Integrated Care System
Shropshire, Telford and Wrekin

NHS
Shropshire, Telford and Wrekin

Strategic Decision-Making Framework

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1. Executive Summary

1.1 Integrated Care Systems (ICSs) are partnerships of health and care organisations that come together to plan and deliver joined up services and to improve the health of people who live and work in their area. They exist to achieve four aims:

1.2 Integrated Care Boards (ICB) are regularly required to make decisions on the best use of NHS resources on behalf of their local population. The ICB is responsible for making sure that taxpayers' money is spent wisely, so that our residents can have access to high- quality health services which help them to stay as healthy as possible.

1.3 In the current challenging financial climate, it is important for NHS Shropshire, Telford and Wrekin ICB to demonstrate that it is making the most effective use of public money to commission the right care, in the right place, at the right time within the context of our resources in a safe, fair and transparent manner, and in order to deliver our statutory responsibilities, alongside meeting the needs of the Shropshire, Telford and Wrekin population.

1.4 The decision-making process followed by the ICB when deciding what services and treatments to commission should be open and transparent. It is also important that the ICB engages with patients and the public on the future of local health services and consideration should be paid to NHSE guidance for major service change to assess requirements for engagement and/or consultation.

2. Aims of the Policy

2.1 The aim of the policy is to: -

a) Provide a rationale and process to allow services to be identified for review prior to any decision to decommission, disinvest or invest in services.
b) Deliver best value for money by ensuring that local health care resources are directed to the most effective services for the local population.
c) Ensure all commissioned services are monitored in terms of performance and health outcomes.
d) Efficiency, demand management and fitness for purpose to allow for a robust decision to be made regarding continuation of that service.
e) Contribute to the delivery of the ICB's commissioning plan and efficiency agenda, to ensure that resources are directed to the highest priority area to achieve the best possible health outcomes for the local population against available resources.
f) Ensure all investment, decommissioning and disinvestment decisions are taken in a fully informed manner and follow a set procedure agreed by the ICB Board.
g) Ensure that the way in which commissioning decisions are made reflect the ICB Operating Model and are in line with the commissioning cycle.
h) Ensure the safety of patients remains paramount.

3. Principles

3.1 This policy is designed to ensure that the ICB acts in accordance with a set of agreed principles and strong governance when they made decisions about services and are compliant with statutory frameworks at the time of consideration. Briefly these include:

- Equality and quality are the primary guiding principles.
  a) Ensuring the needs of service users are considered throughout.
  b) Better outcomes are achieved.
  c) Health Inequalities reduced.
  d) Equity of access to services.

- Efficiency to make more effective use of resources.
  e) Secure best value for money.
  f) Reducing variation wherever possible.
  g) Improving Productivity

- Processes for identification and evaluation should be:
  h) Systematic and robust.
  i) Transparent and inclusive.

- The process applied should be proportionate and ensure that there is provision for:
  j) Strong governance.
  k) Appropriate engagement and consultation.
  l) Consideration of challenge and appeal.

4. Process

4.1 Changes to currently commissioned services should be assessed using the prioritisation framework and aligned with the Commissioning Cycle. This will provide a consistent methodology that can be kept on record to support the decisions made by the ICB and will ensure that this is embedded as part of the ICB's strategic business and planning cycle.

4.2 There is no definition of service change in the NHS however commissioning decisions are required to be made for all changes to services both current and proposed. All service changes will need to consider the following:

- **Overall budget allocation for existing service provision**

- To prioritise or re-prioritise spend across and between the full range of ICB commissioned services.

- **Pathway redesign:**
  - To prioritise interventions or services within a defined care pathway, either in the context of introducing additional stages or disinvesting in some.

- **New resource allocation**
  - To prioritise new proposals for investment such as the introduction of new technologies or interventions.

- **Disinvestment:**
  - To prioritise proposals for service disinvestment.

- **Integration:**
  - To prioritise or re-prioritise services that can be delivered to achieve the ICBs integration duties.

- **Impact of decisions:**
  To pay due regard to the impact the commissioning decision will have across the population and provider landscape.

4.3 A standard template for assessment of proposals against the prioritisation framework will be used alongside the Service Change documentation considering the commissioning principles of NHSSTW ICB. (Appendix One). This is supported by a flowchart outlining the use of the prioritisation framework in the broader process which can be found under section 11.2 of this policy. A final draft priority rating should be decided upon according to the guidance within this flowchart.

4.4 Assessment of equity and quality is a statutory requirement and guidance should be followed accordingly. An Equality and Quality Impact Assessment (EQIA) and Integrated Impact Assessment (IIA) will be required for all proposed service changes. This process will be completed a separate document for all changes to services. This process is used to fully identify and mitigate any impact on quality or equality and will be taken through the Equality and Involvement Committee.

4.5 An overall rating will be decided based on the information provided within the prioritisation framework and included in the Service Change documentation. There will be 4 categories for this ranging from Very Low to Very High.

4.6 The Strategic Commissioning Committee will take due regard of the prioritisation rating given in the prioritisation framework, according to the ICB's Ethical Decision-Making Framework.

4.7 Where relevant, public engagement and/or consultation will form part of the decision-making process. The entire process, including recommended final categorisations based on evidence and actions resulting from this can be found in the Flowchart for Decision-Making under section 11.2.

4.8 A Service Change Review Group (SCRG) will be created as a working group of the Strategic Commissioning Committee, and all proposed service changes will be required to follow the process set out below. The Commissioning Working Group will review all proposals ahead of submission to the Strategic Commissioning Committee who will keep a formal record of proposals reviewed and the feedback given.

5. Decision-Making Triggers

5,1 There are several reasons why a decision would need to be made. Decision triggers are a critical part of the overall assurance process. There is not a definitive list of the triggers that would initiate this process, however, below is a list of those common triggers.

- Strategic Programme (local or national)
- Service Review
- New Guidance
- New Service
- Contract Expiring
- Contract Notices
- Quality Issue
- Feedback from people and communities
- Annual Planning
- The service is unable to demonstrate clinical and cost effectiveness.
- The service provided is not a statutory responsibility of the ICB
- The service is deemed low priority /of limited clinical value relative to other services that need to be protected or enhanced
- A needs assessment demonstrates existing services are not meeting the health needs of the population

6. Process for Relative Prioritisation

6.1 The relative prioritisation process should be used in conjunction with the Scheme of Reservation and Delegation. Each service change will require a rating to inform the decision regarding the priority of the service change proposed. This will be referred to as the Prioritisation Rating.

6.2 An overall rating will be decided based on the information provided within the prioritisation framework and included in the Service Change documentation. There will be 4 categories for this ranging from Very Low to Very High.

7. Prioritisation Elements

7.1 The prioritisation elements will align to the four aims of the ICB with an overarching element for strategic fit. Some aims have subheadings to make the evidence supplied more granular. This also impacts on how each element is weighted.

1. **Strategic Fit**
2. **Improve outcomes in population health and healthcare**
    - Clinical Effectiveness
    - Anticipated Health Benefits/Health Gain
3. **Tackle inequalities in outcomes, experience, and access**
4. **Enhance productivity and value for money**

- Cost effectiveness (inc. comparison to alternative models of care)
- Affordability (inc. opportunity costs)

5. Help the NHS support broader social and economic development.

7.2 The process of determining the Prioritisation Rating will be based on 7 elements. Each element will be weighted, and a score calculated based on a matrix. The combined score will generate the provisional Prioritisation Rating, and this will be reviewed and approved in accordance with the Scheme of Reservation and Delegation. Each element will require evidence as to why the rating has been applied

Strategic Fit

- Is the ICB mandated to commission the service?
- Is it a national 'must do'?
- Is it subject to National Institute for Health and Care Excellence (NICE) technology appraisal guidance (TAG)?
- How does the service fit with the delivery of current national targets for the ICB?
- How does the service align with the ICBs Strategic Commissioning Intentions, Joint Forward Plan, Clinical Strategy, ICP Strategy, HWBB Strategy, Workforce Strategy, Long Term Financial Plan, LTC Strategy, HTP, LCTP (including planned shifts of services/ activity to community/self-care/management)?

Clinical Effectiveness

- Assessment of the existing evidence and strength of the evidence that the service may be effective compared to other existing or standard treatments.

Anticipated Health Benefits/Health Gain

- Overview of the size of the potential benefits that the population accessing this service can expect, in terms of increase in life expectancy, improved quality of life in those with long-term conditions and recovery from acute illness or injury.
- Identify any specific needs by population.
- Consider Rural health requirements
- Impact on Health Inequalities
- Population Health Management – evidence of potential impact?

Impact on Health Inequalities / Delivering Health Equity

- Could this service act towards reducing health inequalities in the local area?
- Is it accessed disproportionately by a marginalised or deprived group/area or targeted at such?
- Evidence from Core 20 plus 5
- Evidence from JSNA's
- Evidence from Population Health Management Data

Cost effectiveness and Opportunity Costs

- Is there evidence or expectation of improved value for money?

- How does this compare, in terms of cost effectiveness, to alternative services/service models/different settings for the same patient group or conditions?
- Is there an opportunity for releasing resources for alternative uses? (resources include staff time, estate and finance). How does this affect system finances/other partners?
- What is the opportunity cost i.e. how much will the service or intervention cost per head of population per year?

Return on Investment

- What is the Return on Investment?

Help the NHS support broader social and economic development.

- How will the service engage the widest range of partners?
- Does the service have an impact on both the ICB and LA?
- Does the service align with the HWB?
- Population health management?
- Impact on social value?

8. Prioritisation Framework Weightings

8.1 Each service change will require a rating to inform the decision regarding the priority of the service change proposed. This will be referred to as the Prioritisation Rating, an overall rating will be decided based on the information provided within the prioritisation framework (above) and included in the Service Change documentation. There will be 4 categories for this ranging from Very Low to Very High and scores will be moderated by the SCRG.

8.2 Each prioritisation framework element will be weighted, and a score calculated based on the below matrix, the combined score will generate the provisional Prioritisation Rating, this will be reviewed and approved in accordance with the Scheme of Reservation and Delegation.

9.0 Prioritisation Rating Matrix

Prioritisation Framework Criteria Scorecard		Very Low	Low	High	Very High	Score = weighting x points
	Weighting	1	2	3	4	
Completion Note		Enter as 1	Enter as 2	Enter as 3	Enter as 4	
Strategic Fit	1	-	-	-	-	0
Clinical effectiveness	2	-	-	-	-	0
Anticipated Health Benefits/Health Gain	3	-	-	-	-	0
Impact on Health Inequalities	3	-	-	-	-	0

Cost effectiveness and opportunity costs	**2**	-	-	-	-	**0**
Return on Investment	**2**	-	-	-	-	**0**
Help the NHS support broader social and economic development	**2**	-	-	-	-	**0**
Total Score						**0**

9.1 Based on the weighting, the range for the prioritisation rating is between 15-62.

9.2 The following table shows how the individual weighted points drive the final prioritisation rating:

Minimal/ No investment 1	Minor investment 2	Moderate investment 3	Major investment 4
15 - 26	**27 - 38**	**39 – 50**	**51 - 62**

9.3 In-year changes that are proposed and rated as a priority could be added to a future commissioning list for prioritisation of resources in future years, this may be a useful process if service developments are proposed that cannot be resourced in year but could be prioritised as part of the planning process.

10.0 Scheme of Reservation and Delegation

10.1 This will form part of the overall decision-making process with formal decisions being made in the correct forum or by the correctly delegated individuals or groups.

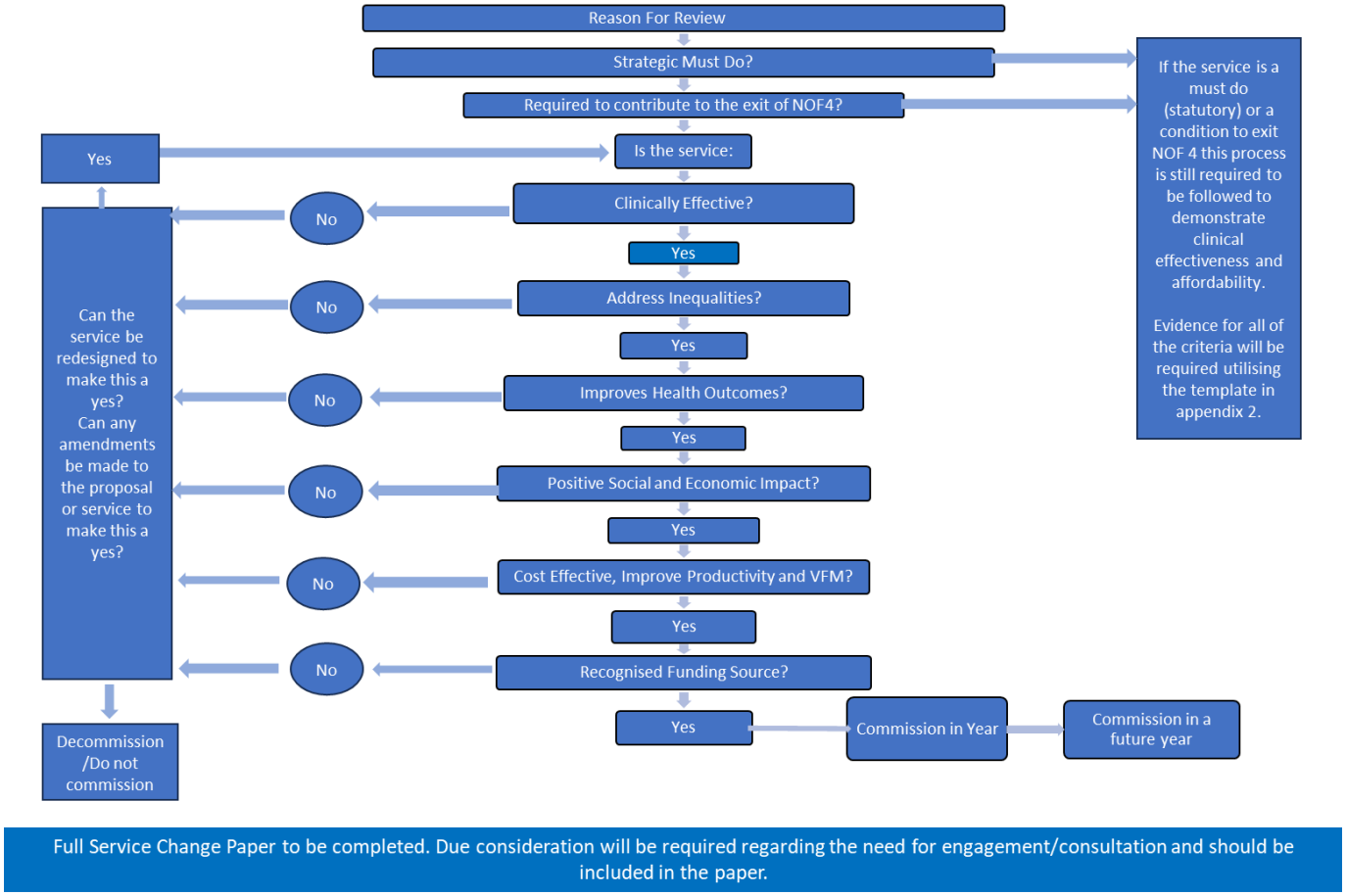
10.2 The below flow diagram will inform, with the use of evidence whether the recommendation is to commission or not it will also indicate on what population footprint is appropriate for the service. Following this a service change paper will be required for review at the Service Change Review Group (SCRG). This group will be created to increase the clinical and financial review to allow the group to assure the proposed prioritisation ratings indicated. Proposals should indicate where the subject matter experts have been involved and where sign off from an appropriate forum has been achieved. This will not remove the need for involvement of these functions in the development of the proposal.

10.3 Following the SCRG the paper will be submitted to appropriate decision-making forum in line with the Scheme of Reservation and Delegation.

11.0 Flowchart for Decision-Making

11.1 The below flowchart will be used to finalise the recommended commissioning decision.

11.2 The evidence used to rate the elements above will also be used to make the decisions required in the flowchart.



11.3 The above flowchart is used to confirm whether a service should be commissioned / continued or not. However, aligned with the ICB's Operating Model, consideration should be given to the way in which commissioning can be most effective including via individual providers, Provider Collaboration or Place.

12.0 Provider Selection Regime (PSR)

12.1 PSR is designed to make it straightforward for systems to continue with existing service provision where the arrangements are working well and there is no value in seeking an alternative provider. Where systems want or need to consider making changes to service provision the new regime will allow for a flexible, sensible, transparent, and proportionate process for decision-making that allows shared responsibility to flow through it.

12.4 The central requirement of the new regime is that arrangements for the delivery of NHS services must be made in a transparent way, in the best interests of patients,

taxpayers and the population.

12.5 There are three broad circumstances that decision-making bodies could be in when arranging services:

- **Direct award processes (A, B, and C)**. These involve awarding contracts to providers when there is limited or no reason to seek to change from the existing provider; or to assess providers against one another, because:
    - the existing provider is the only provider that can deliver the health care services **(direct award process A)**
    - patients have a choice of providers and the number of providers is not restricted by the relevant authority **(direct award process B)**
    - the existing provider is satisfying its existing contract, will likely satisfy the new contract to a sufficient standard, and the proposed contracting arrangements are not changing considerably. In addition, the service does not meet the test for 'considerable change' under Direct Award C, a service must not be materially different in character to the existing service, and the new contract must not exceed £500,000 of the lifetime value of the existing Contract or 25% higher than the lifetime value of the Contract. **(direct award process C).**

- **Most suitable provider process**. This involves awarding a contract to providers without running a competitive process, because the relevant authority can identify the most suitable provider.

- **Competitive process.** This involves running a competitive process to award a contract.

12.6 NHS Shropshire, Telford and Wrekin Integrated Care Board needs to comply with defined processes in each case to evidence their decision-making, including record keeping and the publication of transparency notices. STW ICB must consider five key criteria when applying direct award process C, the most suitable provider process or the competitive process. These are:

- quality and innovation
- value
- integration, collaboration and service sustainability
- improving access, reducing health inequalities and facilitating choice
- social value

13.0 Formal Decision-Making

13.1 The ICB will make commissioning decisions in line with the extant Scheme of Reservation and Delegation. The above process is designed to give a structure to inform the decision. Each element of the above process will determine the next step ultimately leading to the formal decision at the appropriate decision-making forum.

13.2 The process for relative prioritisation will score a proposal to indicate whether it is of high or low priority, this evidence will be crucial in running the proposal through the decision flow diagram. The decision flow diagram will inform whether the proposal should be commissioned or not, including de-commissioning or commissioning in future years.

13.3 The basis of the commissioning footprint will guide whether there is an opportunity to commission the service on a place or provider collaborative at scale and the final process of determining the most appropriate procurement process. All these elements will come

together to form the recommendation to the decision- making forum. Each element will be transparent and evidenced appropriately to allow the decision to be made in the most robust manner.

Appendix One: ICB Commissioning Principles

Core Principles

Principle 1: The values and principles driving priority setting at all levels of decision-making must be consistent.

Principle 2: NHSTWICB has a duty to provide a comprehensive healthcare service. Within that duty the NHS must meet all reasonable requirements for healthcare, subject to the duty to live within its allocated resources.

Principle 3: NHSTWICB has a responsibility to make rational decisions in determining the way it allocates resources to the services it directly commissions. It must act fairly in balancing competing claims on resources between different patient groups and individuals**.**

Principle 4: Competing needs of patients and services within the areas of responsibility of NHSTWICB should have an equal chance of being considered, subject to the capacity of NHSTWICB to conduct the necessary healthcare needs and services assessments. As far as is practicable, all potential calls on new and existing funds should be considered as part of a priority setting process. Services, clinicians, and individual patients should not be allowed to bypass normal priority setting processes.

Principle 5: Access to services should be governed, as far as practicable, by the principle of equal access for equal clinical need. Individual patients or groups should not be unjustifiably advantaged or disadvantaged on the basis of age, gender, sexuality, race, religion, lifestyle, occupation, social position, financial status, family status (including responsibility for dependants), intellectual / cognitive function or physical functions.

There are proven links between social inequalities and inequalities in health, health needs and access to healthcare. In making commissioning decisions, priority may be given to health services targeting the needs of sub-groups of the population who currently have poorer than average health outcomes (including morbidity and mortality) or poorer access to services.

Principle 6: NHSTWICB should only invest in treatments and services which are of proven cost-effectiveness unless it does so in the context of well-designed and properly conducted clinical trials that will enable the NHS to assess the effectiveness and/or value for money of a treatment or other healthcare intervention.

Principle 7: New treatments should be assessed for funding on a similar basis to decisions to continue to fund existing treatments, namely according to the principles of clinical effectiveness, safety, cost-effectiveness and then prioritised in a way which supports consistent and affordable decision-making.

Principle 8: NHSTWICB must ensure that the decisions it takes demonstrate value for money and an appropriate use of NHS funding based on the needs of the population it serves.

Principle 9: All NHS commissioned care for which NHSTWICB is responsible should be provided because of a decision by NHSTWICB. No other body or individual, other than those authorised to take decisions under the policies of NHSTWICB, has a mandate to commit NHSTWICB to fund any healthcare intervention unless directed to do so by the Secretary of State for Health.

Principle 10: NHSTWICB should strive, as far as is practical, to provide equal treatment to individuals in the same clinical circumstance where the healthcare intervention is clearly defined. NHSTWICB should not, therefore, agree to fund treatment for one patient which cannot be afforded for, and openly offered to, all patients with similar clinical circumstances and needs.

Principle 11: Interventions of proven effectiveness and cost-effectiveness should be prioritised above funding research and evaluation unless there are sound reasons for not doing so.

Principle 12: Because the capacity of the NHS to fund research is limited, requests for funding to support research on matters relevant to the health service must be subject to normal prioritisation processes.

Principle 13: If a treatment is provided within the NHS which has not been commissioned in advance by NHSTWICB save for those treatments approved by another responsible commissioner, the responsibility for ensuring on-going access to that treatment lies with the organisation that initiated treatment.

Principle 14: Patients participating in clinical trials are entitled to be informed about the outcome of the trial and to share any benefits resulting from having been in the trial. They should be fully informed of the arrangements for continuation of treatment after the trial has ended. The responsibility for this lies with the party initiating and funding the trial and not NHSTW ICB unless NHSTWICB has either funded the trial itself or agreed in advance to fund aftercare for patients entering the trial.

Principle 15: Unless the requested treatment is approved under existing policies of NHSTW ICB, in general it will not, except in exceptional circumstances, commission a continuation of privately funded treatment even if that treatment has been shown to have clinical benefit for the individual patient.

Appendix Two: Impact Assessment (IA)

Service Title		**ICB Lead**	
Executive Lead		**Clinical Lead**	

Service Details

Provider	
Service Description	
Contract Type / Duration	
Notice period required	
Cost per annum	
Cost per patient/service user	
Service metrics	
Reason for Consideration	
Other affected commissioners	

Assessment

Supporting information

Has the QIA been completed and submitted?	
Has the EQIA been completed and submitted?	

Please note: No submission will be considered at stage two without the QIA and EQIA having been fully completed and submitted alongside the IIA.

Recommendation

Decommission service	☐	Disinvest in service	☐	Continue service	☐		
Invest in Service		Redesign Service					

Governance

Template completed by	
Date template completed	

For audit purposes please record the SCC decision below following the meeting: