

**Clinical Policy Review Framework**

The purpose of this document is to provide a consistent and proportionate approach to clinical policy review to ensure robust and defendable decision-making.

All clinical policy reviews will have regard to NICE, EBI and Royal College guidance where available.

All clinical policy reviews should consult the [Policy Considerations Aide Memoire](#Considerations).

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| **Policy**  |
| Name: |  |
| Condition: |  |
| Treatment:  |  |
| Principal Evidence: |  |
| Baseline policy position  | Describe variation inherited from CCGs |
| Review date if applicable: | All low risk were extended to March 2024? |
| Date submitted: |  |
| Review lead:  |  |

**Recommendation**

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| Policy | State if the policy is to be retired, standardised, or reframed? |
| Rationale  | Summarise the main Policy Considerations which provide the basis for the Recommendation.  |

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| Detailed rational where applicable | Use this space to document where there is a significant Policy Consideration and if further review is required. |
| Evidence |  |
| Ethical |  |
| Financial |  |
| Operational |  |
| Future |  |
| Access |  |
| Health Outcomes  |  |

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| EQIA:  | Required where the policy recommendation results in material change  |

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| **Evidence**  |
| NICE | Is the recommendation in line with applicable NICE guidance? Case law is clear that we cannot choose not to follow NICE guidance without a clear description of reasons. |
| Evidence-Based Interventions | Supports delivery of requirements identified through scrutiny processes, e.g. as a result of patient safety incidents, external reviews or inquiries, benchmarking reports or risk management processes. |
| Supports Clinical Guidelines | Improves adherence and compliance with other relevant clinical guidelines from other professional bodies |
| Clinical Evidence Base | Supported by the clinical evidence base in the literature, e.g. controlled trials, 'before and after' studies |
| **Ethical**  |
| Ethical Considerations | Supports the ethical principles of respect for autonomy, beneficence, non-maleficence, and justice.  |
| Reducing Health Inequalities | The extent to which the policy will reduce health inequalities - preventable, unfair and unjust difference in health status between groups, populations or individuals that arise from the unequal distribution of social, environmental and economic conditions within societies, which determine the risk of people getting ill, their ability to prevent sickness, or opportunities to take action and access treatment when ill health occurs. |
| Societal Value | The extent to which greater societal value is achieved, including but not limited to:  increased employment status, enhanced family relationships, reduced tax spend / increased tax revenue, positive environmental impact, reduced carbon footprint, reduced social isolation, improved community cohesion, positive impact on local economy. Societal value supports the 4th purpose of ICSs (social and economic development) |
| **Financial**  |
| Cost-Benefit Ratio | Is a cost-benefit ratio available in the evidence-base? This is an indicator showing the relationship between the relative costs and benefits of a proposal, expressed in monetary terms.  A cost-benefit ratio greater than 1.0 results in a positive return on investment.  |
| Cost Reduction | Achieves a reduction in the current cost of services, e.g. the cost of staffing, premises, medicines, equipment.  |
| Cost Avoidance | Achieves a reduction in the future cost of services, e.g. the cost of staffing, premises, medicines, equipment.   |
| **Operational**  |
| Operational Feasibility | How well the policy will work, including service availability, management support, how end users/patients will feel about it, potential resistance, changes to the working environment and track record in delivery. |
| Ease of Implementation | How easy the policy would be to implement, on a scale of low to high ease of implementation.  Factors include the number and nature of stakeholders, the length of time needed for implementation, the level of investment required, organisational/system readiness, use of a systematic implementation approach, level of familiarity with business processes and technology, support from leadership. |
| Strategic Feasibility | The level of 'political' acceptability to all stakeholders such that proposals can overcome enough resistance to move from the stage of an idea to agreement. |
| **Future**  |
| Future Benefits or Opportunities | The extent to which the policy will generate future (long term) benefits or opportunities.  Balancing immediate needs with future, potentially high-risk but high-benefit future gains.   |
| System Integration | The extent to which the policy will reduce service fragmentation, enable working across organisational boundaries, positively impact the population rather than organisations and support the best use of elements of the health system.   |
| **Access to Health Services** |
| Service Access | The extent to which the policy will improve access or utilisation, or reduce wait times, especially in high-demand or pressure areas.   |
| Service Demand | The extent to which the policy will reduce demand for services, e.g. a reduction in avoidable contact, attendance, or admission |
| **Health Outcomes - consider if there is no published guidance**  |
| Number of Patients/Population | The number of patients/population in the Integrated Care System area that would benefit from the policy. |
| Population Health Benefit | The product of the number of patients who benefit from the intervention and the potential benefit in quality and length of life, assuming successful implementation, to the 'typical' beneficiary.  (NB - this would be used instead of the separate 'number of patients' and 'health gains' criteria above as it is the same factors). |
| Decrease in Mortality Rate | Decrease in mortality rate associated with a disease area as a result of an intervention. |
| Morbidity Rate | The morbidity rate (prevalence or incidence) of a disease area. |