NHS
Staffordshire and Stoke-on-Trent
Integrated Care Board

Policy on the Prioritisation of Healthcare Resources

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Ratified by:	Integrated Care Board
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Target audience:	NHS and partnering agencies, health, and care professionals; general public

NHS
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Integrated Care Board

CONSULTATION SCHEDULE

Name and Title of Individual	Groups consulted	Date Consulted
Clinical Leads (1 per CCG)	Internal	2021/22

RATIFICATION SCHEDULE

Name of Committee approving Policy	Date
Governing Bodies Meeting in common, Staffordshire and Stoke-on-Trent CCGs	March 2021
Integrated Care Board	July 2022

VERSION CONTROL

Version	Version/Description of amendments	Date	Author/amended by
5.0	Combination of existing policies from six CCGs	23.12.2021	Gina Gill Jackie Newman
6.0	Adapted for ICB	22.06.2022	Gina Gill

Impact Assessments – available on request

	Stage	Complete	Comments
Equality Impact Assessment	1	18.01.2019	
Quality Impact Assessment	1	15.02.2019	
Privacy Impact assessment	N/A		

SUMMARY

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This Policy will govern the consideration of services and procedures and their level of clinical priority using the Clinical Prioritisation Process in order to support strategic commissioning.

The ICB ethical framework will set out the organisational values that inform and underpin the prioritisation criteria. This is currently in development and will reflect the NHS England model http://www.england.nhs.uk/wp-content/uploads/2013/04/cp-01.pdf

National guidance and policy may direct the ICB to give priority to particular categories of patients or treatments and this may influence the conclusions reached and investment decisions made as a result of the prioritisation process.

Wherever possible services will be evaluated in line with existing local and national prescribing guidelines, including guidance from the National Institute for Health and Clinical Excellence or other sources of authoritative evidence-based recommendations and guidelines.

The prioritisation process provides a robust mechanism to endorse, implement or introduce new therapies, procedures or services in-year that are not routinely commissioned. These will be treated as new service developments and considered through the ICB's annual prioritisation process.

In making its recommendations CPAG will ensure that discussions, decision making, and articulation of the reasons for the decisions are consistent with the Policy on the Prioritisation of Healthcare Resources.

Where a particular treatment or procedure is not part of an existing agreed pathway or existing commissioned service it can still be considered if it meets the acceptance criteria (section 5.3) to be put forward for prioritisation by CPAG.

CONTENTS

This policy sets out the approach which the Staffordshire and Stoke-on-Trent Integrated Care Board (the ICB) has adopted, ensuring the ICB has a robust policy and processes to evaluate and prioritise all options for investment, and disinvestment, in the strategic context of programme budgets.

Throughout the policy reference is made to “the ICB” which means the Integrated Care Board responsible for ratifying this policy.

1.0 INTRODUCTION

1.1 The ICB has an obligation to provide a fair system for deciding which treatments to commission, recognising that the ICB does not have the budget to fulfil all the needs of all patients within its areas of responsibility [1].

1.2 This means that the key outcome of priority setting is to choose between competing claims on the ICB's budget. This requires the ICB to adopt policies that allow potential and existing demands on funds to be ranked, preferentially, in the context of a sustainable transformation plan for services for specific patient groups. The ICB is adopting a programme budget approach to developing those plans.

1.3 Programme budgeting and marginal analysis (PBMA) provides a framework for applying epidemiology, economics, and evidence of efficacy in health care priority setting. Programme budgeting involves an assessment of how health care resources are currently distributed amongst programmes and within programmes. Such data can be used along with other information on local needs to decide on the main areas of change in service delivery. As resources are fixed, areas of change requiring more resources will be funded from service reductions within the same programme or within another programme. Candidates for more resources should be compared with each other and with candidates for service reduction to determine whether and what changes should go ahead. This involves 'marginal analysis' of costs and benefits of the candidates. [2]

1.4 Prioritisation is the process of ranking competing items, such as tasks or potential purchases, in order of clinical value. Priority setting, as a key component of the process of evaluating health interventions is part of the commissioning business cycle.

1.5 A number of explicit criteria and systematic models for prioritisation have been developed since the late 1980s. These models make it clear it is important to inform and involve the public.

2.0 SCOPE

2.1 The aim of this policy is to provide clarity to commissioners when ranking competing options for investment in order of importance and determining which investments should be made within limited resources. The policy will also act as a mechanism to provide healthcare providers and the public, as potential customers, with clarity around how the ICB manages its commissioning priorities and competing requirements for resources. It acts as a transparent way of informing patients of the same.

2.2 The purpose of the policy therefore is to set out the principles and considerations which will guide priority setting and programme budget allocation:

- providing a coherent framework for decision-making
- promoting fairness and consistency in decision-making
- providing clear and comprehensive reasons behind decisions that have been taken.

2.3 Prioritisation is a fundamental aspect of the management of resources which seeks to fulfil the STP vision:

Staffordshire and Stoke-on-Trent will be vibrant, healthy and caring places where people will be as independent as possible and able to live happy and healthy lives, getting high quality health and care support when required.

3.0 LEGAL AND ETHICAL FRAMEWORKS

3.1 This Policy will govern the consideration of services and procedures and their level of clinical priority using the ICB prioritisation process. The ICB ethical framework sets out the organisational values that inform and underpin the prioritisation criteria.

3.2 The ICB is a public, statutory NHS body, with delegated responsibility from the Secretary of State for Health for commissioning healthcare for its patients and for protecting and improving the health of its population.

3.3 The National Health Service Act 2006 [3] sets out a general duty to provide services to support the prevention, diagnosis and treatment of illness. This is a target duty, rather than a specific legal duty owed to each and every individual in the ICB's population. In consequence, the provision of healthcare services is legitimately subject to decisions as to what is considered appropriate and affordable within the overall prioritisation of healthcare interventions.

3.4 The ICB has a statutory duty to achieve financial balance despite the infinite demands placed on its finite resources. The affordability of treatment is therefore an inevitable and important consideration when the ICB considers the outcomes of evaluation by CPAG of any treatment or service. The ICB is constantly making difficult decisions regarding the treatments it prioritises for investment but does so responsibly within the context of the needs of the wider population.

3.5 the ICB will, under no circumstance consider funding treatments and services which fall under the responsibility of the National Commissioning Board (NHS England) or Local Authority. In a circumstance where a service or treatment has been de-commissioned by one of those bodies the responsibility for commissioning it will not automatically become the responsibility of the ICB.

3.6 In performing these functions, the ICB has regard to the NHS Constitution, in the knowledge that patients have a right to expect that the ICB will assess the health requirements of the local community and will commission and put in place the services to meet those needs as considered necessary.

3.7 In discharging its obligations under this Policy the ICB acknowledges that patients also have a right to expect that local decisions on the funding of drugs and treatments which have not been mandated by the National Institute for Health and Clinical Excellence will be made rationally following a proper consideration of the evidence.

4.0 ROLES & RESPONSIBILITIES

- ICB Chief Executive Officer – overall responsibility for ensuring compliance with the policy and that healthcare is commissioned in a consistent manner, promoting equity and fairness.
- Healthcare commissioners - comply with the policy and its relevant procedures. Ensure identified priorities for investment or disinvestment are implemented through all relevant commissioning policies and contracts and monitor outcomes.
- Healthcare providers – refer to the policy when requesting commissioners to invest in healthcare services in order to understand ICB rationale and processes to be followed.
- Patients – have access to the policy so that they may be helped to understand how the policy has an impact on their healthcare when expecting or requiring specific aspects of care.
- Customer services/PALS – Support patients in their understanding and use of the policy and procedures.
- Healthwatch/Patient representatives
- Clinical Priorities Advisory Group (CPAG) – oversees the implementation and ongoing development of the policy and undertakes the prioritisation process.
- Strategy, Finance and Performance (SFP) Committee – CPAG is a sub-committee of the SFP Committee. The SFP Committee will therefore receive reports on the impact of the policy at agreed intervals; take account of prioritisation in all investment decisions. Ensure adequate resources are available to support the programme budgeting approach and the prioritisation process

5.0 CPAG FRAMEWORK

5.1 The prioritisation process has five key features:

1. Initial technical assessment
   CPAG has developed a prioritisation working template for presentation of the evidence and relevant information needed to assess each identified candidate treatment or service. This must be completed for all treatment or services.

2. Scoring system
   A Multi-Criteria Decision Analysis tool is used (see appendix A) which is intended to provide as much clarity as possible about the relative clinical value of the intervention by addressing the important issues which the ICB needs to take into account when making commissioning decisions. [see 5.3]

3. Decision making
   To commission or not (the decision-making framework of the ICB sets out the wider aspects of decision making and governance in the ICB)

4. Review of implementation
   A quarterly report from the head of Strategic Commissioning or nominated deputy is made to the Clinical Priorities Advisory Group.

5. Information management

Prioritisation of healthcare is likely to be a sensitive issue, liable to attract public interest and scrutiny. Good record keeping on decisions and the rationale used to reach a decision is important and the policy requires that full documentation is maintained. See Sections 9 and section 13 for information on audit and quality assurance.

5.2 Candidate services/interventions for commissioning or de-commissioning are identified in a number of ways including the following:

- Programme budgeting analysis
- Development and validation of the Staffordshire Prioritised List of healthcare interventions (SPL).
- National priorities such as Quality, Innovation, Prevention, Productivity (QIPP), and the RightCare analyses.
- Individual Funding Requests (IFRs)
- Review of low priority treatments, locally and nationally (e.g. Academy of Medical Royal Colleges *Choosing Wisely* programme)
- Providers – proposals for service developments
- Monitoring and evaluation of services/interventions

5.2.2 The systematic review of commissioned services through the prioritisation process will maintain a ranked list, the Staffordshire Prioritised List, as part of the pan-Staffordshire Prioritisation Programme.

5.3 Criteria used for the prioritisation process

5.3.1 The CCGs use a modified version of the Portsmouth scorecard. (see appendix A). The criteria in the scorecard have been subject to clarification through discussion by CPAG and supplementary papers are used to enable the group to apply criteria consistently.

5.3.2 CPAG has developed a standard format taking the criteria into account for presentation of the relevant information and evidence needed to assess each identified candidate intervention/service. This format must be completed for all assessed intentions. For audit purposes, this form must be dated with the month when the topic is to be considered.

5.4 Programme budgeting

5.4.1 The programme budgeting approach will be applied to up to five programmes concurrently. These will be identified using tools such as the RightCare data and the line by line analysis of the SPL.

5.4.2 The ICB will establish working groups to undertake the modelling and analysis for each programme. These groups will be supported by the technical support group.
The working groups will undertake the following process;

- define the patient pathways for different groups of conditions
- map the current services, with costs and outcomes

- understand the relative clinical priority of each element of the service
- identify options for change, including disinvestment and reallocation of resources.
- agree a short and medium strategy for transformation

6.0 THRESHOLD FOR ESTABLISHING CLINICAL PRIORITY

6.1 The threshold for investment will be set by the ICB and revisited on a regular basis.

6.2 The threshold will be reviewed constantly by CPAG in the light of changing strength of evidence and experience using the criteria, who will make recommendations to the ICB.

6.3 All services/interventions that may be commissioned will have been scored above the agreed upper threshold score (= Tx). Any that may be fully de-commissioned in order to reinvest, or not commissioned will have scored below the lower threshold score (=Tz).

6.5 As CPAG scores are treated as part of the care pathway, the relative clinical value as expressed by the individual intervention score can be judged with respect to its contribution to the pathway. Topics scoring between Tz and Tx which meet one of the three criteria below will be restricted, in the context of the clinical pathway -

- For a life-threatening condition – 3rd line or greater
- For a progressive condition - 3rd line or greater
- For severe condition with increasing pain and/or increasing limitation of function – 3rd line or greater

N.B. When the Staffordshire Prioritised List is completely costed the threshold will be reconciled with the line which exhausts total available resources.

7.0 PRIORITISATION PROCESS

7.1 In order of action/event:

- Identification of topic (any service or specific intervention aimed at improving health and wellbeing) for assessment – forwarded to the Strategic Commissioning team

- Topic forwarded for initial assessment by Specialist in Public Health who acts as coordinator for evidence papers.

- Acknowledgement sent to originator by the strategic commissioning team stating whether suitable for scoring or not (e.g. If the intervention is subject to NICE TAG it will not be necessary to give it a prioritisation score)

- Evidence review is drafted by member of support group and edited by Public Health Specialist. Engagement with clinicians at this stage is necessary where clarification is required on indications or clinical evidence.

- Formal assessment by CPAG committee, the outcome of which will be documented in the CPAG minutes providing detail on the reasons for the scores for each of the prioritisation criteria.

7.2 The outcome of the decision will decide the next action:

- If the prioritisation score is less than Tz, and does not require disinvestment since it is not currently a commissioned intervention, this will be recorded and communicated by the commissioning department.

- If the prioritisation score is more than Tx and the topic requires investment since it is not a currently commissioned intervention, a business case will be developed and submitted to the ICB.

- If the prioritisation score is less than Tz and the topic requires disinvestment since it is currently a commissioned intervention, an implementation plan will be developed and submitted to the ICB.

- If the prioritisation score is between Tz and Tx and the topic requires clinical eligibility criteria, the business case will be developed and submitted to the ICB

7.3 All topics approved for investment and disinvestment should be linked to outcomes or measures of impact. The commissioning department will be responsible for ensuring this process is set up and monitored.

8.0 CPAG STRUCTURE

8.1 CPAG Membership

8.1.1 Members of CPAG will be invited from these parties:

- A clinical Chair and Vice chair as appointed by the group
- ICB Clinicians
- Medicines Optimisation representation
- Consultant in public health or nominated representative
- Secondary care clinician as appointed by the group

8.2 CPAG Panel Quoracy (see Terms of Reference, appendix C)

8.2.1 In the interests of full stakeholder engagement-CPAG panels will always be convened under the rules of quorate membership.

8.2.2 CPAG meetings that are not quorate will be suspended and resume at the next opportunity, or within one calendar month, whichever is sooner.

9.0 GOVERNANCE

9.1.1 The Clinical Priorities Advisory Groups are accountable to the SFP Committee. The Committee makes the strategic commissioning decisions.

9.1.2 Compliance will be maintained with all ICB governance policies including the Information and Security Data Management policy and Risk Management.

9.1.3 The terms of reference for CPAG can be found at Appendix C.

9.1.4 The ICB acknowledges the key role of public health specialists in implementing this policy. The respective responsibilities of Staffordshire Public Health, which is part of the County Council, and Stoke on Trent Public Health which is part of Stoke on Trent City Council, and the ICB is set out in the Memorandum of Understanding (MoU) between the local authorities and the ICB. The Public Health departments have agreed to provide expertise and advice to support the prioritisation process for commissioning or decommissioning of services. Specifically Public Health will nominate the attendees at the CPAG as set out in the terms of reference; establish and sustain the technical sub-group which will supply the necessary evidence for the CPAG to undertake the scoring; deliver the allocated functions set out in section 6 of this Policy.

9.2 Risk Management

9.2.1 The ICB should ensure that any priorities waiting for investment or disinvestment posing a high risk to the organisation or patients should be highlighted in the ICB risk register.

9.3 Fresh evidence

9.3.1 Where a service or treatment has already been evaluated and scored by CPAG and new evidence or guidance comes to light, this new evidence may be submitted to CPAG via the ICB.

9.3.2 The new material will be examined and screened in accordance with section 5 above. If it is considered to demonstrate evidence that is likely to change the original CPAG prioritisation scores it will be considered and re-scored by CPAG.

9.3.3 The CPAG panel will consider the fresh evidence in the context of the original evidence submitted rather than in isolation i.e.: it will consider the totality of the evidence, old and new.

9.4 Resource implications

9.4.1 Commissioning budget

The aim of assessing priorities in healthcare is to identify which healthcare services or interventions are to be commissioned within a finite commissioning budget. Services or interventions that are deemed not to be a clinical priority for the population will be disinvested in order to provide more effective healthcare for the population with the aim of meeting strategic objectives for improving health.

9.4.2 Technical skills

The ICB will ensure the resources required in order to implement this policy and procedures, undertake the prioritisation process, review the low priority treatments and maintain the individual funding requests processes, are identified and made available. Access to appropriate public health skills is seen as essential implementing this policy.

9.5 Managing information

9.5.1 Prioritisation of healthcare is likely to be a sensitive issue, and liable to attract public interest and scrutiny. Good record keeping on decisions and the rationale used to reach a decision is important and the policy requires that full documentation is maintained. See Section 13 for information on audit and quality assurance.

9.5.2 All information received and considered under this Policy remains confidential and will be managed in accordance with the Data Protection Act 2018 and will be held, processed and shared only as required for the purposes of delivering services in accordance with the principles of the Policy.

9.5.3 All reporting will take place as described in section 13

9.4.4 All communications regarding prioritisation and decisions surrounding investment or dis-investment opportunities will be regarded as commercially sensitive and treated with the strictest confidence until approved by the ICB.

9.6 Consultation

9.6.1 The CPAG page on the ICB website will provide a link to the policy and the pages defining the interpretation of each criterion.

9.6.2 A list of topics to be considered by CPAG will be available on request to the administrator

9.6.3 Instructions on how to provide comments/evidence will be available in response to any enquiry.

9.6.4 The decision made by the ICB is final; therefore there is not an appeal process.

10. POLICY APPROVAL AND RATIFICATION

10.1 The policy will be approved and ratified by the Unitary Integrated Care Board.

10.2 Impact assessment

10.2.1 The ICB aims to design and implement services, policies and measures that meet the diverse needs of our service, population and workforce, ensuring that none are placed at a disadvantage over others'. Quality and equality impact assessments were undertaken on the policy which acknowledged the positive impacts associated with an aligned process and policy. It is recognised that further impact assessments may be required for specific interventions following recommendation from CPAG and as part of the ICB's decision making process.

10.3 Links with other policies

10.3.1 This policy must be read in conjunction with:

- Information Security and Data Protection
- Records Management
- Individual Funding Request (IFR)
- Policy on Exclusions and Restrictions
- Risk Management

11.0 TRAINING

11.1 Training will be provided for those who are required to implement and maintain the use of the policy and relevant procedures. The staff and agencies using the policy must ensure that any new personnel that are expected to use the policy and procedures clearly understand the requirements and are able to work with them and this forms part of their local induction.

12.0 MONITORING AND EVALUATION

12.1 Audit and quality assurance

In order to ensure compliance with the policy, an annual audit should be undertaken. This is to consist of a review of all of the priorities assessed as not for investment/or for disinvestment and 10% of those that were approved for investment. An audit template has been developed to ensure consistency of assessment. The audit must assess consistency of the use of the prioritisation format; assessment and decision making to timescale, documentation management and the monitoring of implementation of priorities. The audit must be presented to the ICB Audit Committee.

12.2 Key performance criteria:

- The standardised prioritisation format was used in all decision making
- 100% of the decisions made have completed accurate documentation
- CPAG has reported to the SFP Committee on an annual basis
- A clear and concise summary of all CPAG recommendations and scores is accessible to the ICB upon request at any time to use as a framework for their commissioning decisions
- There is evidence that the policy has been reviewed as a minimum on an annual basis

- An annual audit has been completed and the policy reviewed as a result of any learning
- Prioritised topics are subject to decision and implementation by the ICB.

13.0 REVIEW

13.1 Prioritisation of healthcare is evolving therefore CPAG will ensure this policy is kept under constant review. As a minimum the policy will be reviewed on an annual basis.

14.0 GLOSSARY

- CPAG - Clinical Priorities Advisory Group
- ICB - Integrated Care Board
- PBMA - Programme budgeting and marginal analysis
- Prioritisation - determining which investments should be made within limited resources
- NCB - National Commissioning Board
- NHSE - NHS England
- LA - Local Authority

15.0 REFERENCES

[1] Commissioning policy: Ethical framework for priority setting and resource allocation. NHS Commissioning Board, April 2013
[2] Donaldson C. Economics, public health and health care purchasing: reinventing the wheel?
Health Policy 1995;33(2):79-90.
[3] National Health Service Act 2006, Section 3

16.0 APPENDICES

Appendix A – Portsmouth scorecard
Appendix B – Prioritisation process
Appendix C – CPAG Terms of Reference

Appendix A Staffordshire ICB's Prioritisation framework

Factor	Scale					Score
	Very Low	**Low**	**Medium**	**High**	**Very High**	
1 Strength and quality of evidence* **Is there a robust evidence base, appropriate for the intervention, which shows the benefit of the proposed intervention? Scores will be reduced from the indicative hierarchy scores where the studies are of low or moderate quality (see guidance notes).**	**< 10 points** if poor quality evidence **OR** strong evidence it does **NOT** work =0	**10 points**	**20 points** if there is modest evidence for benefit	**30 points**	**40 points** if there is very strong evidence that the service or intervention **DOES** work	
2 Magnitude of health improvement for the patient group or population* **To what extent does this intervention increase the health gain or life expectancy for the patients/population? Appraise outcome measures eg improvement in functionality, clinical markers, QoL, HLE ***	**<10 points** if **negligible** or **no** improvement in health or life expectancy (<10% improvement)	**10 points**	**20 points** if there is **moderate** benefit (20 – 30% improvement)	**30 points**	**40 points** if there are **large** health improvement benefits (≥50% improvement in outcome measures such as QoL, HLE)	

3 Prevention of future illness or disability* **Does this intervention contribute to prevention of future new health conditions?**	**0points** if it does **not** prevent future illness	**10 points**	**20 points** if there is a **moderate** prevention benefit	**30 points**	**40 points** if it has a **very high** prevention benefit	
4 Supports people with existing health problems **Does this intervention prevent or reduce complications in people with ongoing conditions?**	**0 points** if it does **not** support people with health problems	**10 points**	**20 points** if there is a **moderate** benefit for people with health problems	**30 points**	**40 points** if it is **highly** supportive of people with health problems	
5 Cost effectiveness ratio* **What is the cost per ICER or QALY of this intervention?** **If no information, default score =10**	**0 points** >£30000	**5 points** £>20000 - £30000	**10 points** £>10000 - £20000	**15 points** £5000 - £10000	**20 points** <£5000	
6 Opportunity costs **What is the cost per head for the population that**	**>£20K** 5 points	**£>10 - 20K** 10 points	**£>5 - 10K** 15 points	**£1 - 5K** 20 points	**<£1K** 30 points	

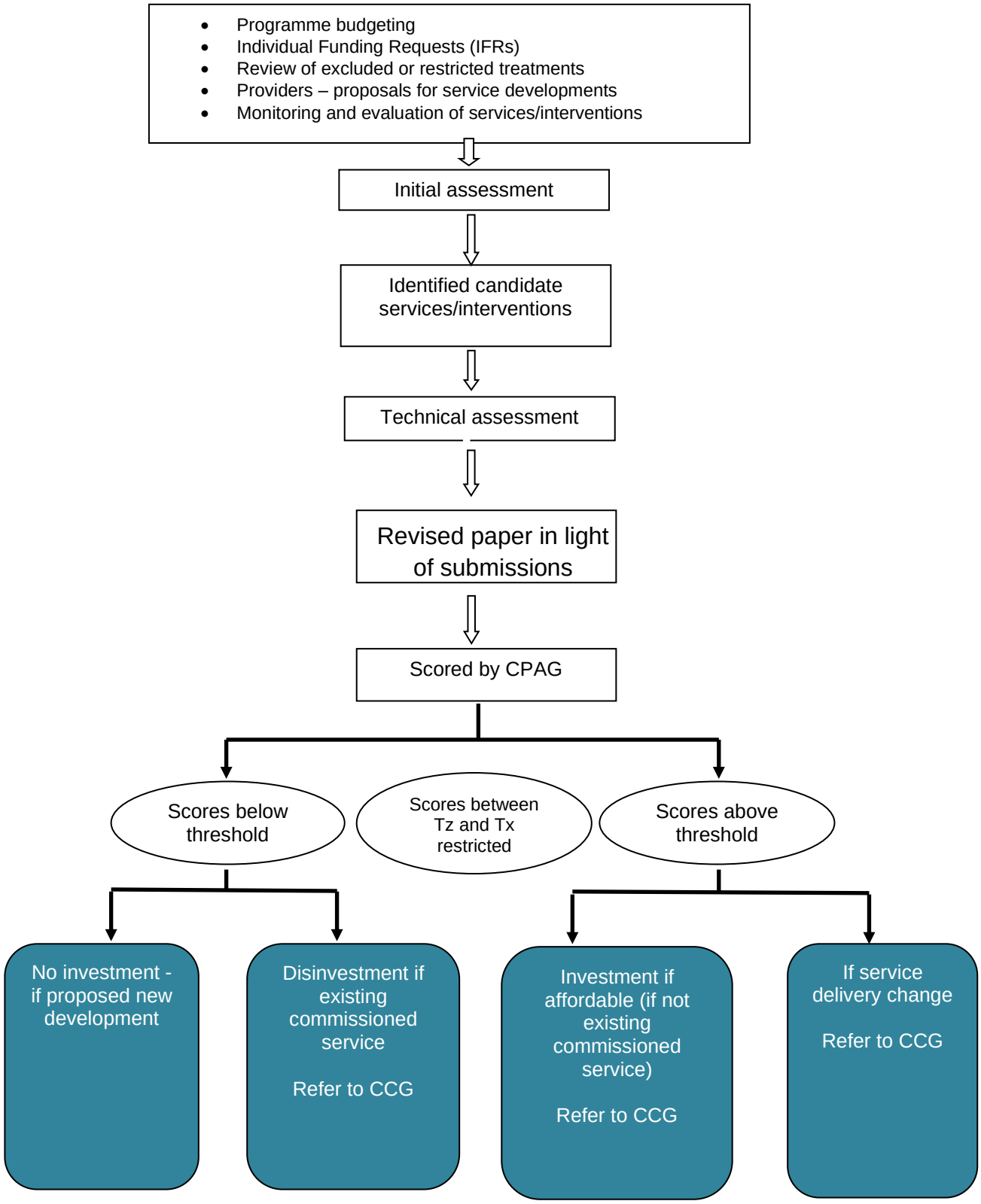
might benefit potentially from this intervention? Cost per annum, one-off or recurring.						
7 Addresses health inequality or health inequity* **Does this intervention reduce or narrow identified inequalities or inequities in the local population?**	**0 points** if it does **not** address any inequality or inequity	**5 points**	**10 points** if it **partially** addresses an identified inequality or inequity	**15 points**	**20 points** if it **completely** addresses an identified inequality or inequity	
8 Delivers national or local requirements and targets **Does this intervention support the ICB in delivering identified national requirements or local priorities/targets?**	**0 points** if **not** a requirement	**10 points** if it addresses **one** target or requirement	**20 points** if it addresses **two** targets or requirements	**30 points** if it addresses **three** targets or requirements	**40 points** if it addresses **four or more** targets or requirements	
TOTAL SCORE						

Maximum score = 270

***= subject to further notes below**

Appendix B Prioritisation Process

This process matches the business cycle which has three main components – strategic planning, procuring services, and monitoring & evaluation. This is a sub-set of the decision-making framework.



Appendix C – TERMS OF REFERENCE (Version 1.0)

Name of group:	**Staffordshire and Stoke-on-Trent ICB's Clinical Priorities Advisory Group (CPAG)**
Accountable to:	1. Governing Board 2. An update from the action log and minutes are to be presented to Strategy, Finance and Performance (SFP) Committee three times per year. 3. An annual report will go to the SFP Committee. 4. Recommendations for commissioning decisions will go to SFP Committee
Purpose:	1. Inform strategic commissioning 2. Inform annual commissioning cycle by recommending priorities determined through the prioritisation process for investment and disinvestment. 3. Inform and guide the programme budget based commission programme
Responsibilities:	1. Manage the prioritisation framework of the Staffordshire and Stoke on Trent ICB to inform investment and disinvestment decisions during the annual commissioning cycle. 2. Undertake an ongoing programme of work throughout the year providing explicit advice on what healthcare interventions (including therapeutics, interventional procedures, technology, healthcare, pathways and public health programmes) should be the subject of investment or disinvestment by the ICB. 3. Review existing and new commissioning policies, specifically the Excluded and Restricted Procedures Policy. 4. To consider and make recommendations on locally identified innovations or service developments. These may be identified via a variety of mechanisms including: 4.1 Service reviews which may be triggered nationally or locally, including outcomes of care pathway planning 4.2 Opportunities for improvement in productivity/efficiency recommended by the NHS Institute for Innovation and Improvement where a policy change (e.g. restricting/extending patient selection criteria for an

	intervention) would be required; 4.3 Review of intervention(s) identified through the Individual Funding Request (IFR) 4.4 Review of interventions or new treatments identified through horizon scanning; 4.5 Provider proposals to commission new interventions / innovations 5. Act as steering group for the programme budget based commissioning programme 5.1 To advise on and approve the care pathway models 5.2 To support the creation of a ranked Staffordshire Prioritised List by scoring pathways and interventions, and validating the ranking through regular reviews of individual lines
Contextual frameworks	1. Ethical considerations In making its recommendations and developing local policies, CPAG will ensure that discussions, decision making, and articulation of the reasons for the decisions are consistent with the ethical policy framework. 2. Prioritisation policy In making its recommendations and developing local policies, CPAG will ensure that discussions, decision making, and articulation of the reasons for the decisions are consistent with the prioritisation policy.
Membership	Chair: A clinical chair and vice-chair will be appointed as nominated by the membership Core members: • Clinicians (6) from across the ICB, • Consultant in Public Health • Medicines Optimisation representative • Secondary care clinician as appointed by the group Attendees • CPAG Administrator

	Quorum will be attendance by a minimum of four members which must include a ICB clinician and a Public Health Consultant.
Invited to attend:	The Chief Transformation Officer will be invited to attend quarterly to discuss the actions taken on previous scored items. CPAG may invite clinical specialists to attend as expert advisors, or they may co-opt members where there are perceived gaps in knowledge but will not form part of the decision making process.
Meeting frequency:	The Group will meet monthly with a minimum of 10 meetings per annum.
Minutes/Agendas:	Minutes will be made available 5 working days prior to the next meeting and will be circulated to group members and others listed in the distribution list. Agendas and papers will be agreed by the Chair (or delegated CPAG core member) and circulated to group members no less than 5 working days before the meeting.
Declaration of interest:	A member of the CPAG who has a conflict of interest has to inform the Chair of the group in writing at the earliest opportunity. The Chair will also seek declarations at the beginning of each meeting. Declarations of interest must be clearly identified within the minutes of the meeting including any need to withdraw and reasons for not doing so. The CPAG administrator will hold a central Register of Interests for the group. Register of interests to be reviewed annually.
Review date:	The Terms of Reference will be reviewed annually. Next Review Date – April 2023