NHS
Gloucestershire
Clinical Commissioning Group

Governing Body

Extraordinary Meeting to be held at 2pm on Thursday 24th October 2013 Board Room, Sanger House, Brockworth, Gloucester, GL3 4FE

No.	Item	Lead	Recommendation
1	Apologies for Absence	Chair	
2	Declarations of Interest	Chair	
3	Gloucestershire NHS 111 Update	Mark Walkingshaw/ Jeremy Welch	Information
4	CCG Prioritisation Processes	Marion Andrews-Evans	Approval
5	Public Questions	Chair	
Date and time of next meeting: 28th November 2013 at 2pm in Board Room at Sanger House			

Questions should be sent in advance to the Associate Director of Corporate Governance: alan.potter1@nhs.net by 12 noon on Monday 21st October 2013. Questions must relate to items on the agenda.

Please note: there is very limited parking available at Sanger House and all spaces must be booked in advance. If parking is required by members of the public, please e-mail Alan Potter (as above) to establish if there are any visitor spaces available.

NHS
Gloucestershire
Clinical Commissioning Group

Agenda Item 3

Governing Body

Governing Body Meeting Date	Thursday 24th October 2013
Title	Gloucestershire NHS 111 Update
Executive Summary	This paper is intended to update the Governing Body on the current NHS 111 service in Gloucestershire, and in particular to: - Update on Rectification process and performance. - NHS England Checkpoint process. - Progress towards Full Service Commencement (FSC). - Confirm process for financial settlement for services provided to date and before Full Service Commencement (FSC). It recommends Full Service Commencement on 28 October 2013, and continued collaborative working with the Provider, Harmoni, in line with formal contract monitoring processes to ensure performance continues to be delivered at the required standards.
Key Issues	Need to ensure service is within contractual framework and process
Risk Issues: **Original Risk** **Residual Risk**	Risk of failing to provide a high quality, effective NHS 111 service and the resultant impact upon the wider urgent care system.
Financial Impact	Potential negative financial impact on wider urgent care system. Contingency costs incurred.

Legal Issues (including NHS Constitution)	Contract management process is in place, with legal advice secured (particularly in terms of contract definitions/terms).
Impact on Health Inequalities	Inequalities Impact Assessment completed as part of tender process.
Impact on Equality and Diversity	Equality and Diversity Impact Assessment completed as part of tender process.
Impact on Sustainable Development	None identified.
Patient and Public Involvement	Patient representatives at Clinical Governance forum for NHS 111 service.
Recommendation	Decision required: - Support the proposed next steps set out in sections 3, 4, 5 and 6. - To continue to provide delegated authority to Cath Leech (Chief Financial Officer) to agree and formally sign-off financial settlement for services provided to date (to include minor variations to the terms of the settlement necessary to obtain agreement).
Author	Kate Liddington
Designation	Senior Commissioning Manager
Sponsoring Director (if not author)	Mark Walkingshaw Deputy Accountable Officer/Director of Commissioning Implementation CCG Clinical Lead: Dr Jeremy Welch NHS 111 Clinical Lead for Gloucestershire & Tewkesbury GP

NHS
Gloucestershire
Clinical Commissioning Group

Agenda Item 3

Governing Body

24th October 2013

Gloucestershire NHS 111 Update

1 Introduction

1.1 This paper is intended to update the Governing Body on the current position with regard to the NHS 111 service in Gloucestershire and to seek agreement on next steps.

1.2 At the end of the first Rectification Plan (26 June 2013), all call handling key performance indicators (KPI) were achieved, with the exception of one – the 'warm transfer' KPI. Warm transfer (% of calls passed as a 'live transfer' to clinical advisor, not a call back) is used as a measure of the clinical quality of the service and is nationally set target is 98% achievement. Harmoni reported that the service had not achieved this target due to the inability to recruit clinical advisor staff as quickly as they anticipated.

1.3 Harmoni proceeded into a second Rectification Plan where they set out a further process to recruit additional clinical staff to ensure this KPI could be consistently met, with the aim of achieving full recruitment of clinical advisors at the end of September 2013. Clinical Governance lead GPs agreed that achievement at a minimum of 70%, supported by operational protocols to manage the call queue, and ensure patients who are not 'warm transferred' are called back within 10 minutes, is acceptable in the short-term and whilst the service continues to take increased call volumes and proceeds towards full service commencement (FSC).

1.4 Previous updates have described the Rectification process put in place following early poor performance, the Checkpoint process set out by NHS England, and the financial settlement that is being discussed with Harmoni.

2 Update on the Rectification process

2.1 The Rectification taskforce have remained in place, receiving daily

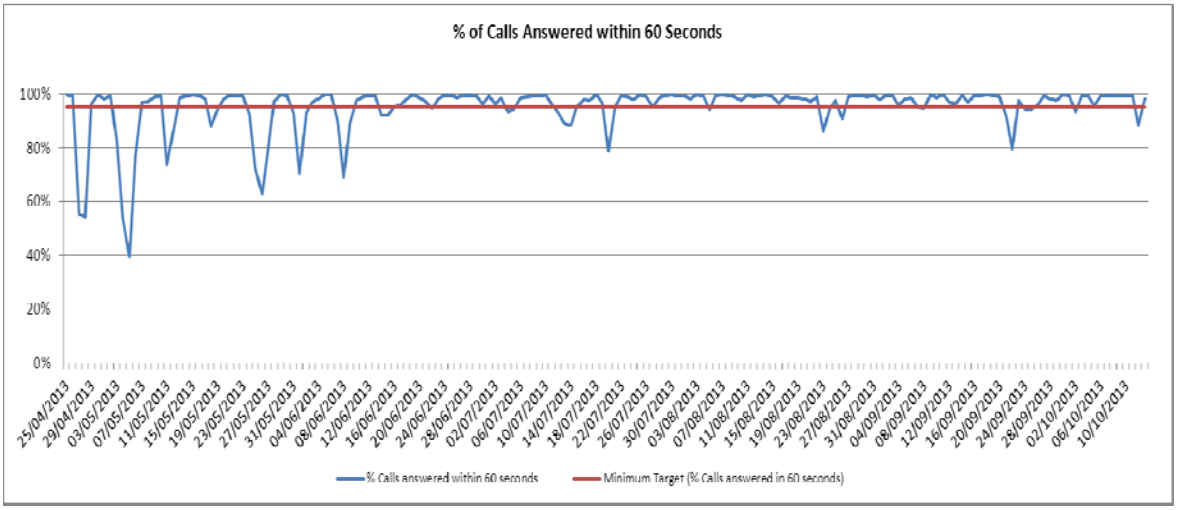
performance data, and meeting fortnightly with Harmoni.

2.2 Performance has continued to improve across all the KPIs including;

- Percentage of calls answered in 60 seconds.
- Percentage of calls abandoned after 30 seconds.
- Percentage of calls triaged.
- Longest wait for a clinician call back.
- Percentage of calls warm transferred.

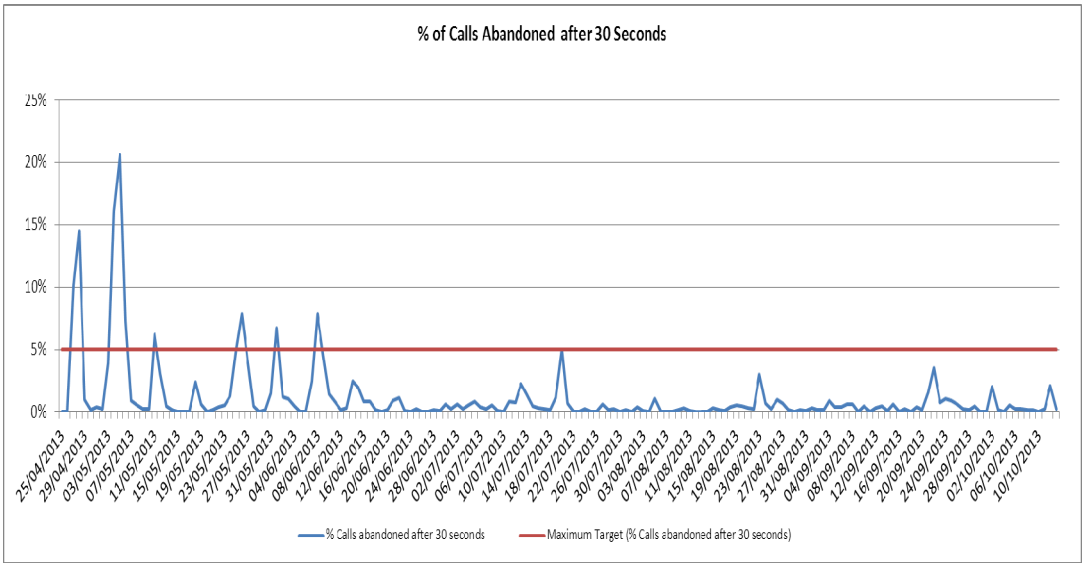
2.3 Graph 1: Percentage of calls answered in 60 seconds. (minimum standard = 95%)

There has been considerable improvement in the percentage of calls answered within 60 seconds, directly correlating with the increase in recruitment and training of Call Handlers. However there have been isolated occasions of approximately 4-hour periods during specific days where the call demand was particularly high in the urgent care system, and this meant there were short periods where performance dropped to 80-95%. The root causes of these have been reviewed against escalation processes and rigorous demand and capacity planning.



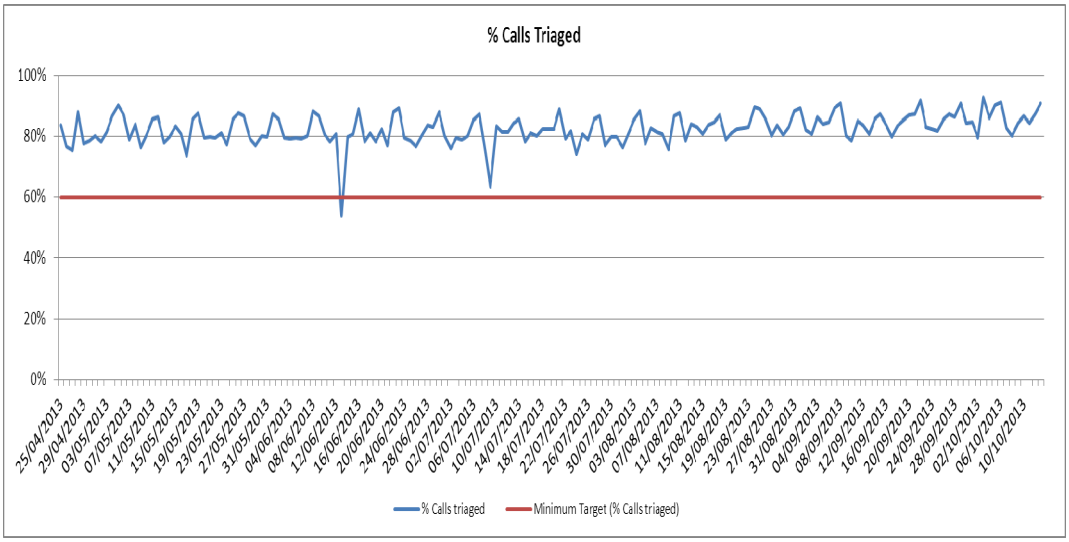
2.4 Graph 2: Percentage of calls abandoned after 30 seconds (maximum standard = 5%)

The number of abandoned calls after 30 seconds has improved dramatically and even when demand is high callers rarely abandon. This position has been sustained since the beginning of June, and is linked to increased numbers of Call Handlers being in post.



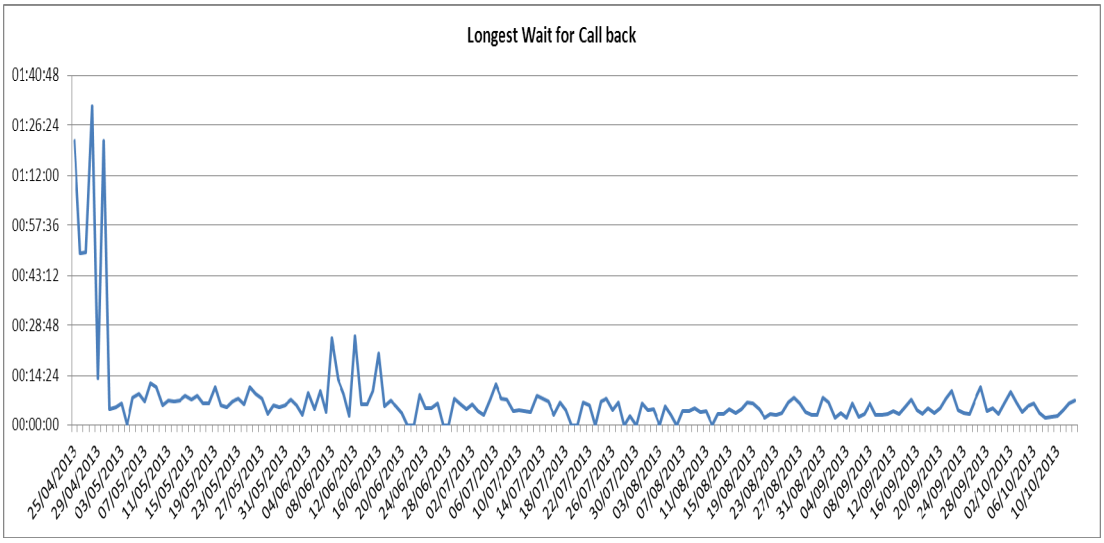
2.5 Graph 3: Percentage of calls triaged (minimum standard = 60%)

The percentage of calls triaged has consistently been around 80% since the beginning of Rectification, and thereby the standard has been achieved since the beginning of June.



2.6 Graph 4: Longest wait for a clinician call back (maximum standard = 10 mins)

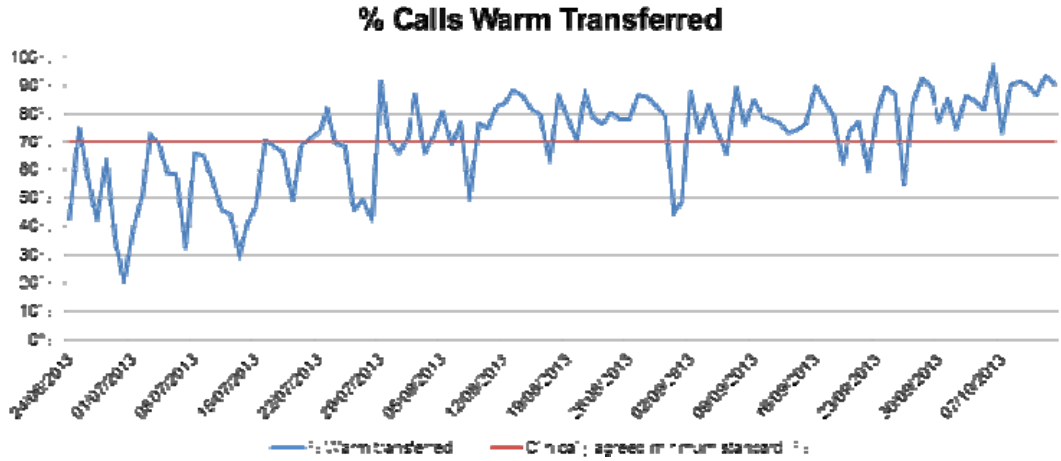
Despite initial poor performance, there has been a dramatic improvement in this standard. The maximum target of call back within 10 minutes has been consistently achieved since the end of June.



2.7 Graph 5: Percentage of calls warm transferred
(Clinically agreed minimum standard = 70% supported by approved operating protocols and call back within 10 minutes).

During Rectification improvements have been seen in the achievement of the warm transfer standard. Since August, achievement has been broadly in line with the agreed trajectories set out within the Rectification Plans. This improved performance is due to the recruitment of Clinical Advisors.

Since September the majority of performance has been above 70%, with consistent delivery over consecutive periods of three weekends and 2 weeks. This performance has enabled the submission of checkpoint 5 and checkpoint 6 applications. Harmoni continue to seek to make further improvements to this performance, whilst working within the agreed clinical protocols and call back within 10 minutes.



2.8 All KPIs are monitored by the Rectification Taskforce, and are also regularly reported to the Governance Group. This provides a clinically

led forum to critically appraise the service, and to review all feedback from patients and other healthcare professionals. The outcome of these meetings directly influences training for staff and operating protocols in the call centre and between Harmoni and other Providers in the urgent care system.

2.9 The Rectification Taskforce has also continued to monitor staffing numbers in the call centre, as it is known that maintaining consistent levels of staffing (modelled in line with anticipated demand) is key to performance achievement against agreed KPIs. Progress in staffing recruitment is shown in table 1 below.

Table 1: Staffing in the Bristol call centre.

Staff type	Start of service (March 2013)	Revised workforce modelling for Rectification	Current numbers (October 2013)
Call Handlers (CH) total - on rota - in training	106 84 15	168	166 154 12
Clinical Advisors (CA) total - on rota - in training	16 10 6	43	43 39 4

2.10 On 16 September 2013, NHS Direct was switched off and calls diverted to NHS 111. Since then, the Rectification taskforce has continued to monitor performance with the aim of progressing through the next step of NHS England sign-off process, checkpoint 6, and to FSC when appropriate to do so.

2.11 Harmoni have met the Clinical Advisor and Call Handlers recruitment levels planned, and have continued to deliver the required performance levels of call handling KPIs, as well as warm transfer performance above the clinically-accepted minimum level of 70%.

3 Checkpoint process

3.1 A national checkpoint process was put in place by NHS England in April 2013 in response to the early operational difficulties experienced by the providers of 111 services. At each stage commissioners and providers must complete a comprehensive protocol with supporting information about their 111 service and its performance. The intent of the checkpoint review protocol is to ensure that all aspects of an NHS 111 service are ready for the next stage of roll out in terms of capacity, functionality, performance and resilience. The required outcome is

that that NHS 111 services rollout successfully (defined by KPI achievement) and do so in a way that maintains public/patient safety whilst retaining the confidence of the public, elected officials and other stakeholders.

3.2 From a national perspective, it was intended that all NHS 111 services were to have passed through Checkpoint 6 and be in FSC by Summer 2013. In Gloucestershire, commissioners were not assured by performance in order to meet with summer deadline, and therefore delayed checkpoint 6 and FSC, (communicating the rationale for this to NHS England).

3.3 Gloucestershire CCG has continued to work with Harmoni to realise improved performance before making further checkpoint submissions. This has been managed within the overall contractual framework that is in place for the NHS 111 service with Harmoni.

3.4 The service in Gloucestershire went through checkpoint 5 on 16th September 2013. This meant that the 0845 NHS Direct service was switched off and calls diverted to 111. (At this stage the service also received a percentage share of calls received nationally into 111 with an unknown location).

3.5 The next stage in the NHS England sign-off process is checkpoint 6. This is the official public launch of the service, and is when local marketing and publicity commences in the NHS 111 launch area. The date of checkpoint 6 should align with the contractual FSC.

3.6 Since adding NHS Direct call volumes into the NHS 111 service, the KPIs have been met at the required levels for a consecutive period of three weekends and two weeks. Therefore the Rectification taskforce have worked with Harmoni to prepare checkpoint 6 documents and the required supporting evidence.

3.7 Whilst preparing checkpoint 6, commissioners and Harmoni have given particular focus to demand and capacity planning of the service, as well as the outcome of NHS 111 calls on ambulance dispatch and Emergency Department attendances. As part of this process, Harmoni have shared plans to increased recruitment over the winter period to ensure that an *additional* 12 Call Handlers per month are recruited and an additional 7 Clinical Advisors are available within the Bristol call centre.

3.8 Feedback from NHS England has been that they have sufficient assurance to support the service progressing through checkpoint 6 and to FSC. It is acknowledged that all commissioners will continue to work collaboratively with Harmoni to ensure improvements are sustained, and there is further scrutiny of supporting plans, especially the demand modelling and winter plans as part of local assurance processes.

3.9 Therefore it is proposed that the NHS 111 service goes through checkpoint 6 and to FSC on 28th October 2013. This will mean the service is in a 'business as usual' and full contractual position.

4 Full Service Commencement (FSC)

4.1 All other CCGs with contracts with Harmoni for NHS 111 services operating from the Bristol call centre have delegated authority to proceed through Checkpoint 6 and to FSC and plan to do so given sustained high performance.

4.2 It is proposed that from 28th October 2013 the NHS 111 service contract with Harmoni will move to 'business as usual' within agreed contractual and governance structures.

This will include the following:

- A monthly Contract Board meeting with individual CCGs.
- A quarterly Contract Board meeting with all Commissioners involved in the Bristol based Harmoni service.
- A monthly Clinical Quality Review Group with individual CCGs. This will replace the existing monthly NHS 111 clinical governance meeting for Gloucestershire, but will provide quality assurance to the contract board and into the Gloucestershire Urgent Care Governance Group. This will include responding to all public/patient and clinical professional feedback.
- The existing monthly clinical governance forum of GP leads across Avon, Gloucestershire and Wiltshire (AGW) will also continue.

These arrangements will be regularly reviewed to ensure they remain fit for purpose and ensure all financial, performance and quality aspects of the NHS 111 service are being met.

4.3 This will mean that performance of the service is managed within a clear contractual framework. If performance levels are not met, performance notices will be issued to Harmoni, with a requirement for

clear action plan/s to be put in place, and financial penalties made so that the income Harmoni receive is reduced if KPIs are not met.

4.4 The NHS 111 service contract was awarded to Harmoni in 2012/13, and has been in transition between 'soft' and Full Service Commencement since February 2013. FSC will mean that all formal contractual levers can be used, instead of Rectification process, to ensure the service continues to deliver at required performance levels. In the long-term this is the best position for the service to be in as it provides a clear contractual framework and structure for both the provider and commissioners.

5 Financial settlement for services provided to date and before Full Service Commencement (FSC)

5.1 As part of Commercial in Confidence discussions, it is proposed that delegated authority continues to be given to Cath Leech (Chief Financial Officer) to agree and formally sign-off the financial settlement for services provided to date (to include minor variations to the terms of the settlement necessary to obtain agreement and in negotiation with Harmoni, other commissioners and legal teams).

6 Next Steps

6.1 An informal meeting of Health Overview and Scrutiny committee members (HOSC) and CCG representatives is planned to take place on 17th October 2013. Mark Walkingshaw and Jeremy Welch will provide verbal feedback from this meeting to the Governing Body on 24th October 2013.

6.2 Given sustained performance proceed to go through checkpoint 6 and into FSC on 28th October 2013.

6.3 Proceed to agree a financial settlement for services provided to date and before Full Service Commencement.

6.4 Gloucestershire CCG has a requirement to keep NHS England informed of expected timescales, and will continue to provide a weekly report in this regard.

7 Recommendation(s)

7.1 The Governing Body are asked to:

- Support the proposed next steps set out in sections 3, 4, 5 and 6.

- To continue to provide delegated authority to Cath Leech (Chief Financial Officer) to agree and formally sign-off financial settlement for services provided to date (to include minor variations to the terms of the settlement necessary to obtain agreement).

NHS
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Clinical Commissioning Group

Agenda Item 4

Governing Body

Governing Body Meeting Date	Thursday 24th October 2013
Title	CCG Prioritisation Processes
Executive Summary	The NHS constitution imposes a statutory duty on each CCG to have a priority setting system in place that explains how the CCG decides whether to fund a healthcare intervention or service. This paper outlines the actions required for the CCG to be legally compliant.
Key Issues	The CCG are asked to agree the prioritisation process, which will comprise an Ethical Framework, Prioritisation Framework, a Priorities Committee and Individual Funding Request panel.
Risk Issues: **Original Risk** **Residual Risk**	Failure to have an agreed and publically available prioritisation system could result in any decision made by the CCG being challenged via a judicial review.
Financial Impact	N/A
Legal Issues (including NHS Constitution)	The CCG is required to have an ethical framework for decision making if it is to meet its statutory duty under the NHS Constitution.
Impact on Health Inequalities	The Prioritisation Framework and Ethical Framework both ensure that the needs of the population are given due consideration by the CCG in its decision making processes.
Impact on Equality and Diversity	**Yes** Having an agreed Ethical Framework will help to ensure that the decisions made by the CCG consider the needs of individuals with protected characteristics.

Impact on Sustainable Development	**N/A**
Patient and Public Involvement	The Ethical Framework and Prioritisation Framework will be available on the CCG website, so ensuring the public understand the methods we use for making decisions about service change.
Recommendation	The CCG Governing Body are asked to agree: - The adoption of the Ethical Framework to underpin the CCG decision-making processes. - The Prioritisation Framework to be used to support decision-making in respect of services and treatments to be commissioned by the CCG. - The establishment of a Priorities Committee as a committee of the Governing Body to provide advice to the Governing Body and act on its behalf where delegation has been agreed.
Author	Marion Andrews-Evans
Designation	Executive Nurse & Quality Lead
Sponsoring Director (if not author)	

NHS
Gloucestershire
Clinical Commissioning Group

Agenda Item 4

Governing Body

24th October 2013

CCG Prioritisation Processes

1 Introduction

1.1 The NHS constitution imposes a statutory duty on each CCG to have a priority setting system in place that explains how the CCG decides whether to fund a healthcare intervention or service. It further has the duty to publish the decision-making process on its website. Until such processes are in place the CCG is in breach of its statutory obligations and therefore the implementation of a prioritisation system in the CCG has to be implemented as a matter of urgency.

1.2 The CCG is therefore required to agree and establish a prioritisation process which will comprise an Ethical Framework, Prioritisation Framework, a Priorities Committee and Individual Funding Request panel.

2 Ethical Framework

2.1 The purpose of the Ethical Framework (Appendix 1) is to guide and underpin the decision making processes of the CCG and the work of the Priorities Committee, it further supports a consistent approach to commissioning. The Ethical Framework does this by:

- 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 within an Ethical Framework

- Supporting and integrating with the development of CCG Commissioning Plans

2.2 The Ethical Framework is particularly concerned with evidence of clinical and cost effectiveness; equity; healthcare need and capacity to benefit; cost of treatment and opportunity costs; needs of the community and national policy drivers. All these key areas will need to be considered when the CCG makes decisions regarding the priorities it gives to the treatments and services it commissions.

3 Prioritisation Framework

3.1 Over several months the CCG has been developing a Prioritisation Framework (Appendix 2) which has been based on a wide source of evidence and published research in this field.

3.2 The Prioritisation Framework has been considered by the GPs, Lay, Professional and Executive Governing Body members at 2 development meetings. It has also been issued for consultation to member practices through the seven locality executive groups and has been discussed with the service providers at the Clinical Priorities Forum

3.3 The Prioritisation Framework covers 12 key areas, with specific areas receiving double weighting due to their greater importance in the decision-making process.

4 Priorities Committee

4.1 The purpose of the priorities committee is to advise the local NHS Health economy as to the health care interventions and policies that should be given high or low priority. It will further make decisions on priorities in areas which have been delegated by the Governing Body. The Priorities Committee helps the CCG and its Localities choose how to allocate its resources to promote the health of the local community, based on the local health needs assessment.

4.2 The Terms of Reference of the Priorities Committee are attached (Appendix 3) and the membership is designed to be as inclusive as possible, so ensuring that Governing Body

Members are fully involved in the CCG decision-making process.

4.3 The Clinical Programme Groups will be sub-committees of the Priorities Committee, with the GP leads being members of the Committee.

5 Individual Funding Requests

5.1 Requests by individuals for specific not routinely commissioned treatments, will be managed in accordance with the CCG agreed procedure and supporting policies.

5.2 The CCG already has an established Individual Funding Request panel which will continue to make decisions regarding the funding for these specific treatments.

6 Recommendation(s)

The CCG Governing Body are asked to agree:

- The adoption of the Ethical Framework to underpin the CCG decision-making processes.
- The Prioritisation Framework to be used to support decision-making in respect of services and treatments to be commissioned by the CCG.
- The establishment of a Priorities Committee as a committee of the Governing Body to provide advice to the Governing Body and act on its behalf where delegation has been agreed.

7 Appendices

Appendix 1 – Ethical Framework for Decision Making
Appendix 2 – Prioritisation Framework
Appendix 3 – CCG Priorities Committee – Terms of Reference

Appendix 1

NHS
Gloucestershire
Clinical Commissioning Group

ETHICAL FRAMEWORK FOR DECISION MAKING

1 Introduction and Background

The CCG is under a statutory duty to promote the health of the local community. They are also under a duty not to exceed their annual financial allocation. These legal requirements mean that, from time to time, difficult choices have to be made.

The CCG has established a prioritisation process comprising of a prioritisation framework, a priorities committee and individual funding request panel. The purpose of the priorities committee is to advise the local NHS Health economy as to the health care interventions and policies that should be given high or low priority. The priorities committee helps the CCG and its Localities choose how to allocate its resources to promote the health of the local community, based on the local health needs assessment.

2 Purpose of the Ethical Framework

The purpose of the Ethical Framework is to guide and underpin the decision making processes of the CCG and the work of the Priorities Committee, it further supports a consistent approach to commissioning by:

- 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 within an Ethical Framework
- 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 out with the Priorities Committee. Although there is no objective or infallible measure by which such decisions can be based, the Ethical Framework supported by the CCG Prioritisation Framework, enables decisions to be made within a consistent setting which respects the needs of individuals and the community. The Committee recognises that their discretion may be affected by National Service Frameworks, National Institute for Health and Care Excellence (NICE) technology appraisal guidance and Secretary of State Directions to the NHS.

The Ethical Framework is especially concerned with the following:

A. EVIDENCE OF CLINICAL AND COST EFFECTIVENESS

The Priorities 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 Committee. Choice of appropriate clinically and patient-defined outcomes needs to be given careful consideration, and where possible quality of life measures and cost utility analysis should be considered.

The Committee will promote treatments for which there is good evidence of clinical effectiveness in improving the health status of patients and will not normally recommend treatment that is shown to be ineffective. Issues such as safety and drug licensing will also be carefully considered. When assessing evidence of clinical effectiveness the outcome measures that will be given greatest importance are those considered important to patients' health status. Patient satisfaction will not necessarily be taken as evidence of clinical effectiveness. Trials of longer duration and clinically relevant outcomes data may be considered more reliable than those of shorter duration with surrogate outcomes. Reliable evidence will often be available from 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 and Patient Outcome Measures and patient experience will be considered as part of the CCG Prioritisation Framework.

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 (e.g. quality adjusted life years), but these will not by themselves be decisive. The Priorities Committee will use the Ethical Framework and Prioritisation Framework to guide context-specific judgements about the relative priority that should be given to each topic.

B. EQUITY

The CCG 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 Priorities Committee will not discriminate on grounds of personal or protected 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

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 Priorities 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.

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.

Because the 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

Public health is an important concern of the Priorities Committee and the CCG 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 National Service Frameworks). Others are produced locally. The Committee will also support 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. These requests are managed through the Individual Funding Request process and panel.

F. POLICY DRIVERS

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 the CCG. The Committee operates with these factors in mind and recognises that their discretion may be affected by National Service Frameworks, 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 Locality within the CCG and these will be described in the Locality Plans and CCG Commissioning Strategy (QIPP) and Operating Plans.

G. EXCEPTIONAL NEED

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. The CCG have procedures in place to consider such exceptional cases on their merits through the individual Funding Request process and panel.

Approved: 24th October 2013

Appendix 2

NHS Gloucestershire Clinical Commissioning Group

Prioritisation Framework

	Weighting	Scoring Description 0	1	2	3	4
Mandatory / Patient Safety	14	Not Mandatory or considered High Risk				Mandatory and/or high risk
National alignment	1	Not linked to constitution / NHS targets / NHS Domains	Addresses or contributes to one target / NHS Domain	Addresses or contributes to two targets / NHS Domains	Addresses or contributes to three targets / NHS Domains	Addresses or contributes to four or more targets/ NHS Domains
Local Alignment	1	This proposal / area is not identified as a local priority	Tactical alignment - enabler to Gloucestershire / Locality priorities	Initiative / area aligns with Gloucestershire / Locality priorities	Initiative features in Gloucestershire / Locality plans	Initiative contributes significantly to Gloucestershire / Locality priorities
Evidence	2	No evidence of benefit in clinical outcomes		Some evidence from validated sources		Strong evidence from validated sources
Outcomes - Clinical Benefit & Safety	1	No impact	Small improvement in health or life expectancy	Moderate improvements in health or life expectancy	Demonstrable improvements in health or life expectancy	Large and proven improvements in health and/or life expectancy
Population Need & Inequalities	1	No impact	Small improvement in inequalities	Moderate improvements in inequalities	Demonstrable improvements in inequalities	Large and proven improvements in inequalities
Urgency	1	Not Urgent or important	Can be infill work & completed on best endeavours	Some degree of priority can be attached	Deadline date & important	Deadline date & urgent
Financial benefits (FYE)	2	No impact or creates a cost pressure	£1 - £100k Benefits attached	£101k - £250k Benefits attached	£251k - £500k Benefits attached	£501k+ Benefits attached
Access	1	No impact	Could increase care closer to home / reduced waiting times or LOS	Moderate improvement in closer to home / reduced waiting times / LOS	Demonstrable improvement in one access area	Will result in significant improvement in access
Scale of impact	1	No Impact	Limited Impact - less than 100 patients	Moderate Impact - 100 - 1,000 patients	Significant Impact - 1,001 - 5,000 patients	High Impact - over 5,000 patients
Do-ability	2	No resource or budget available Internal/External	Internal Stakeholder support, resource/funds not identified (including staff availability)	Resource identified internally/external issues remain (including staff availability)	Full Stakeholder support, resource/funds now identified (including staff availability)	Resource & Budget secured
Patient experience	1	Worsening, or no impact on, patient experience	Small improvement in patient experience	Moderate improvement in patient experience	Demonstrable improvement in an aspect of patient experience	Will result in significant benefits to patient experience

In addition, the following areas will need to be considered within the final business case : sustainability; organisational readiness of provider(s); any disbenefits.

Self Assessment

(populate 'Prioritisation' tab with list of initiatives)

	Raw Score	Weighted Score
Mandatory / Patient Safety		0
National alignment		0
Local Alignment		0
Evidence		0
Outcomes - Clinical Benefit & Safety		0
Population Need & Inequalities		0
Urgency		0
Financial benefits (FYE)		0
Access		0
Scale of impact		0
Do-ability		0
Patient experience		0
Total	**0**	**0**

NHS
Gloucestershire
Clinical Commissioning Group

CCG Priorities Committee

Terms of Reference

Strategic purpose
The CCG has established a prioritisation process comprising a Prioritisation Framework, a Priorities Committee and individual Funding Request panel. The purpose of the Priorities Committee is to advise the local NHS health economy as to the health care interventions and policies that should be given high or low priority. The priorities committee helps the CCG and its Localities choose how to allocate its resources to promote the health of the local community, based on the local health needs assessment.

Purpose
The purpose of the Priorities Committee is to guide and underpin the decision making processes of the CCG and it further supports a consistent approach to commissioning by:

- 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 within an Ethical Framework.
- Supporting and integrating with the development of CCG Commissioning Plans.

Key responsibilities as delegated by the Governing Body:

- To set the organisational priorities within which commissioning plans are developed.
- To provide guidance to the clinical programme groups on the priority areas for their work.
- To agree programme scope and outcomes to deliver organisational priorities and deliver transformational change.
- To use a transparent prioritisation framework to agree commissioning priorities, plans and projects; this includes decisions regarding investment, service redesign and disinvestment.
- To review the robustness of the prioritisation framework annually or more frequently if necessary.
- To agree indicative resources to programmes using a programme budgeting approach.
- To supervise the development of an annual programme plan for each clinical programme group, that outlines the key priorities and makes explicit the links to the CCG overall strategic objectives, using the programme budget to understand the overall cost of the programme and support decision-making.
- To receive recommendations (programme business case) for investment, disinvestment and service redesign at least annually.
- To monitor and resolve impacts between programmes and barriers to progress that require strategic input.
- To understand the aggregate impact of all clinical programmes on key providers and ensure alignment with overall strategic objectives recommending adjustments to individual programme business cases as required.
- To ensure that localities and locality plans are sufficiently represented within the programme plans both as generators of evidence/ideas but also as stakeholders with whom the programme consults and as implementation leads.

- To seek assurance from programme leads that they have consulted with other key stakeholders including partner organisations and communities of interest for that programme and to carry out more strategic consultations through CCG representation at key events and meetings.
- To sign off the programme business cases ensuring they are resourced and deliverable within the overall organisational financial plans.
- To agree specific outputs from clinical programme groups as required e.g. new care pathways.
- To receive and review a programme plan to deliver the business case and receive reports that monitor progress against programme outcomes with quarterly programme updates that demonstrate that the programme plan is delivering.

Membership:

Chair – Clinical Commissioning Group - Chair
Vice Chair – Clinical Commissioning Group - Vice Chair

Members (or their delegated representatives)

- CCG GP Governing Body Members
- CCG Lay Governing Body Members
- CCG Executive Governing Body Members
- CCG Healthcare Professional Governing Body Members
- Director of Public Health (GCC)
- Director of Adult Services (GCC)

Other CCG staff or representative from other organisations will be invited to attend for specific items on the agenda.

Accountability and reporting:

The CCG Priorities Committee will be accountable to Gloucestershire Clinical Commissioning Group Governing Body. The Committee will have delegated powers to make decisions on behalf of the governing body as described in the CCG Governing Body constitution.

The CCG Priorities Committee will be responsible for prioritisation across the range of programmes and healthcare services.

The Associate Director Clinical Programmes will provide routine updates to the committee on the progress with the work of the clinical programme groups (CPGs).

The CPG clinical leads will provide information and updates on individual programmes on an ad hoc basis as required.

The Associate Director of strategic Planning will provide regular updates to the committee on progress with specific projects and programmes initiated by the CCG.

Quorum
Chair or Vice Chair, 3 CCG GPs, a Governing Body Lay Member, Accountable Officer or Deputy; Chief Financial Officer or deputy; Executive Nurse or Deputy.

Frequency of CCG Priorities Committee
A minimum of 4 meetings per annum

Sub-groups

All Clinical Programme Groups will formally report to the CCG Priorities Committee.

Secretariat to be provided by
The Director of Transformation and Service Re-design team

Agenda and papers:
The agenda and papers will be circulated electronically one week prior to the meeting. Agenda items and relevant papers should be submitted at least 1 week prior to this date.

Minutes will be circulated in draft within 5 working days of the meeting to allow members to respond.

Review:
These terms of reference will be reviewed annually