NHS
Shropshire
Clinical Commissioning Group

Report to:	**Shropshire Council - Health and Adult Social Care Scrutiny Committee - Prioritisation Monday 20th February 2017**
Title:	Prioritisation and Value for Money Methodology
Sponsor:	Dr Julie Davies, Director of Performance and Delivery *Shropshire Clinical Commissioning Group*
Author:	Dr Julie Davies, Director of Performance and Delivery *Shropshire Clinical Commissioning Group*
Purpose:	This paper outlines the process by which Shropshire CCG will prioritise healthcare service commissioning.
Recommendation or Action required of the Committee:	This paper is provided for information.

Contents

Who Should Read this Document?

- Members of the public in Shropshire
- The CCG's Governing Body
- Sustainability and Transformation Plan stakeholders
- The CCG's membership
- The Health and Wellbeing Board
- Commissioning staff
- Healthcare professionals
- Overview and Scrutiny Committee members

Introduction

Shropshire Clinical Commissioning Group (Shropshire CCG or 'the CGG') commissions healthcare services across the county of Shropshire, with the exception of those residents living in the Telford and Wrekin area. The CCG aims to ensure that services are provided in such a way as to meet the healthcare needs of the resident population fairly, that helps to reduce heath inequalities.

The national Five Year Forward View (NHS England., 2014) summarised the challenges faced by the entire NHS and established the guiding principles and objectives to be considered in order to support sustainable healthcare delivery. Other frameworks, against which this method is aligned includes the NHS constitution, parts of the Human Rights Act and the Equality Acts of 2010; the CCGs values and strategic objectives, particularly the strive for safe, high quality services and better outcomes and achieving value for money e.g. obtaining maximum population benefit from the goods and services commissioned within the available resources.

It is considered likely, in the context of the Sustainability and Transformation Plan, NHS Five Year Forward View that there will need to be step-changes in productivity resulting from major service reconfiguration of health and care services. Commissioners and providers will rapidly, have to make informed, rational choices about the future shape of healthcare interventions and introduce innovative new models of delivery and challenge one another to establish whether the services provided meet local needs and deliver value for money.

The CCG will demonstrate through this method the four key tests for service change, as set out in the Operating Framework for 2010-2011. Firstly, does the initiative have the support of GP Members? Has there been strengthened public and patient engagement? Is there a clear clinical evidence base? Is the scheme consistent with current and prospective patient choice?

Guiding Principles for prioritisation in the Shropshire CCG:

- **Striving to constantly improve quality and safety of care** – Delivering quality and equality for the people of Shropshire are primary guiding principles of the CCG
- **Attaining financial stability** – Seeking value for money to efficiently make improved use of resources and reducing waste and variation
- **Leading the local health economy** – Ensuring local transformation is well-led, transparent, inclusive systematic and robust

What is the Purpose of this Methodology?

This methodology sets out the process by which the Shropshire CCG will prioritise the commissioning of healthcare services, but also in some instances including areas for investment as well as services where funding may be withdrawn as a result of adoption of different care models. This document describes the criteria by which these decisions will be evaluated. As with other Commissioning Groups, a scoring and ranking mechanism will be applied to support objectivity and transparency with our stakeholders.

The key aim of the methodology is to assess the service priorities in Shropshire and identify which and how much of different interventions are commissioned within a finite commissioning budget. Services deemed not to be a clinical priority for the population as part of the assessment process may receive a withdrawal of funding, in order to provide more effective healthcare for the population.

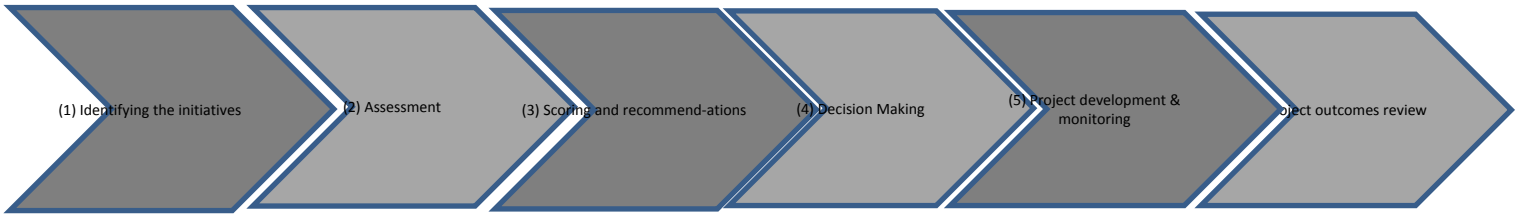
This approach will provide the public, patients, healthcare providers, members and the Governing Body and others with clarity and assurance about how the CCG will manage commissioning priorities and requirements over the years ahead.

What Approach is Taken to Prioritisation?

Priorities for commissioning healthcare services are set at the Shropshire CCG as part of an annual planning cycle, where decisions are made about schemes and investments for the year ahead and beyond. The process involves a systematic review of the CCGs vision and strategy and the development of individual plans to meet system objectives, so that the investment decisions reflect local priorities.

The outcome of the annual priority setting process is then captured in our operating plan moving forward. This operating plan is then used to measure our performance and progress throughout the year. The CCG may sometimes have to review decisions about priorities and investments made as part of the earlier planning process to ensure the organisation complies with all its statutory duties or changing requirements. In this instance, the principles of the prioritisation process within this document will also be upheld. No significant decisions for investment or redistribution of funds will be made without making use of this defined process. Adoption of this process and policy will not obviate the requirement of the CCG to publicly consult on significant service change.

Figure 1: The prioritisation process is formed of 6 stages



This policy focuses upon stages 1 through to 3 of the prioritisation process (See Appendix I).
The Shropshire CCG has, along with other commissioners in England adopted a systematic approach which results in a ranked list of key priorities.
These stages will now be explained:

Identifying the Initiatives

Potential schemes for transformation, investment or disinvestment will be identified from a wide range of sources, which may include:

- Local JSNA guidance
- Strategic Commissioning Plan
- National & Local targets / operational standards
- The Sustainability and Transformation Plan
- The Future Fit Programme
- Horizon scanning about technology
- National directives
- Clinical & strategic networks
- Provider performance reports
- Health & Well Being Strategies
- Quality, Safety & patient experience reports
- Locality Delivery & Programme Board Plans
- Patient & Public Involvement
- Recommendations from Public Health England,
- Recommendations from NICE
- Medicines Management guidance
- Developments previously considered and not supported
- Service benchmarking indicators such as ‘Rightcare’
- Development proposals from providers
- Engagement activities including focus groups
- NHS Right Care programme
- Commissioning for Value packs
- Patient surveys
- Programme budgeting

- Complaints & compliments, the PALS office
- Other applicable evidence

When a potential initiative is identified, a commissioning manager will complete a Project Identification Sheet (Appendix II). The sheet captures key information for the CCG's Clinical Commissioning Committee who will make the recommendations to the CCG's Governing Body. CCG staff will complete the Project Identification Sheet with as much evidence as possible supporting the case for transformation, involving a range of stakeholders as required, including GPs, patients, such as the Shropshire Patient Participation Group, voluntary groups, the local authorities and public health specialists. Each form will require a supporting equality and quality impact assessment and risk assessment.

CCG Engagement Approach for Prioritisation

The following principles for decision making regarding prioritisation apply:

- The public will be engaged in the prioritisation process
- Member practices will also be involved as required
- The CCG Board has a role to oversee and approve proposals for prioritisation. They will refer any proposals that are high value, high risk or deemed contentious to the CCG Governing Body
- The CCG Governing Body, as the legally accountable body for NHS resources in Shropshire, will ultimately make the decision in public about the prioritisation process
- Engagement and consultation will be carried out following Shropshire CCG Engagement and Consultation Guidelines
- The CCG will retain an auditable documentation trail regarding all key decisions from the Clinical Commissioning Committee
- A review process will be put in place so that any affected stakeholders can request a review of the decision making process, in line with the approach to transparency and openness

Draft project identification sheets will be posted on the CCG's website to invite feedback from patients, service users, providers and stakeholders. Additional information and updates will be added to the Prioritisation Identification Sheet, in light of the comment received. The completed sheet and any supporting papers are then submitted to the CCGs Clinical Commissioning Committee for consideration.

Note: The risks associated with each scheme will not form part of the scoring process. They will instead be managed and reported in accordance with the CCG's risk management framework. The CCG Governing Body will ensure that any priorities posing a high risk to the organisation or patients should be highlighted in the CCG Risk Register. Each risk will have a named risk owner, will have mitigating actions and be reviewed on a monthly basis.

Assessment

The Project Identification Sheet presented in Appendix II will be the template used to capture key information as part of the priority assessment process. This task will be completed by the commissioning managers at the Shropshire CCG.

The Clinical Commissioning Committee will meet to consider each project identification sheet, discuss the content and make recommendations to the CCGs Governing Body.

The next stage is the scoring process. The approach involves a modified version of the Portsmouth Scorecard, which has been used successfully in Shropshire in previous years.

The scoring criteria are published in section 3 and within the appendices.

Scoring and Recommendations

Each scheme will be scored by the respective Commissioning and Clinical Leads against ten criteria, which are grouped together into factors which reflect the importance of the scheme and deliverability. When scored, the criteria are weighted with the overall score for the quality based criteria in each section accounting for 65% of the overall mark and the financial criteria, 35%.

Figure 2 below describes the criteria and how they are categorised:

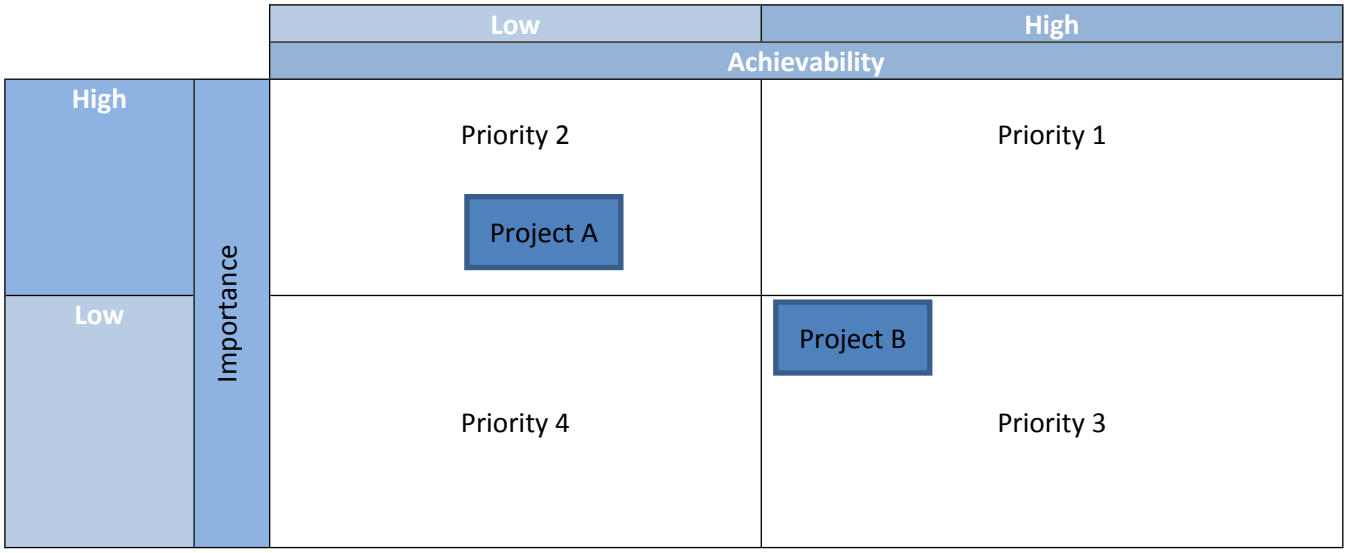
Figure 2: Scoring criteria and weighting Priority Selector Matrix for

	Importance	Achievability
65%	Patient Benefit	Stakeholders
	Clinical Benefit	Building and Equipment
	National Priority	Workforce
	Local Priority	Service Delivery
35%	Financial Benefit	Investment Required

Note: Appendix II shows the marking criteria for the scheme and Appendix III the weighted scoring matrix.

Once all the weighted scores have been agreed, the results are plotted on a prioritisation matrix by the Commissioning Leads. This process helps health professionals consider capacity to deliver and the schemes identified to be recommended to be taken forward. Figure 3 below provides a schematic example of the prioritisation selector matrix that helps with establishing the most suitable phasing of project work.

Figure 3: Priority Selector Matrix



After the above analysis and discussion, the priorities are approved and recommendations are made by the Clinical Commissioning Committee to take forward the projects.

Note: Prioritisation of healthcare is likely to be a sensitive issue and is liable to attract public interest and scrutiny, so consideration of national guidance will be required, for instance NHS England and NHS Improvement documents such

as the Competition and Pricing Frameworks. Good record keeping in relation to decisions and the rationale used to reach a decision is important and the policy requires that full documentation is maintained.

Decision Making, Project Development and Project Outcome Testing

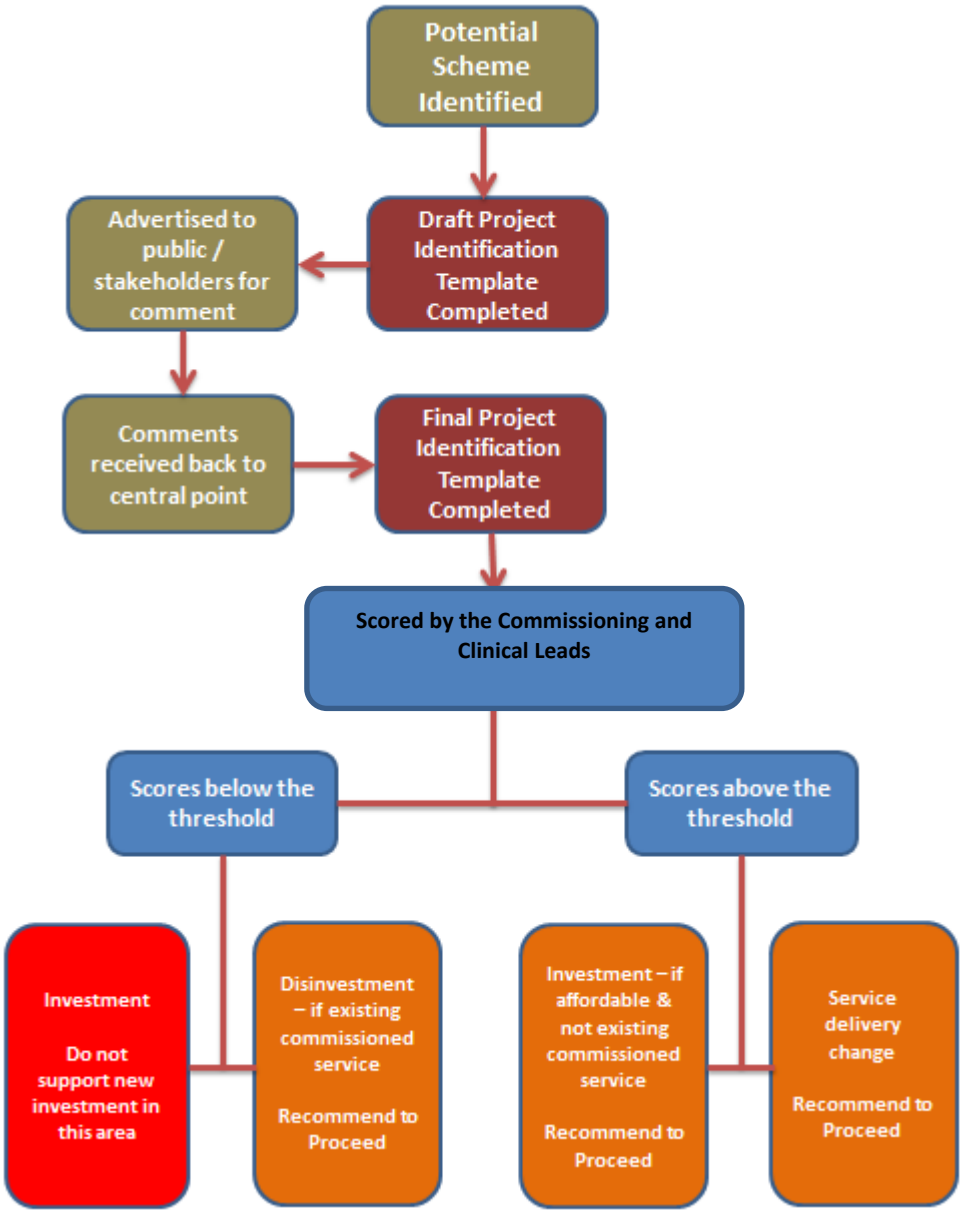
Following the recommendations of the schemes to be taken forward, a final decision (Stage 4) will be made by the CCG's Governing Body.

The results of the prioritisation process will be published on the CCG's website. If the proposal represents significant service change, there will be a consultation process with the public. The schemes will then be further developed (Stage 5) by CCG staff and system stakeholders for implementation. This will include consultation and stakeholder engagement in line with CCG policy and processes.

Following the delivery of all projects, outcomes and benefits will be carefully reviewed and assessed with feedback to the Clinical Commissioning Committee.

APPENDIX I: Process Flow for Stages 1 – 3 of the Prioritisation Process

The process is aligned with the CCG's business cycle and has three main components: strategic planning, procuring services and monitoring & evaluation. This is a sub-set of the decision making / governance framework.



APPENDIX II: Project Identification Sheet

NHS
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PROJECT IDENTIFICATION SHEET

Unique Reference Number		**Commissioning Manager / Lead Name**	
Name of Project			
Clinical Lead		**Sponsoring Executive**	

Background to the Proposal
Please provide an overview of the proposal *Include details of background, scope, rationale* *What is the supporting data / comparative benchmark data?* *Is the CCG an outlier?*
Aims and Objectives
What are the deliverable outcomes & benefits from this proposal? *If it is a de-commissioning proposal, what are the potential impacts?*
Governance
Where is the accountability for this proposal? *e.g. Exec Team / Locality Group / STP / Clinical Commissioning Committee*
Assumptions & Constraints
Please provide details of any identified

Project Milestones		**QIPP**	
Please provide indicative dates for each of these gateways. If not applicable enter N/A		***Which QIPP Element does this proposal relate to ? (X)***	
Project Scoping		Quality	
Health Needs Assessment / Evidence Gathering		Innovation	
Patient Engagement & Stakeholder Assessment		Productivity	
Investment Appraisal		Prevention	
Service Specification		***Which QIPP Level? (X)***	
Procurement & Contracting		Individuals / Organisation	
Service Implementation & Planning /			
Mobilisation			
Service Review & Project Close		National	

Risks & Mitigations	**Equality & Quality Impact Assessment**
Please outline the key risks & attach a copy of the risk assessment form.	*Please highlight any impact on any of the protected groups and attach a copy of the completed Pre-pare toolkit*

Headline Financial Impact							
	Recurrent	**Non-Recurrent**	***If non-recurrent over which financial years (where year 1 is 2017/2018)***				
			Year 1	**Year 2**	**Year 3**	**Year 4**	**Year 5**
Investment							
Saving							

Headline Activity Impact			
Provider	**POD / Block**	**Impact (+ / -)**	**Year of Impact**

Outcome	
Importance Score	
Achievability Score	
Prioritisation Map Quadrant	
Outcome *(Proceed / Hold / Cancel)*	

IMPORTANCE CRITERIA
1. Patient Benefit
• *How would this improve convenience and ease of access for users of the service?* • *How many patients would benefit from this service?* • *To what extent would it contribute to reducing health inequalities?* • *To what extent would it contribute to adopting a preventative and early intervention approach that promotes people's independence and wellbeing?* • *To what extent would it contribute to patient choice*
2. Clinical Benefit
• *How does this enhance the implementation of clinical practices designed to improve quality of life (eg admission avoidance or case management)* • *How does it enable the achievement of evidence-based health outcomes (eg through implementation of NSFs, NICE)* • *Give examples of the clinical evidence that supports this submission*
3. National Priority
• *How does this address the key national priorities set out in the outcome frameworks, the reform agenda and the FYFV?*
4. Local Priority
• *How does the scheme address key local priorities and objectives? (eg Health & Wellbeing strategies, JSNA or other local health assessments)* • *To what extent is there pressure for change in the health economy from local people or organisations outside of the health economy (eg patient groups, politicians)* • *To what extent is there pressure for change in the health economy from internal factors (eg workforce, equipment, changes in regulations, alternative providers)*
5. Financial Benefit
• *Would the initiative result in financial savings?* • *What is the timeline for the release of these savings?* • *What is the risk to their release?*

ACHIEVABILITY CRITERIA
6. Stakeholders
• *To what extent are Stakeholders within the local health community supportive of this scheme?* • *What is the likely reaction of local patient groups and politicians to the scheme?*
7. Buildings & Equipment (including technology and connectivity)
• *To what extent would this scheme require change to buildings and equipment?* • *Are there any implications for void space* • *Have these impacts been considered as part of the financial investment / benefit criteria?* • *What are the information technology requirements, considering connectivity e.g. N3?*
8. Workforce
• *Would this initiative require the current workforce to be re-deployed?* • *What new or additional skills would be required for the scheme to start or long-term training once staff have been appointed?* • *To what extent will new ways of working / skill mix be utilised differently e.g. Nurse led follow up, multi-disciplinary team working etc.*
9. Service Delivery
• *To what extent does this require complex service change?* • *What are the interdependencies on other projects / services?* • *Does this include cross-organisational working?* • *Would this affect the viability of other services or impact on service delivery for other commissioners?* • *Is there a provider capable of delivering the service required through this project?* • *Has this scheme been implemented successfully elsewhere?*
10. Investment Required
• *Would the initiative require any additional financial investment?* • *Is this recurrent / non recurrent?* • *Would it be funded by savings elsewhere?* • *Is it possible to release those savings?*

PRIORITISATION PROCESS MARKING CRITERIA

IMPORTANCE CRITERIA				
11. Patient Benefit				
• To what extend would the initiative improve convenience and ease of access for users of the service				
0 No information provided	**1** Unable to determine from the information provided	**2** Slight improvement in access OR May cause small access issues	**3** Some improvement in access OR May cause some access issues	**4** Significant improvement in access to services OR Does not cause new access issues
• How many patients would benefit from improved convenience and ease of access?				
0 No information provided	**1** 0% - 25% Of impacted population	**2** 25% - 50% Of impacted population	**3** 50% - 75% Of impacted population	**4** 75% - 100% Of impacted population
• To what extend would the initiative contribute to reducing health inequalities				
0 No information provided	**1** No reduction OR May create a significant HI gap	**2** Some reduction OR May create a marginal HI gap	**3** Significant reduction OR May create a small HI gap	**4** HI gap completely closed OR Does not create a HI gap
12. Clinical Benefit				
• To what extent would the initiative enhance the implementation of clinical practices designed to improve the quality of life? (eg admission avoidance or case management)				
0 No information provided	**1** There would be no improvement in the quality of life of the impacted cohort OR There could be a significant reduction in the quality of life of the impacted cohort	**2** There would be minor improvement in the quality of life of the impacted cohort OR There could be some reduction in the quality of life of the impacted cohort	**3** There would be significant improvement in the quality of life of the impacted cohort OR There could be minor reduction in the quality of life of the impacted cohort	**4** There would be a huge improvement in the quality of life of the impacted cohort OR There would be no reduction in the quality of life of the impacted cohort
• To what extent would the initiative enable the achievement of evidence-based health outcomes?				
0 No information provided	**1** There is little or no clinical evidence to support this project	**2** There is some clinical evidence to support his project	**3** There is a lot of clinical evidence to support this project	**4** The basis of this project is well documented best practice
13. National Priority				
• To what extent does the initiative address key national priorities?				
0 No information provided	**1** This scheme is not one of the key national priority areas	**2** This scheme starts to address key national priorities	**3** This scheme goes some way to supporting key national priorities	**4** This scheme is proposed specifically to address key national priorities
14. Local Priority				
• Does the initiative address key local priorities and objectives?				
0 No information provided	**1** This scheme is not supportive of local priorities and objectives	**2** This scheme starts to address local priorities and objectives	**3** This scheme goes some way to supporting key local priorities and objectives	**4** This scheme is proposed specifically to address key local priorities

• Is there pressure for change from people / organisations outside of the local health community? (eg patient groups / politicians)				
0 No information provided	**1** There is or would be no external interest in this scheme	**2** There might be some external interest in this scheme	**3** It is highly likely that there would be some external interest in this scheme	**4** There is or would be significant external interest in this scheme
• Is there pressure for change in this area from within the health economy?				
0 No information provided	**1** There is or would be no local interest in this scheme	**2** There might be some local interest in this scheme	**3** It is highly likely that there would be some local interest in this scheme	**4** There is or would be significant local interest in this scheme
15. Financial Benefit				
• Would the initiative result in financial savings?				
0 No information provided	**1** 0% - 2% of total service costs saved	**2** 2% -5% of total service costs saved	**3** 5% - 7% of total service costs saved	**4** Greater than 7% of service costs saved
• How long would it b before these are released or there is a return on any investment that will be required?				
0 No information provided	**1** No return on investment	**2** Long term return ie greater than 7 years	**3** Medium term return ie between 3 and 7 years	**4** Short term return ie immediate to 3 years

ACHIEVABILITY CRITERIA				
16. Stakeholders				
• Are stakeholders within the local health community supportive of this project?				
0 No information provided	**1** There is no local support for this project	**2** There is little local support for this scheme	**3** It is a lot of local support for this scheme	**4** There is significant local support for this scheme
• What is the likely reaction of local patient groups and politicians?				
0 No information provided	**1** There is or would be no local interest in this scheme	**2** There might be some local interest in this scheme	**3** It is highly likely that there would be some local interest in this scheme	**4** There is or would be significant local interest in this scheme
17. Buildings & Equipment (including technology and connectivity)				
• Does this require change to buildings and equipment				
0 No information provided	**1** There would be significant change required OR This would leave a significant space or equipment unutilised	**2** There would be some changes required OR There would be some space or equipment left unutilised	**3** Minor cosmetic changes would be required OR A small amount of space or equipment would be left unutilised	**4** There is very little or no impact on buildings or equipment OR OR The resource would be made available to be utilised more efficiently and effectively
18. Workforce				
• Will current workforce have to be redeployed				
0 No information provided	**1** There would be significant redeployment required OR Displacement of many staff	**2** There would be some redeployment OR Displacement of some staff	**3** A few staff would need to be redeployed OR displaced	**4** There is very little or no impact on staffing OR Staff could be used more efficiently and effectively
• Is this project reliant on securing new or additional skills or reliant on long-term on-going training once staff are appointed?				
0 No information provided	**1** There is a skills shortage within this area & staff would be difficult to recruit OR Staff will need constant on-going training	**2** It may prove difficult to recruit staff with the required skills OR Staff will need some on-going / refresher training	**3** It would not be difficult to recruit new staff with the required skill set OR There is little on-going training requirement	**4** Staff are already recruited who have the required skill sets & this service would see them use those skills more effectively
19. Service Delivery				
• Does this represent a complex service change?				
0 No information provided	**1** YES	**2** Fairly complex	**3** Some minor redesign	**4** NO
• Would this affect the viability of other services?				
0 No information provided	**1** YES	**2** It could do	**3** Minor impact	**4** NO
• Is there a provider in the marketplace capable of providing this service?				
0 No information provided	**1** NO	**2** Limited Choice	**3** A few providers	**4** Many providers
• Has this initiative been undertaken successfully elsewhere?				
0 No information	**1** NO	**2** Limited Success	**3** Some success	**4** Great success

provided				Best Practice
20. Investment Required				
• Would this initiative require significant financial investment?				
0 No information provided	**1** Significant recurrent investment AND/OR Longer term non-recurrent investment to support transition	**2** Some recurrent investment AND/OR Non-recurrent transitional support required	**3** No recurrent requirement AND/OR Short term non-recurrent investment	**4** No additional financial impact Saves money

APPENDIX III: Weighted Scoring Matrix

Scoring and Weighting Summary						Actual scores (example)	
Quality Indicators	**65%**						
Importance	Question weighting	Maximum score	Question weighted score	Overall weighted score	% contribution	Score awarded	Final weighted score
Patient benefit	20%	4	0.8	0.52	13.0%	4	0.52
Clinical benefit	20%	4	0.8	0.52	13.0%	3	0.39
National priority	15%	4	0.6	0.39	9.8%	4	0.39
Local priority	10%	4	0.4	0.26	6.5%	2	0.13
Total importance		**16**	**2.6**	**1.69**	**42%**	**13**	**1.43**
Achievability							
Stakeholders	10%	4	0.4	0.26	6.5%	2	0.13
Buildings and equipment	5%	4	0.2	0.13	3.3%	1	0.03
Workforce	10%	4	0.4	0.26	6.5%	3	0.20
Service delivery	10%	4	0.4	0.26	6.5%	1	0.07
Total achievability	100%	16	1.4	0.91	23%	**7**	**0.42**
TOTAL QUALITY		**32**	**4**	**2.6**	**65%**	**20**	**1.85**
Financial indicators	**35%**						
Importance							
Financial benefit	60%	4	2.4	0.84	21.0%	2	0.42
Achievability							
Investment required	40%	4	1.6	0.56	14.0%	1	0.14
TOTAL FINANCIAL	**100%**	**8**	**4**	**1.4**	**35.0%**	**3**	**0.56**
GRAND TOTAL		**40**		**4**	**100%**	**23**	**2.41**

Final Score		
Importance	Quality	**1.43**
	Financial	0.42
Total Importance Score		**1.85**
Achievability	Quality	0.42
	Financial	0.14
Total Achievability Score		**0.56**

APPENDIX IV: Responsibilities

Key roles and responsibilities in relation to this methodology:

Role	Responsibility
The CCG Chair and Accountable Officer	Overall responsibility for ensuring compliance with the methodology and that healthcare is commissioned in a consistent manner, promoting equity and fairness
The CCG Governing Body	Receive reports on the impact of the approach at agreed intervals; take into account the prioritisation in all investment decisions
Other healthcare commissioners	Comply with the document and its relevant procedures and highlight any need for future amendments. Ensure approved priorities for investment or disinvestment are implemented and remain on track to deliver both to agreed timescales
Healthcare providers	Refer to this document when requesting commissioners to invest in healthcare services in order to understand CCG rationale and processes followed
Healthcare professionals	Have access to the document so that they may understand the impact on their healthcare when expecting or requiring specific aspects of care
The general public, patients, carers	Support service users and patients to understanding the method
Clinical Commissioning Committee	Oversee the implementation and ongoing development of the policy and undertake the prioritisation process