (ARND)	New policy recommendation
12. Shoulder Replacement for Osteoarthritis, Rheumatoid Arthritis and Rotator Cuff Arthropathy	No policy recommendation
Policy updates of existing policies	**Outcome of review**
1. Hysterectomy and Uterine Artery Embolisation	Uterine Embolisation of Fibroids – withdrawn Hysterectomy policy updated
2. Functional Electrical Stimulation for upper and lower limbs (FES)	Policy update
3. Female Sterilisation	Policy update
4. Male Sterilisation	Policy update
5. Male Circumcision	Policy update
6. Reversal of Sterilisation and Vasectomy	Policy update
7. Treatment Pathway for Adults with Attention Deficit Hyperactivity Disorder (ADHD)	Policy update

8. Policy review for potential withdrawal/update	
• Multiple Chemical Sensitivities (MCS) and Clinical Ecology Environmental Medicine	Policy withdrawn
• Elfornithine for facial hirsutism	For further review
• Rectal Investigation and Surgery	Policy withdrawn
• Prostatism	Policy withdrawn
• Speech and Language Therapy in Parkinson's Disease	Policy withdrawn
• Chronic Fatigue Syndrome	For further review
• Short Burst Oxygen Therapy for the Relief of Breathlessness	For further review
• Non pharmacological services for dementia patients	For further review
9. Asymptomatic Gallstones	Policy update
10. Sequential use of Biologics in Rheumatoid Arthritis	Policy update

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

- Some of the agreed policies offer financial savings by recommending the use of equally effective but more cost-effective interventions as the first line treatment and by clarifying the place of treatment in a care pathway (for example Sequential use of Biologics in Rheumatoid Arthritis)
- Policies have also been developed to restrict procedures or interventions which are not supported by a robust evidence base (for example Female Sterilisation, Specialist Diagnostics of Foetal Alcohol Syndrome Disorder).
- Endorsing national best practice and high quality care for patients (for example Snoring and CPAP use, Asymptomatic Gallstones, Haemorrhoids)

Direct savings associated with the recommendations arise from agreeing appropriate clinical thresholds or adopting a not normally funded policy position. Examples include interventions for Social Snoring, Female Sterilisation, Specialist Diagnostics of Foetal Alcohol Syndrome Disorder and FES. The impact of new threshold policies will be realised over time via the contract challenge process.

Three new topics were deferred to 2018-19 work programme: Iron Chelation for Myelodysplastic Syndromes and Steroid injections to joints due to change in agenda; and Threshold for Referral for Investigation of Hypersomnia's and Circadian Rhythm Sleep-wake Disorders, due to delay in NICE guidance publication.

In addition to the work programme topics, the Committee has also responded to two formal consultations on behalf of Thames Valley CCGs: Department of Health and Social care, Gluten free foods prescribing; NHS England, Gender Identity Services for Adults; and supported response to joint

NHS England and NHS Clinical Commissioners consultation, on 'Items which should not be routinely prescribed in primary care'.

2.3 New topics for the 2018-2019 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. A scoring system is used to help prioritise topics that will bring the greatest financial or quality benefit to their population. This year 15 new topic submissions were received from the CCGs. The Priorities Committee topic working group convened in November 2017 to debate and score the new topics and those with the highest scores selected for inclusion. Two further topics were raised as an in-year request (Table 2).

Table 2: New topic submissions scored November 2017 for 2018-19 work programme

Topic No	Title	Topic Score
077	Breast reconstruction surgery post breast cancer	29.5
078	Lycra dynamic splinting garments for children with neurological impairment	12
079	Chelation therapy (removing heavy metals from the body) for the treatment of cardiovascular disease, autism and CFS	In NICE 'Do not do' list - not scored
080	Lymphoedema treatments	29
081	Laproscopic ventral rectopexy and internal rectal prolapse (obstructive defaecation)	19
082	Sequential use and dose escalation of biologics in Crohn's disease	35
083	Sequential use of biologic drugs for ankylosing spondylitis and axial spondyloarthritis	27
084	Topical negative pressure for wound closure; vacuum-assisted wound closure dressings	32
085	Uni compartmental knee replacement compared to total knee replacement	30
086	Bevacizumab for radiation retinopathies	Specialist Commissioning - not scored
087	Arthroscopy for non OA conditions of the knee	26
088	Compulsory weight loss before surgery	29
089	Smoking cessation before elective surgery	39
090	Continuous glucose monitoring – children	23
077	Risk reduction surgery for breast cancer	Add to aesthetic surgery policy
	Additional In-year requests scored	
	Lidocaine infusions for chronic pain	17
	Botox use for achalasia, anal achalasia, anismus, gastroparesis, hemifacial spasm, hip abductor spasticity, ophthalmic facial dystonia and spasmodic dysphonia.	12

Primary Care Fertility Care Pathway has been under review by CCG representatives and will be included in the 2018-19 work programme for the Committee consideration.

2.4 Current policies schedule for updates

Each CCG has developed/inherited a number of policies over the years which are now in need of updating to reflect current best practice. A schedule for updating the existing joint Thames Valley clinical policies has therefore been developed for 2018-2019 to run alongside the new topics work programme, prioritising any policies that are not in line with national guidance and those which carry the greatest risk/benefits to patients or the CCGs.

2.5 Committee Operating Procedures and Annual Training Event

The Terms of Reference, Standard Operating Procedures and Ethical Framework that form the basis of the Committee operation were reviewed in July 2017, as part of the annual training event. The aim of the event was to offer the new and current members of the Committee an opportunity to explore the core principles and processes of the Committee and, in particular, to review the principles of the Ethical Framework, in order to ensure they remain robust to support the Committee decision making process.

The Committee has received feedback and analysis of priority setting and Individual Funding Request related developments, regulation and judicial reviews as part of the on-going development of the Committee process. A copy of the current Terms of Reference can be found in Appendix 1. and Ethical Framework in Appendix 2.

3. Future developments

The Committee has now been in operation for over four years and has grown in strength. However, continual assessment and development is a key to ensuring that the Priorities Committee is used effectively and new strategic opportunities are realised going forward. There are several areas in the Next steps on the NHS Five Year Forward View where the TVPC can contribute to practical steps to deliver better, more joined-up and more responsive NHS care. In particular, taking note of the plans for 'The NHS' 10 Point Efficiency Plan' of reducing avoidable demand and meeting demand more appropriately and reducing unwarranted variation in clinical quality and efficiency.

Key priorities for the year ahead include:

- Draw attention of the Committee to support the work of the CCGs towards achieving the ambitious plans as set out in the NHS Forward View.

- Ensure the Committee is adaptable to supporting the development of STPs and the Integrated Care Systems and their work streams. In particular reducing clinical variation, improving consistency in care pathways and access criteria and increasing involvement, trust and partnership with clinicians.

- Encourage continued engagement and feedback from both CCGs and Provider organisations on the evidence reviews prepared for the Committee, to ensure clinical feedback is captured and inputted during the consultation and decision phases.

- Encourage CCG stakeholders to submit topics in priority, high impact areas for consideration by November each year.

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

Appendix 1: Thames Valley Priorities Committee Terms of Reference

The Thames Valley Priorities Committee operates as an advisory body to the ten 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

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 representatives.

The **Term of Office** for members is three years, and can be renewed after that period.

All members and attendees attending a Priorities Committees will be asked to declare any conflict of interest to the Committee secretariat (annually and at each meeting in relation to the agenda) and to the Committee Chair, in a meeting.

2.2 Membership

TITLE	No. delegates	Voting rights
Independent Lay Member Chair	1	√
NHS Clinical Commissioning Groups*		
Oxfordshire 1 CCG	2	√
Buckinghamshire 2 CCG	2	√
Berkshire West 4 CCGs	2	√
Berkshire East 3 CCGs	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	√
Head of Corporate Affairs (host CCG)	1	
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.

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
- a Public Health consultant (or designated deputy)
- 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 Federation of East Berkshire CCGs will manage and administer the Priorities Committee and will liaise with the service provider, Central Southern Commissioning Support Unit, 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 are able to attend, they should inform the CSU 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 Chair and Chief Officer. 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 Central Southern CSU, Lead Commissioners will communicate the clinical policies to provider organisations.

Central Southern 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 in March of each year.

February 2014
Updated March 2016/July 2017

Appendix 2: 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]. 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 ten Thames Valley Clinical Commissioning Groups (CCGs) and includes lay members as well as clinicians and managers. The purpose of the Priorities Committee is to make recommendations, in the form of policies, to the local CCGs as to the services and health care interventions that should or should not be funded.

To help in this process, health care commissioners in the Thames Valley region have developed a decision-making tool - the 'Ethical Framework', to facilitate fairness and transparency in the priority-setting process.

The Ethical Framework was originally developed in 2004 by the NHS public health organisation *Priorities Support Unit* (now *Solutions for Public Health)* and the Berkshire PCTs. Since then, the Framework has been revised to take account of policy developments in the NHS and changes in the law, and has been adopted more widely.

The purpose of the Ethical Framework

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

- 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.

[1] Five year forward view (2014) https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf
[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] Transforming Participation in Health and Care NHS England (2013)

- 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:

- 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[5], 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. EXCEPTIONAL NEED

There will be no blanket bans on treatments since there may be cases in which a patient has special circumstances which present an exceptional need for treatment. Individual cases are considered by each respective CCG. Each case will be considered on its own merits in light of the clinical evidence. CCGs have procedures in place to consider such exceptional cases through their Individual Funding Request Process.

Thames Valley Priorities Committee
Date of issue: 7th February 2014
Updated: 23rd March 2016/July 2017

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