Isle of Man Government

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Clinical Recommendations Committee (CRC)

Terms of Reference

Department of Health & Social Care

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Contents

1. Background

The Department of Health and Social Care (DHSC) receives a fixed budget from the Treasury with which to fund all the health and social care required for the residents of the Isle of Man. Under the National Health Service Act 2001 (Section 1), the DHSC has a duty to *'continue to promote in the Island a comprehensive health service designed to secure improvement in (a) the physical and mental health of the people of the Island and (b) the prevention, diagnosis and treatment of illness.'*

It is not possible to fund all types of health and social care which may be requested within a fixed budget. The National Health Service Act 2001 reflects the reality of budget constraints by conferring a duty to 'promote a comprehensive health service', that is a target or aspirational duty which the DHSC must continually work towards, rather than a duty to fund a comprehensive service at any given point in time.

It follows, therefore, that decisions have to be made about which types of treatment and care are priorities for funding. The DHSC believes that the best and fairest way to fund and provide effective care for residents is through the development of clear care pathways and funding policies that allow equal access to all patients with similar clinical need.

The DHSC considers that the most effective way of allocating resources to achieve maximum improvement in population health is through its Finance and Commissioning Committee, which is one of the sub-committees of the DHSC. This approach enables the comparison and relative prioritisation of all potential calls on the DHSC's resources for the following year.

2. Purpose

The role of the Clinical Recommendations Committee (CRC) is to advise the DHSC on which proposals for investment or disinvestment should go forward to the short list for final prioritisation to the Finance and Commissioning Committee. Once a proposal has received support from CRC, the clinical team/care provider which would deliver the intervention should develop a business case for submission to the Finance and Commissioning Committee. Proposals not supported by CRC should not progress to the business case stage.

Very rarely, CRC may consider that a proposal has compelling reasons for in year introduction without the need for prioritisation against other calls on resources. Any decision to support in year introduction will necessarily imply that resources should be diverted to this proposal from the priorities identified for the current year. In such cases, DHSC will need to understand the potential impact on current priorities should the recommendation be supported, before a final policy decision is made.

In some cases, a proposal for a new intervention or service could be introduced in year without requiring additional resources, i.e. it would be cost-neutral. CRC may make a recommendation for in-year introduction on the basis of cost-neutrality. However, DHSC will require a business case providing assurance of cost-neutrality before approving the recommendation as policy.

CRC will also advise DHSC on areas for potential disinvestment. This could include recommendations to withdraw funding from interventions for which CRC concludes there is inadequate evidence of clinical and/or cost effectiveness; recommendations to withdraw funding from interventions which have minimal impact on health outcome (sometimes referred to as interventions of lower clinical value); and recommendations to limit access to certain interventions to patients who have reached a specified threshold for that intervention (e.g. their symptoms fit specified criteria for severity and/or they have failed to respond to interventions offered earlier in the pathway).

3. Duties

The CRC will:

- Agree with DHSC an annual work programme of interventions[1] for possible investment, disinvestment or threshold setting to be assessed by CRC.
- Undertake single issue assessment of interventions for possible investment or disinvestment against the criteria set out in the Ethical Framework document referenced: CRC02 31 Aug 2016.
- Advise DHSC on whether each intervention considered should:
  a) Go forward to a business case, consideration and prioritization within the annual commissioning round; or
  b) Be considered for in year introduction with funding subject to DHSC confirming and identifying a source of funds; or
  c) Be considered for in-year introduction on a cost-neutral basis subject to DHSC assuring itself of the funding position; or
  d) Not progress to further consideration.
- On confirmation from DHSC, issue a final policy statement in-year in respect of interventions assessed as falling within categories b), c) or d) above.

[1] 'Intervention' is the specific proposal being assessed, usually a drug treatment, procedure, device, therapy or any other health or social care intervention.

- Issue a final policy statement in respect of interventions assessed as falling within category a) at the point at which DHSC makes a funding/prioritization decision.
- Advise DHSC on the implications of following NICE technology appraisal guidance on the Isle of Man.
- Ensure one point of contact for clinicians who wish to submit proposals for a policy decision. Each proposal should have a named senior clinical sponsor usually the clinical lead for the service through which the intervention would be offered.
- Review policies as indicated by changes in available evidence. Review may be triggered by a submission from the sponsoring clinician.
- Work with providers to ensure that implementation of policies is regularly audited and audit results are reported to CRC and DHSC.
- Carry out regular audit of CRC's own practice by reviewing recommendations against the Ethical Framework.

Advice to DHSC will be in the form of a draft policy recommendation.

The term 'clinician(s)' used throughout this document refers to clinicians providing care to Isle of Man residents. 'Appropriate clinicians' refers to those clinicians who would deliver the intervention under consideration to Isle of Man residents.

4. Support

The CRC requires the following support to fulfil the duties above:

Secretariat:

- Management of meetings, venues, agendas, papers, minutes, drafting of policies, project management of work programme, management of consultation process.

Technical:

- Horizon scanning in conjunction with health and care providers to identify potential topics for inclusion in work programme.
- Scoping of each agreed topic against standard Patients, Intervention, Comparators, Outcomes and Studies (PICOS) framework.

- Production of a Rapid Evidence Review (RER) for each topic in line with the PICOS, comprising literature search, description of intervention and patient group, appraisal of evidence of clinical and cost effectiveness and safety, modelling of potential local activity and cost, identification of potential ethical issues, policy options for discussion by CRC.
- Cost and activity modelling of implications of NICE technology appraisal guidance.
- Consultation with appropriate clinicians regarding the technical accuracy of the draft RER.

Patient and public consultation is NOT included in the process.

5. Method of Working

The CRC is a multidisciplinary body that will meet on a regular basis, to consider health and care policy issues. The CRC holds no budget and is not a decision making body but makes recommendations on policy to DHSC as set out in section 1.

The process for reaching a recommendation and policy drafting will:

- Follow a systematic and explicit methodology
- Be transparent – all policy statements will include clear reasons for the recommendation
- Be consistent
- Be based on best available evidence
- Be informed by consultation with appropriate clinicians
- Support DHSC resources in using resources to deliver maximum health benefit and value for money.

6. Membership

The membership of the CRC shall be representative of primary, secondary and mental health. It will include lay representation.

The membership is as follows:

- DHSC Elected Member (Chair)
- Medical Director (Vice-Chair)
- Director of Public Health
- Director of Commissioning
- Finance Director
- Pharmaceutical Adviser
- Medical Consultant (Acute)
- Medical Consultant (Mental Health)
- Chief Nurse
- General Medical Practitioner
- Manager of Therapy Services (Acute)
- Lay Members (x2)

Members of the CRC will observe the highest standards of impartiality, integrity and equity in relation to the advice they provide

Members of the CRC will abide by the principles of collective responsibility and support the recommendations agreed through due process by the CRC.

For each intervention considered, the CRC may invite appropriate clinicians to the relevant meeting to contribute to discussion and inform the CRC's work. These individuals will be invited to leave the meeting before the CRC finalises its decision on the intervention.

A decision on the recommendation to be made to DHSC will generally be reached by consensus. Where consensus cannot be reached, the decision will be taken by vote – each full member having one vote, Chair's vote (or in their absence the Vice-Chair's vote) casting.

No deputies are permitted.

7. Terms of Office

Members appointed to the CRC by virtue of being designated post holders shall continue to serve as members of the CRC for so long as they hold their designated post.

The General Medical Practitioner, the Medical Consultants, and the Lay Members shall be appointed for a period of no longer than 3 years in any one term. These members can be reappointed but may not serve a total period of more than 6 years consecutively.

These members shall be appointed by the DHSC and, in the cases of the General Medical Practitioner and the Medical Consultants, after consultation with the Medical Staff Committee and Isle of Man Medical Society respectively.

8. Role of the Chair

The CRC will be chaired by an elected member appointed by the Minister for Health and Social Care. In their absence the CRC will be chaired by the Vice-Chair.

The Chair is responsible for ensuring that the notes of meetings, produced by the secretariat, are an accurate record of decisions taken and that the reasons for each decision is clearly set out.

9. Confidentiality

All discussions within the context of the CRC will be treated as strictly confidential amongst the members of the CRC.

10. Declarations of Interest

CRC members will declare their relevant personal and non-personal interests at the beginning each meeting. Declarations will be recorded in the minutes.

Members may be requested to withdraw for items which they have declared an interest, if the consensus of the meeting is that the declared interest constitutes a significant conflict of interest for the individual concerned.

11. Quoracy

The meeting will be considered quorate if 5 voting members are present. This should include the Chair (or in their absence the Vice-Chair), 2 medical members and 2 non-medical members.

Very rarely, a meeting may become inquorate due to the necessary early departure of one or more members. If this occurs, the remaining members may choose to adjourn or continue the meeting and ratify the decisions at the next meeting or by Chair's Action (or in their absence the Vice-Chair's) – email comment and approval.

12. Accountability

The CRC is accountable to the Minister for Health and Social Care through the Finance and Commissioning Committee and the DHSC Department meeting.

13. Deliverables

- Work programme agreed with DHSC
- Rapid evidence review for each intervention on the work programme
- Draft policy recommendations submitted to DHSC
- Final policy statements published on confirmation from DHSC and made publicly available via website.
- Audit reports as detailed under section 3.

14. Review

The terms of reference and outputs of the CRC will be reviewed by DHSC on an annual basis.

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This document can be provided in large print or in audio format on request

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