North Staffordshire Clinical Commissioning Group

Policy on the Prioritisation of Healthcare Resources

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Name of originator/author:	John Harvey Consultant in Public Health
Name of responsible committee/individual:	Clinical Priorities Advisory Group
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Target audience:	Commissioners, Care providers and public

CONSULTATION AND RATIFICATION SCHEDULE

Name and Title of Individual	Date Consulted
Head of Governance	

Name of Committee	Date of Committee
CPAG committee	27/04/16

VERSION CONTROL

Version	Date	Author	Detail of Change
2.0	1 March 2013	J Harvey	Annual review and changes to reflect CCG structure
2.1	26 February 2014	J Harvey	Annual review and changes to reflect introduction of consultation
3.0	27 April 2016	J Harvey	Review to change in respect of single CPAG for N Staffs and Stoke

Contents

1. Introduction

1.1 All primary care trusts were instructed to "have in place arrangements for making decisions and adopting policies on whether particular health care interventions are to be made available for patients for which the (Primary Care Trust)is responsible."[1] This was a requirement of a specific direction to primary care trusts from the Secretary of State for Health which came into effect on 1 April 2009,[1] and is now the responsibility of the Clinical Commissioning Group. In addition each commissioning organisation "must on request provide a written statement of the reasons for its general policy on whether a particular health care intervention is to be made available for the benefit of patients for which the (organisation) is responsible."

1.2 Prioritisation is the process of ranking competing items, such as tasks or potential purchases, in order of importance. Priority setting is a key component of the process of evaluating health interventions in order to decide what investments should be made with limited resources. It is part of the commissioning business cycle.

1.3 A number of explicit criteria and systematic models for prioritisation have been developed since the late 1980s. These models increasingly seek to inform and involve the public.

1.4 This policy sets out the approach which North Staffordshire Clinical Commissioning Group (the CCG) has adopted, ensuring the CCG has a robust policy and processes to evaluate and prioritise all options for investment, and disinvestment.

2. Purpose

The purpose of this policy is to provide clarity to commissioners when ranking competing options for investment[2] 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 CCG manages its commissioning priorities and requirements and acts as a transparent way of informing patients of the same.

3. Values

The Clinical Commissioning Group has responsibility to make decisions aimed at delivering the CCG mission**.** This is set out in the CCG's first Joint Five Year Strategy and One Year Operating Plan. It sets out our determination to commission high quality, safe and effective services for the people of North Staffordshire from 2016/17-2021/22.

[1] Directions to Primary Care Trusts and NHS trusts concerning decisions about drugs and other treatments. DH. March 2009

[2] When the term "investment" is used it is taken to mean investment or disinvestment

We envisage a very different health system in North Staffordshire to the one we have inherited, based around the patient and the patient journey, with a renewed focus on quality and patient safety, led by clinicians with the support of skilled managers, and involving our patients and the wider public in the decisions that affect their health and the services they receive.

This is reflected in our Vision:

Quality care, best value, better outcomes

*Quality is our guiding principle and underpins everything we do. By **quality care**, we mean that the health services we commission for the people of North Staffordshire will be safe; the interventions will be clinically effective, delivering a positive outcome and the patient experience will be a good one. Our focus on quality will realise a quality premium – by doing things right the first time, we will secure **best value** from the resources we invest and achieve **better outcomes** for our patients.*

4. Target audience

CCG Board, CCG commissioning staff, Midlands and Lancashire Commissioning Support Unit, GP's, members of the public who consider they have a need to understand how the CCG commissions, service providers, those who scrutinise the commissioning and provision of healthcare.

5. Responsibilities

CCG Accountable 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 and highlight any need for future amendments. Ensure approved priorities for investment or disinvestment are implemented and remain on track, and monitor outcomes.

Healthcare providers – refer to the policy when requesting commissioners to invest in healthcare services in order to understand CCG rationale and processes to be followed.

Patients – have access to the policy so that they may be helped to understand how the policy may 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.

Clinical Priorities Advisory Group (CPAG) – oversees the implementation and ongoing development of the policy and undertake the prioritisation process. North Staffordshire CCG and Stoke on Trent CCG have agreed to share a single CPAG from May 2016. This arrangement is subject to the agreement set out in the Memorandum of Understanding between the CCGs.

Clinical Commissioning Group Board – receive reports on the impact of the policy at agreed intervals; take account of prioritisation in all investment decisions.

6. Prioritisation system

6.1 The prioritisation system has five key features:

- Initial technical assessment
- Scoring system intended to provide as much clarity as possible about the relative importance of issues which North Staffordshire CCG needs to take into account when making commissioning decisions
- Decision making – to commission or not (the decision making framework of the CCG sets out the wider aspects of decision making and governance in the CCG)
- Review of implementation
- Information management

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

- The Joint Strategic Needs Assessment (JSNA)
- Development and validation of the Staffordshire Prioritised List of healthcare interventions (SPL)
- National priorities such as Quality, Innovation, Prevention, Productivity (QIPP)
- Individual Funding Requests (IFRs)
- Review of low priority treatments
- Providers – proposals for service developments
- Commissioning intentions
- Monitoring and evaluation of services/interventions

6.3 A systematic review of commissioned services through the prioritisation process to maintain a ranked list, incorporating the State of Oregon Prioritised List is part of the pan-Staffordshire Prioritisation Programme.

6.4 Criteria used for the prioritisation process

North Staffordshire CCG uses 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.

CPAG has developed a prioritisation working format against the standard criteria to present 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.

6.5 Threshold for establishing clinical priority

All services/interventions that may be commissioned will be scored above the agreed threshold score (= Tx). Any that may be de-commissioned in order to reinvest will be scored below the threshold score.

This threshold will be reviewed constantly in the light of changing strength of evidence and experience using the criteria.

6.6 Prioritisation process

In order of action/event:

- Identification of topic for assessment – forwarded to Public Health
- Receipt of topic[3] for initial assessment by Specialist in Public Health who acts as co-ordinator
- Acknowledgement sent to originator by PH administrator stating whether suitable for scoring or not.[4]
- Initial paper on each item from Public Health is subject to consultation (see section 6.7)
- 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
- The outcome of the decision will decide the next action:

    - If the prioritisation score is less than Tx, 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 Clinical Commissioning Group.

    - If the prioritisation score is less than Tx and the topic requires disinvestment since it is currently a commissioned intervention, a business case will be developed and submitted to the Clinical Commissioning Group.

    - If the prioritisation score is more than Tx and the topic requires a service delivery plan as it is already commissioned in some form, the business case will be developed and submitted to the Clinical Commissioning Group
- Once the decision has been made the topic will be recorded in an investment portfolio. 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.

6.7 Consultation

[3] "topic" to mean any service or specific intervention aimed at improving health and wellbeing
[4] If the intervention is subject to NICE TAG it will not be necessary to give it a prioritisation score.

1. The CPAG page on the CCG website will set out the process and indicative timetable for consultations
2. The CPAG page will also link to the policy and the pages defining the interpretation of each criterion.
3. A list of topics to be considered by CPAG will be posted on the website on a three monthly basis, with the proviso that topics may be added at any time – but this would be signposted on the website.
4. For each topic:
    - the first draft working form will be posted by a published date. This draft would indicate the likely assessment of each of the criteria, but not give an indicative score (see example attached).
- comments and further evidence will be invited, but would have to be submitted by the specified date.
- the comments and evidence will be reviewed and the working form amended as appropriate. This is the item that will go to the CPAG meeting for scoring.
- a brief summary of the response to comments and evidence will be shown on the website.
- the final total score will be posted but not the individual criterion scores.

6.8 The decision made by the CCG is final; therefore there is not an appeal process.

6.9 This process is illustrated in the flow chart in Appendix C.

6.10 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 Section 13 for information on audit and quality assurance.

7. Consultation on the policy and communication with stakeholders

Consultation and communication in the development of the previous policy ratified by NHS North Staffordshire PCT was as defined in the policy, "*A Policy for the Development and Management of Policies & Procedural Documents*"[5] and includes service users and external organisations for example health and social care policies.

Ongoing development and revision of the policy and related procedures will be managed through the CPAG, of which it is anticipated there will be at least two members of the public (see Terms of Reference, appendix C).

Consultees will include:

- Members of CPAG
- CCG Executive
- Local authority O&S Committee
- LINKs /Healthwatch

[5] A policy for the development and management of Policies and Procedural Documents. NHS North Staffordshire. November 2008

- Legal advisors
- The public through the patient and public involvement members of CPAG

8. Governance

8.1 The Clinical Priorities Advisory Group is accountable to the Clinical Commissioning Group Governing Board. The CCG Board makes the strategic commissioning decisions.

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

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

8.4 The CCG 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 the CCG are set out in the Memorandum of Understanding (MoU). Staffordshire Public Health has 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.

In addition the MoU describes the role of Staffordshire Public Health in training, audit and quality assurance (see sections 11 and 12).

9. Risk Management

North Staffordshire CCG should ensure that any priorities waiting for investment or disinvestment posing a high risk to the organisation or patients should be highlighted in the CCG risk register.

10. Resource implications

10.1 Commissioning budget

The aim of assessing priorities in healthcare is to identify what 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 meeting strategic objectives for improving health.

10.2 CPAG

The CCG in line with its Memorandum of Understanding with Staffordshire Public Health (see section 8.4) 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.

11. Training

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. Policy approval and ratification

The policy will be approved and ratified by the CCG Board.

13. Audit and quality assurance

13.1 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 is to be 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 CCG Governing Board Audit Committee.

13.2 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 CCG Board on an annual basis
- An annual audit has been completed and the policy reviewed as a result of any learning
- There is evidence that the policy has been reviewed as a minimum on an annual basis
- Prioritised topics are subject to decision and implementation by the CCG.

14. Links with other policies

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

15. Impact assessment

North Staffordshire CCG 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'. The equality impact assessment was completed on the previous version. This version has been revised to take account of the new commissioning arrangements but the overall policy has not changed in any material way, except the addition of the section on consultation.

16. Policy review

Prioritisation of healthcare is evolving therefore CPAG will ensure this policy is kept under constant review. As a minimum the policy will be updated on an annual basis and is therefore due for review in March 2017.

Appendices

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

Appendix A Staffordshire CCGs 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 below).**	**< 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?**	**0 points**	**5 points** £>20000 -	**10 points**	**15 points**	**20 points**	

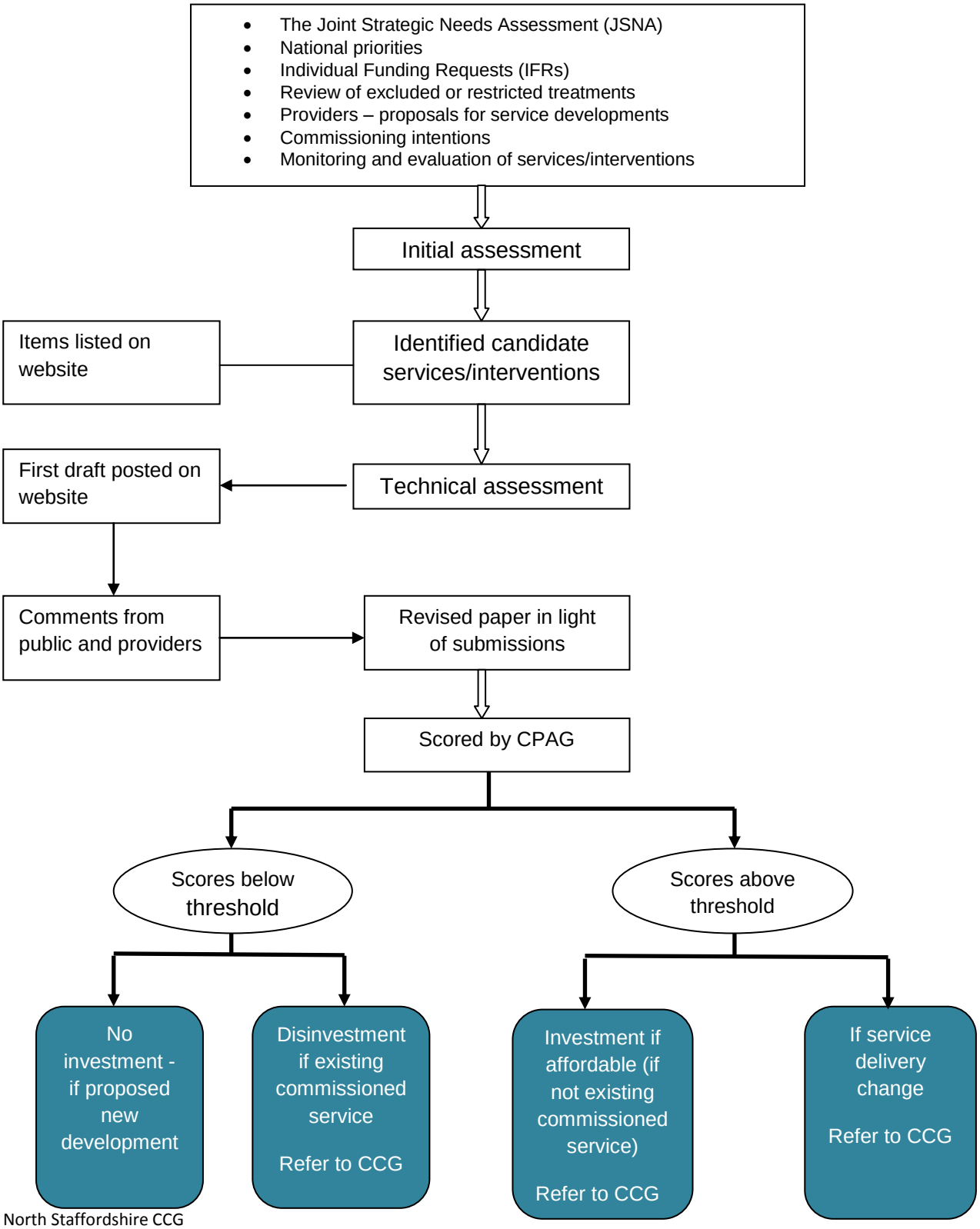
If no information, default score =10	>£30000	£30000	£>10000 - £20000	£5000 - £10000	<£5000	
6 Opportunity costs **What is the cost per head for the population that might benefit potentially from this intervention? Cost per annum, one-off or recurring.**	**>£20K** 5 points	**£>10 - 20K** 10 points	**£>5 - 10K** 15 points	**£1 - 5K** 20 points	**<£1K** 30 points	
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 CCG 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:	**North Staffordshire and Stoke on Trent CCGs' Clinical Priorities Advisory Group (CPAG)**
Accountable to:	1. The Joint Planning Committee 2. An update from the action log and minutes are to be presented to CCG Boards three times per year. 3. An annual report will go to the CCG's Governing Boards 4. Recommendations for commissioning decisions will go to the Joint Planning Committee
Purpose:	1. Inform strategic planning 2. Inform annual commissioning cycle by recommending priorities for investment and disinvestment.
Responsibilities:	1. Manage the prioritisation framework of NHS North Staffordshire CCG and NHS Stoke CCG 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 CCG. 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 undertaken by the Cross Economy Transformation team. 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 4.6 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 chair and vice-chair will be appointed who are clinicians (one from each CCG). Core members: • Clinicians (4) two from each CCG, who may be clinical directors or locality leads. • Clinical Commissioning Group Chairs • Non-Executive Director (2) one from Primary Care and one from Secondary Care • Patient Representative (4) • Consultant in Public Health Attendees • Lay member of the Governing Board (2) • Nominee from Healthwatch (2) • Keele University (Medical School) nominee • Associate Director-Medicines Optimisation • Health Economist/ Epidemiologist • CPAG Administrator Quorum will be attendance by a minimum of six members of whom three must be core members, and two must be clinicians.
Invited to attend:	The Director of Commissioning 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 4 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 2017