Derby and Derbyshire Integrated Care Board

DDICB System Prioritisation Panel

Terms of Reference

Authority

These Terms of Reference, set out the membership, the remit, responsibilities and reporting arrangements of the System Prioritisation Panel (SPP). The SPP provides recommendations based on best available in-system considerations, and with due regard to the aims of the Derby and Derbyshire Integrated Care System.

1. **PURPOSE**

1.1 The Derby and Derbyshire ICB System Prioritisation Panel (SPP) (“the Committee”) is convened at the request of the ICB Executive and/or a Provider Executive.

1.2 SPP is a strategic, local decision-making committee responsible for guiding prioritisation of services within the Derby and Derbyshire ICS ("the System"). It operates through the annual commissioning cycle and at points of service reviews or when concerns arise. The SPP makes recommendations on the relative value of services, which is determined through a prioritisation process.

1.3 SPP will make recommendations relating to prioritisation of services, for the ICB and/or for Providers within the System on request. The recommendations of the SPP will be provided to the ICB Executive and to any relevant Provider Executive, only.

1.4 The decision to act on the recommendations of the SPP, rests with the ICB Executive and/or Provider Executive. The relevant Executive groupings remain accountable for any decision.

1.5 As a standing expectation, SPP will always endeavour to follow any legal statutory duties which include but not exclusive to EQIA/ PPI assessments. For clarity, statutory responsibility for the discharge of these duties always remains with the ICB Executive and/or Provider Executives within the System.

2. DUTIES AND RESPONSIBILITIES OF SPP

2.1 SPP will contribute to the delivery of the four aims of ICSs:

- Improve outcomes in population health and healthcare
- Tackle inequalities in outcomes, experience and access
- Enhance productivity and value for money
- Support broader social and economic development

1.	SPP will assess services using a Prioritisation Framework Tool as a guide. See Appendix 2 for exemplar process flowchart. NHSE planning guidance 2025/26 recommends boards to consider the following principles in addition to matters required by applicable legal duties when making local prioritisation decisions: • safeguard the quality and safety of services, paying particular attention to challenged and fragile services • protect access to essential services, prioritising urgent and emergency care, and those patients with the greatest clinical need • wherever possible take actions that are consistent with narrowing existing health inequalities including inequalities in access • take account of the medium-term quality, financial and population health impacts alongside in-year impacts
2.	Decisions to ask the SPP to convene may only be made as an escalation step, by the ICB Executive or by the Executive of a Provider Trust. (The ICB in-ICB prioritisation pathway should be followed initially; it is expected that Providers will follow their own internal prioritisation pathways.) The Executive should justify their decision to escalate to the SPP, in writing, as part of the request to convene the SPP.
3.	In making recommendations, SPP will ensure that discussions, decision-making, and the rationale for decisions are considered in line with the DDICB Ethical Framework which provides a coherent framework to promote fairness and consistency in decision-making.
4.	Although included in the considerations within the Prioritisation Framework, use of the SPP does not absolve Providers or the ICB of their requirements to identify and address Health Inequalities for individuals across Derbyshire.
5.	On convening, the SPP members will identify a Panel Lead for the SPP process. The Lead will be responsible for communicating information to relevant Executive Boards following conclusion of the SPP process. The Lead may, or may not, be the same as the Chair.
6.	The SPP may call upon wider ICB or Stakeholder involvement on Panel subject to the item(s) in discussion. The ICB Directors Group and/or individual Directorates, will provide operational support and additional information on request.
7.	In future, the SPP may be asked to provide a regular strategic prioritisation review by the ICB Executive or by a Provider Executive. This will require significant additional operational/staffing resource for coordination- and this ToR is not intended to cover that possibility.

3. CHAIRMANSHIP

3.1 The SPP is to be Chaired by Chief Strategy and Delivery Officer/Deputy CEO or a named deputy

3.2 The Chair will be accountable to the Integrated Care Board and will have a named delegated deputy.

4. MEMBERSHIP OF SPP

4.1 In general terms, Core SPP members are expected to hold and act with sufficient authority such that their input and combined recommendations will be held in high regard by the ICB Executive and/or Provider Executives.

4.2 Membership of the SPP committee will comprise of:

Core Membership

ICB Chief Strategy and Delivery Officer

ICB Senior Finance Officer

Chair of the JUCD Clinical and Professional Leadership Group (CPLG)

Representative Place GPs / ICP Provider

ICB Chief Medical Officer *and/or* ICB Chief Nursing Officer

System Equality Lead

Membership with Specialist Knowledge

Public Health Representative from either Derby City or Derbyshire County Council

DDICB Communication Lead

Director of Business Intelligence

Additional members will be co-opted for example from clinical networks, specialist services/organisations, as required according to agenda items under discussion but will not form part of the decision-making process.

5. SPP MEMBERS' RESPONSIBILITIES

Members of SPP are expected to:

1.	Commit to attend meetings regularly.
2.	If unable to attend, nominate a deputy with appropriate authority and experience wherever possible.
3.	Contribute items for the agenda as appropriate, with supporting material, stated purpose and action required, no later than 7 days before the date of the next meeting.

4.	Come to meetings prepared, with all documents and contribute to the debate.
5.	Read and understood the Prioritisation Policy and the values that underpin the Prioritisation Framework.
6.	Declare any conflicts of interest which might have a bearing on their actions, views and involvement in discussions within the committee.
7.	Highlight the impact of any decision on all groups covered by the Equality Act 2010. Where there is a negative impact, actions to mitigate that impact should also be recommended.
8.	Highlight the legal implications of Service line changes or associated risks, as and when these are identified.
9.	Ensure effective communication with appropriate stakeholders.

6. DECLARATIONS OF INTEREST, CONFLICTS AND POTENTIAL CONFLICTS

6.1 The provisions of Managing Conflicts of Interest in the NHS[1] or any successor document will apply at all times.

6.2 Where a member of the committee is aware of an interest, conflict or potential conflict of interest in relation to the scheduled or likely business of the meeting, they will bring this to the attention of the Chair of the meeting as soon as possible, and before the meeting where possible. The Chair will begin each meeting by asking for declaration of relevant interests. If any member has been disqualified from participating in an item on the agenda, by reason of a declaration of conflict of interest, then that individual shall no longer count towards the quorum.

6.3 The Chair of the meeting will determine how this should be managed and inform the member of their decision. The Chair may require the individual to withdraw from the meeting or part of it. Where the Chair is aware that they themselves have such an interest, conflict or potential conflict of interests they will bring it to the attention of the Committee, and the Vice Chair will act as Chair for the relevant part of the meeting.

If a member has an actual or potential interest the chair should consider the following approaches and ensure that the reason for the chosen action is documented in minutes or records:

- Requiring the member to not attend the meeting.
- Ensuring that the member does not receive meeting papers relating to the nature of their interest.
- Requiring the member to not attend all or part of the discussion and decision on the related matter.
- Noting the nature and extent of the interest, but judging it appropriate to allow the member to remain and participate
- Removing the member from the group or process altogether

[1] https://www.england.nhs.uk/long-read/managing-conflicts-of-interest-in-the-nhs/

6.4 Any declarations of interests, conflicts and potential conflicts, and arrangements to manage those agreed in any meeting of the Committee, will be recorded.

6.5 Failure to disclose an interest, whether intentional or otherwise, will be treated in line with the Managing Conflicts of Interest: Revised Statutory Guidance and may result in suspension from the Committee.

6.6 All members of the Committee shall comply with, and are bound by, the requirements in the ICB Constitution, Standards for Business Conduct Policy, the Standards of Business Conduct for NHS staff (where applicable) and NHS Code of Conduct.

6.7 There will be an annual conflicts of interest declaration, at the start of the financial year in April, which will be recorded in a register. It will be the responsibility of the member to declare any change to his/her status at the start of the next ICPP meeting.

7. QUORACY

7.1 SPP will be quorate when the following four core members/deputies are in attendance:- Director of Finance, Chief Strategy and Delivery Officer , ICB Chief Medical Officer *or* ICB Chief Nursing Officer, Chair of the JUCD CPLG.

7.2 Each member will have a nominated deputy.

7.3 Deputies are expected to attend if the appropriate member is unable to do so.

7.4 A duly convened meeting of the SPP at which quorum is present is competent to exercise all or any of the authorities, powers and discretions vested in or exercisable by the SPP.

8. DECISION MAKING AND VOTING

8.1 The SPP will use its best endeavours to make decisions by consensus. Exceptionally, where this is not possible the Chair (or Vice Chair) may call a vote.

8.2 Any member where there is a conflict of interest will be excluded from voting for the proposal where there is a conflict.

8.3 Each voting member is allowed one vote, and a majority will be conclusive on any matter. Where there is a split vote, with no clear majority, the Chair of the SPP will hold the casting vote.

8.4 SPP will help to identify concerns and risks, diagnose and develop actions/improvement plans to mitigate and respond to risks.

9. ACCOUNTABILITY

9.1 The ICB Board and/or the Trust Provider Board remain wholly accountable for any decision made on the recommendation *or* against the recommendation of the SPP.

9.2 The SPP provides recommendations based on best available in-system considerations, and with due regard to the aims of the Derby and Derbyshire Integrated Care System. An SPP recommendation must not be taken as directly equivalent to a decision made by a Trust or ICB-appointed Executive Board.

9.4 Recommendations of the SPP, including completed prioritisation tools and any associated commentary, should be formally recorded and submitted for regular review by a relevant system-level quality oversight committee.

10. REPORTING ARRANGEMENTS

The SPP Lead is responsible for communicating the SPP's recommendation to the relevant Executive Board/s following each meeting, confirming all decisions made.

11. FREQUENCY AND NOTICE OF MEETINGS

11.1 The SPP is expected to meet on request initially and will be convened virtually (MS Teams).

11.2 The agenda will be sent out to members no later than five days before the meeting.

12. REVIEW OF TERMS OF REFERENCE

These terms of reference and the effectiveness of the SPP will be reviewed at least annually or sooner if required.

Reviewed by

Approved by

Review Date:

[Date]

Appendix 1- DDICB PRIORITISATION PANEL MEMBERS (+DECLARATION OF INTEREST) DATE XXX- XXX

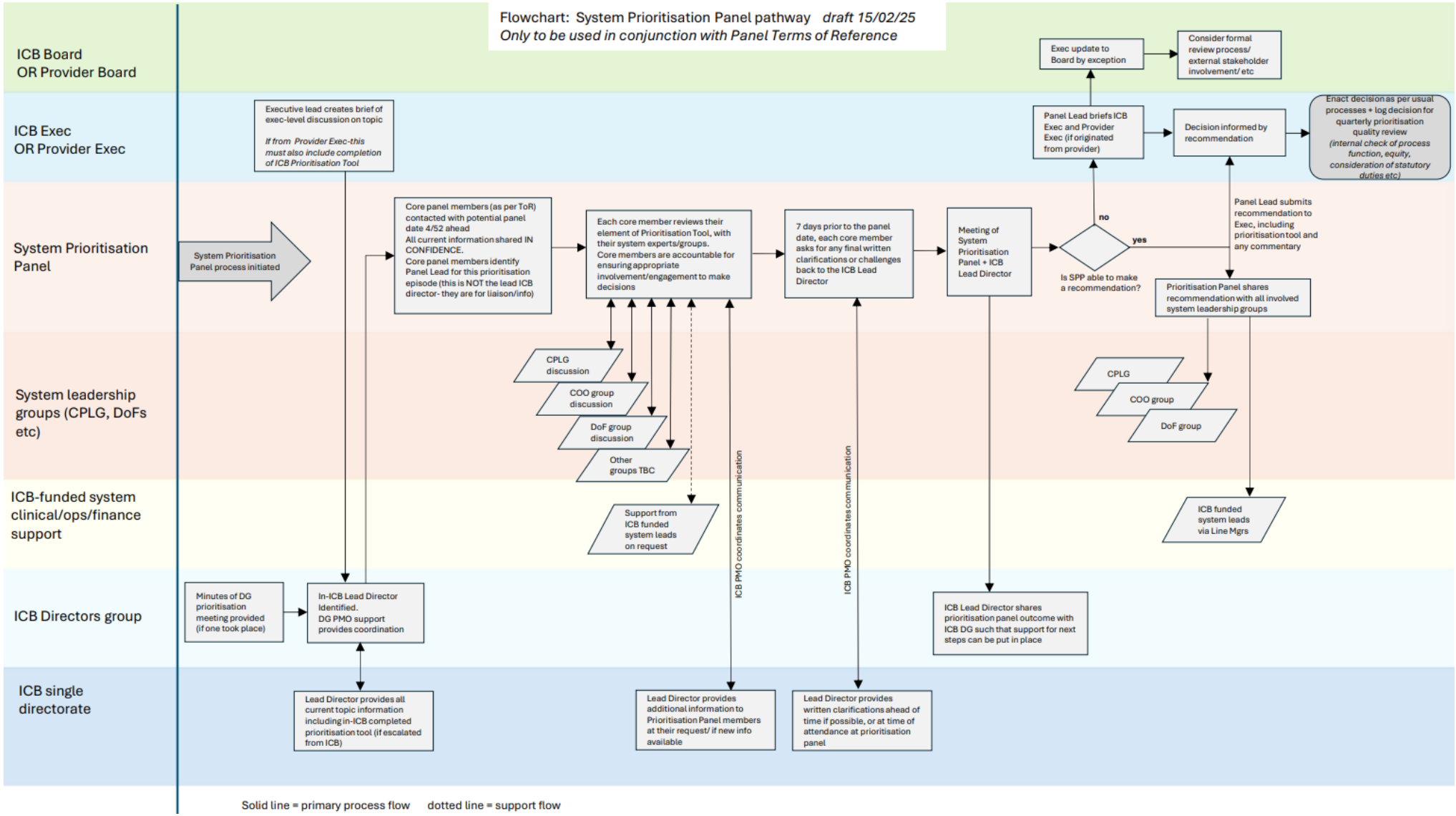
Core Members

TITLE	NAME	DEPUTY
ICB Chief Strategy and Delivery Officer		
ICB Senior Finance Officer		
ICB Chief Medical Officer *and/or* Chief Nursing Officer		
Chair of the JUCD Clinical and Professional Leadership Group	Dr Avi Bhattia	
Clinical Representative Place GPs		
Clinical Representative ICP Provider		
ICB Equality Lead		
ICB Director of Business Intelligence		

Membership with Specialist Knowledge and Additional Members

TITLE	NAME	DEPUTY
Public Health Representative from either Derby City or Derbyshire County Council		
DDICB Communication Lead		

Appendix 2: SPP exemplar flowchart



Derby and Derbyshire Integrated Care Board

NHS Derby and Derbyshire Integrated Care Board

Prioritisation Policy

Framework for Prioritisation

KEY POLICY MESSAGES	
1.	This policy has been developed to establish an evidence-based, fair, transparent, and consistent approach to support the ICB's commissioning processes related to investment, redesigning, or disinvestment decisions.
2.	The principles and values outlined in this policy, along with the associated tests, reflect and align with both the ICS strategy and Joint Forward Plan. These elements will guide and support prioritisation and decision-making processes.
3.	The framework will not adopt a one-size-fits-all approach. Instead, it will establish broad parameters and tests, recognising that not all the tests will be relevant to every service. The framework will not dictate budget allocations among programs, services, or providers. Rather, it will enable the ICB to break down complex decisions into smaller, more manageable components.
4.	This policy does not replace the ICB's statutory duties and legal obligations on commissioning. This includes for example, QEIA assessment and Patient and Public Involvement in service change.

VERSION CONTROL

Title:	NHS Derby and Derbyshire Integrated Care Board Clinically led Prioritisation Policy – Framework for Prioritisation
Supersedes:	N/A
Description of Amendment(s):	N/A
Financial Implications:	N/A
Policy Area:	Medical Directorate
Version No:	1.0
Author:	Strategy and Delivery Team Evidence Based Medicine and Clinical Policy Team To include and list relevant stakeholders
Approved by:	TBC
Effective Date:	TBC
Review Date:	TBC
List of Referenced Policies:	NHS Derby and Derbyshire Integrated Care Board Ethical Framework for Decision-Making
Key Words section (metadata for search facility online):	Prioritisation Framework Ethical. Ethics Decision Making
Reference Number:	TBC
Target Audience:	ICB approved policies apply to all employees, contractors, volunteers, and others working with the ICB in any capacity. Compliance with ICB policy is a formal contractual requirement and failure to comply with the policy, including any arrangements which are put in place under it, will be investigated and may lead to disciplinary action being taken.

CONTENTS

Acronyms

ICB	Integrated Care Board
ICS	Integrated Care System
JFP	Joint Forward Plan
QEIA	Quality and Equality Impact Assessments
PPI	Public and patient involvement

1. INTRODUCTION

1.1 The core purpose of the ICB's is to ensure the Derbyshire population have access to high-quality, affordable and effective healthcare which delivers on the aims and objectives set out within its various delivery plans and strategies – includes but not limited to the NHS Plan (JFP), Integrated care Strategy (ICS), and the Annual Operational Plan. The central objective of these strategies is to continuously improve the health outcomes for all of Derby and Derbyshire's citizens.

1.2 Delivering the challenging health improvements and outcomes set out in the various strategies with finite resources in an increasingly complex, tight financial and delivery environment not only requires the ICB to ensure we are investing in the most impactful interventions which will also help to reduce health and inequalities, but also do so in the most cost effective and efficient manner. In addition, the ICB needs to demonstrate that it is doing this fairly and transparently.

1.3 To effectively commission, we need a consistent set of tools and frameworks. This will aid with establishing the potential relative contribution of prospective interventions which are most likely to achieve the aims and objectives set out in the various ICB plans and strategies.

1.4 The ICB prioritisation framework will set out a series of consistent tests (criteria) to support decision-making for commissioning when appropriate. These can be applied, for example, in a form of ranking or assessment according to pre-set standards (values)[1] or impact, and in doing so minimize biases and avoid analysis paralysis. It is part a tool designed to help the ICB make evidence based, fair and transparent investment/ re-designing or disinvestment decisions.

1.5 The key tests build upon the existing principles within the agreed ICB Ethical Framework for Decision Making Policy . They are informed by various ICB plans and strategies, and will evaluate the extent to which proposed interventions and investments contribute to achieving the core long-term ICB objectives by assessing how they:

1.5.1 Contribute to preventing, postponing, and lessening disease complications.

1.5.2 Reduce inequalities in both health provision and health outcomes for the Derby and Derbyshire population.

1.5.3 Strengthen personalisation and choice, giving localities and communities more say in determining what is required and how it is best delivered, thereby improving reach.

1.5.4 Improve integration of care, streamline services, remove duplication and non-value- adding activities, while delivering cost savings or efficiencies.

1.5.5 Are rooted in robust evidence, focused on clearly identified objectives (aligned with the medium and long-term strategies), and utilise available intelligence with clearly defined, evidenced, and measurable improvement goals for the Derbyshire population.

[1] The principles, values and tests reflect and are aligned with ICB's strategies

2. PURPOSE AND AIMS

2.1 The purpose of this policy is to establish a fair, transparent, and consistent approach to support and underpin commissioning decisions through a series of jointly agreed values which are aligned and reflect both the ICS strategy and Joint Forward Plan.

2.2 The aims are to: -

2.2.1 ensure that the ICB can effectively respond to the healthcare needs of the population, optimise the use of available resources, and support the strategic goals of the Derby and Derbyshire ICS.

2.2.2 enhance decision making - provide a coherent structure for the consideration of health care treatments and services to ensure that all important aspects are discussed.

2.2.3 promote fairness and consistency in decision-making, reducing the potential for inequity.

2.2.4 maximise health outcomes by focusing on interventions that deliver significant health benefits and improve overall population health.

1.1.1 support and integrate with strategic goals and the development of the ICB commissioning plan.

3. SCOPE

3.1 This prioritisation policy is designed to guide commissioning decision-making across a wide range of scenarios where resource allocation and prioritisation are critical. The agreed principles/ values and tests policy underpin a prioritisation process.

3.2 This is a high level ICB owned policy which can be adopted across provider organisations within the Derby and Derbyshire ICS.

3.3 The ambition is to embed and integrate this framework for prioritisation into routine commissioning decisions.

3.4 There is no definitive list of triggers within the operations of the ICB which could initiate this process but is included into the ICB Commissioning Cyle.

1.2 The framework is not designed to produce a single definitive answer but rather to establish an agreed approach or methodology based on common values, tailored to fit the specific area of application. The process is designed to provide a structure framework to inform decision-making, rather than to determine the decision itself.

4. KEY TESTS

4.1 The following key tests should be adopted by appropriate ICB decision-making Committees, which in turn is adopted by decision making sub-groups.

Overarching application:

- ✓ **Cross programme /organisational impacts and interdependencies**
- ✓ **Feasibility/Attainability**
  - Do-ability
  - Return on Investment (ROI)
  - Affordability

Key Tests:

(a) Strategic Fit

(b) Prevention and reduction & delay disease impact

(c) Anticipated Health Benefits

(d) Impact on Health Inequalities

(e) Clinical effectiveness (evidence base)

(f) Cost effectiveness

(g) Environmental Sustainability

4.2 A supporting document is available which details comprehensive explanations of each key test as well as providing examples of Key Lines of Enquiries (KLoE).

5. APPLICATION

5.1 The ambition of the ICB is that the policy will be implemented using a distributed approach, ensuring that the principles outlined within the policy are understood and adopted across the ICB and with Providers.

A dispersed leadership model provides the most effective approach, leveraging the depth of knowledge within the relevant services to carry out the key tests.

5.2 Each area will be responsible for reviewing and making recommendations on prioritisation decisions, particularly where there are direct links to their field of expertise.

At the outset the ICB is engaging with system partners to allow role to allow the system to mature.

5.3 Prioritisation tools can be bespoke and tailored to the service or intervention. Depending on its application, the prioritisation process or tool used may be adjusted accordingly, taking into consideration proportionality and urgency.

This will include the key tests/values and can include agreed weightings where appropriate. These tools may be co-produced by ICB service managers/commissioners in collaboration with relevant stakeholders.

5.4 The prioritisation tool may utilise the listed key tests/values either individually or in groups, recognising differences in terminology. This can be facilitated by using the Key

Lines of Enquiries (KLOE) tool. It is acknowledged that the key tests/ values are interconnected.

5.5 The ICB recognises that not all the key tests/values may be relevant to all services and should be agreed upon with ICB service managers.

6. Governance - TBC

6.1 The governance arrangement for this policy currently has oversight with ICB executives with delegated authority provided to relevant directors within the ICB

6.2 The ICB is currently utilising a qualitative tool to support decision-making and prioritisation. ICB Service managers are responsible for completing the content.

7. EQUALITY STATEMENT

7.1 The ICB aims to design and implement policy documents that meet the diverse needs of our services, population, and workforce, ensuring that none are placed at a disadvantage over others. It considers current UK legislative requirements, including the Equality Act 2010 and the Human Rights Act 1998, and promotes equal opportunities for all. This document has been designed to ensure that no one receives less favourable treatment due to their protected characteristics of their age, disability, sex (gender), gender reassignment, sexual orientation, marriage and civil partnership, race, religion or belief, pregnancy and maternity. Appropriate consideration has also been given to gender identity, socio-economic status, immigration status and the principles of the Human Rights Act.

7.2 In carrying out its function, the ICB must have due regard to the Public Sector Equality Duty (PSED). This applies to all activities for which the ICB is responsible, including policy development, review, and implementation.

1.3 The NHS Act 2006 (as amended, by the Health and Care Act 2022) places a range of health inequalities duties on the NHS. Changes arising from the Health and Care Act 2022 provided extended legal duties on reducing and tackling health inequalities. NHS commissioners (NHS England and ICBs) are under specific legal duties to take account of health inequalities issues in the exercise of their functions.

8. DUE REGARD

8.1 This policy has been reviewed in relation to having due regard to the PSED of the Equality Act 2010 to eliminate discrimination; harassment; victimisation; to advance equality of opportunity; and foster good relations between the protected groups.

9. SUPPORTING DOCUMENTS

Derby and Derbyshire ICB Framework for Prioritisation

(a) Key tests explained

(b) Qualitative prioritisation tool

10. REFERENCES

NHSE Ethical Framework, Published 2013
https://www.england.nhs.uk/wp-content/uploads/2013/04/cp-01.pdf

NHS Derby & Derbyshire ICB Ethical Framework for Decision Making Policy, Published 2022
https://joinedupcarederbyshire.co.uk/derbyshire-integrated-care-board/

Derby and Derbyshire Integrated Care Strategy 2023

Derby and Derbyshire NHS' Five Year Plan 2023-2028

Appendix 2

Derby and Derbyshire ICB Prioritisation Framework - Key Tests explained

The aim of commissioning is to achieve the greatest possible improvement in health outcome for our population, within the resources that we have available.

To effectively commission, a prioritisation framework has been developed, which is informed by the various ICB plans and strategies. They will aid with determining to what extent proposed interventions/investments will contribute to the achievement of the long term ICB objectives.

The framework will not be a 'one size fits all' approach, but an agreed approach/methodology based on common tests, values, and principles, adapted to fit with the specific area (investment decisions, services, and interventions) within which it is being applied. It is intended to inform commissioning decisions, not to determine decisions in isolation. The key tests should not be considered in isolation but recognising the values are interconnected.

There is no definitive list of triggers which would initiate this process, however, the following are some common triggers-

- Service planning and development
    - Strategic Programme
    - New guidance issued
    - Introduction of new Service
    - Modification/ expansion of existing services
    - New model of care/ Pathway re-design
    - Feedback from people and communities

- Resource allocation and budgeting
    - Annual budget planning
    - Ad hoc resource allocation & utilisation

As part of any contract or service commissioning process, it is expected that the ICB or any other contract-holder already has processes in place to ensure management/delivery against contract or commission (KPI etc). The ICB prioritisation framework does not replace this requirement.

<u>Key tests</u>

The agreed key tests and values within this framework should underpin a prioritisation process. These are set out below including their definitions.

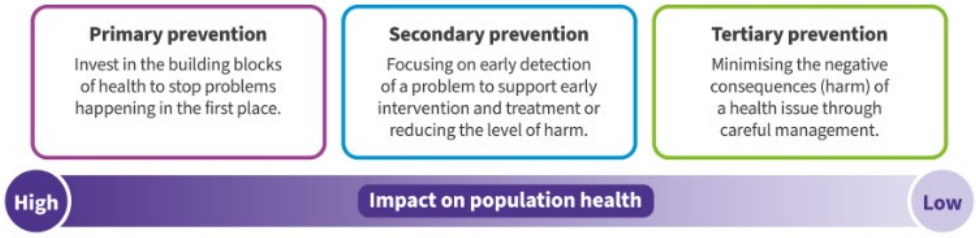
Each test is explored in detail to ensure common understanding, accompanied by examples of Key Lines of Enquiries (KLoE).

Examples are also given on how the key tests may be applied practically in a prioritisation tool.

Cross programme/organisational impacts and interdependencies
Programmes and projects may affect other services. **Commissioners should assess the impact on intended consequences and also explore unintended consequences on neighbouring services and mitigate its impact.**
What impact will the intervention have on other services? To mitigate against unintended consequences, have all the appropriate stakeholders been identified and consulted with during the process? Are there any other projects/programmes critically dependent on this service/ intervention? Are there any other projects/programmes in the ICB/ICS pipeline/plan which is critically dependent on this service/ intervention? Other examples of considerations:- Where does this intervention fit in the clinical pathway? What is the impact of this intervention on demand for other healthcare services?

Strategic Fit
Alignment with and contribution to meeting the broader strategic objectives of the ICB/ICS, including long-term goals and policy priorities.
How does the service/ intervention support or contribute to meeting the strategic goals of the ICB and ICS? *Commissioning Strategy and Operating Plans* *How does the service contribute to the meeting the aims and objectives the ICB strategic plan, Health and Wellbeing Board priorities e.g. JUCD 5 year plan (Start well, Stay well, and Age well)* *Reminder that the high priority clinical areas of focus within Derby & Derbyshire are identified and agreed as:* • *Cardiovascular disease (including diabetes);* • *Respiratory disease;* • *Cancer; and* • *The early years of life (pre-school).* How does the service/intervention align with National Health policies and priorities? *Examples:* • *Secretary of State Directions to the NHS and performance and planning guidance* • *National Improvement Frameworks* • *National High Impact Interventions* • *NICE technology appraisal guidance* • *How the service fits within the delivery of current national targets for the system e.g. Core20PLUS5* Other examples of considerations:- For strategic fit across different stakeholders, consider how the proposal would strengthen or risk existing or new strategic partnerships, and how the proposal affects integration of services in line with ICB plans. Does the service/intervention address identify priorities and gaps in service delivery?

How the service/ intervention currently meets the set targets or mandates of the ICB?
Example of application in a prioritisation tool:- Factors which would merit a **'High'** rank include a service which will help to achieve some of the targets of the ICB's operational plan or strategy, as well as Derby & Derbyshire Health and Wellbeing Board objectives, or national targets e.g. Core20PLUS5. **'Very low'** should be reserved for services which are not specifically in line with the aims of the ICB or other local/national healthcare objectives.

Prevention and reduction & delay disease impact
Enhancing the overall health and well-being of the population through preventing, postponing or reducing health conditions. The key focus should be on healthy life expectancy and differences in life expectancy and healthy life expectancy between communities.
The ICB recognise that there are subtle language difference across different bodies of NHS and non- NHS bodies. The overall objective is to prevent, reduce and delay the disease impact to improve quality of life and life expectancy. Public health recognises three types of prevention as central to addressing poor outcomes.      • Primary prevention is action that tries to stop problems happening. This can be either through actions at a population level that reduce risks or those that address the cause of the problem. • Secondary prevention is action which focuses on early detection of a problem to support early intervention and treatment; reduce the level of harm. • Tertiary prevention is action that attempts to minimise the harm of a problem through careful management. Having a focus on intervening as early as possible to prevent disease progression and the need for more expensive treatment. Does the intervention prevent/delay the onset of a clinical condition? What are the projected outcomes in terms of disease prevention, health promotion, and management of chronic conditions? Does the intervention increase the life expectancy/ quality of life? Does this intervention support primary, secondary or tertiary prevention of future health conditions? Does this intervention improve the longer-term health and wellbeing of the patient and their community?
Example of application in a prioritisation tool:- Factors which would merit a **'High'** rank includes a focus on intervening as early as possible to prevent disease progression and the need for more expensive treatment.

'Very low' should be reserved for services in clinical areas where there are primary modifiable intervention but are not being addressed.

Anticipated Health Benefits

Overview of the scope/size of the potential benefits in health outcomes for patients and communities.

Aim is to widen and increase the size of the potential health benefits that the population accessing health services may attain relative to the current position. This may be measured in terms of increase in life expectancy and improving the quality of life. e.g. reducing morbidities, severity of morbidities.

What is the added value that the service/ intervention brings to patients and communities?

Does the service/intervention demonstrate a proven health care or well-being benefit (physical and/or mental) to those who use it and to the wider population and communities?

This is usually measured in increased life expectancy, decreased morbidity and the impact on activities of daily living may also be relevant.

Can the impact of the potential health benefits that the population accessing can expect be quantified relative to the current baseline?

How do these benefits translate into measurable health gains? (patient orientated outcomes)

NHS Outcome Framework are grouped around five domains, which set out the high-level national outcomes that the NHS should be aiming to improve

1. Preventing people from dying prematurely.
2. Enhancing quality of life for people with long-term conditions.
3. Helping people to recover from episodes of ill health or following injury.
4. Ensuring that people have a positive experience of care.
5. Treating and caring for people in a safe environment and protecting them from avoidable harm.

It is important to consider the size of the potential benefits that the population accessing 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.

<u>Other examples of consideration:</u>
Does the intervention/service improves outcomes in other clinical conditions beyond that which it was intended to treat?

Any other benefits or disadvantages, recognising that what matters to patients is not limited to measured "clinical" outcomes and impacts.

What is the timeline for achieving these health benefits?

Can the impact of the potential health benefits that the population accessing can expect be quantified relative to the current baseline?

Example of application in a prioritisation tool:-

A service/ intervention that brings a benefit/ reduction in disease burden to a large population will be ranked '**High**' or '**Very High'**.

Any treatments which provide a significant increase in life-expectancy on an individual or population level would normally be ranked '**High**' or '**Very High'**.

Impact on Health Inequalities

People should have access to health care on the basis of need. Consider a demonstrable expected impact on reducing inequalities in the local area.

Services should not widen the gap in terms of access, experience and outcomes between populations who need the services/ interventions.

Equity and Accessibility: Consider the diverse needs of all population groups and ensure that healthcare services and resources are distributed equitably and accessible to all, addressing health disparities.
Access – number of residents who will benefit from the intervention per year.

Vulnerable Communities that include health groups with/without protected characteristics – the needs of the vulnerable communities/ population groups in Derby & Derbyshire including but not limited to:

- *Living within the most deprived quintile postcode areas*
- *From Black, Asian and minority ethnic groups*
- *With severe and enduring mental health concerns*
- *With learning disability*
- *With extreme hearing disability*
- *With the State as the parent or guardian*
- *That are without a home*
- *That are at risk of violence, coercion and modern-day slavery.*

Does the service reduce known health disparities among different population groups?
Does the intervention/service change create disadvantage in terms of worsened access, experience or outcomes for a patient group or community?
Consider a demonstrable expected impact on reducing inequalities in the local area with specific reference to National improvement programmes such as the Core20PLUS5

Does the service ensure equitable access to groups/populations?
What measures are in place to ensure equitable implementation and access?

Does the service require a bespoke approach especially for hard to reach groups?

Does the service require a disproportionate approach for equitable outcomes?
How accessible is the service to underserved and vulnerable populations?

Priority may be given to health services targeting health needs in sub-groups of the population who currently have poorer than average health outcomes (including morbidity and mortality) or poorer access to service

Example of application in a prioritisation tool:-

Any service which has been proven to reduce local health inequalities should score '**Very High'**.
Models of care (which may include combination of interventions/approaches) from other ICBs that have demonstrated a reduction in health inequalities (without current available evidence of benefit in local area) should score '**High'**.

Any service which has a limited/marginal effect on health inequality should score '**Low'**. If there is no anticipated effect or there is a negative effect on health inequality then score '**Very Low'**

Clinical Effectiveness (evidence base)

Assessment of the existing evidence and strength of the evidence that the service/intervention may be effective compared to alternative service model/ other existing or standard treatments.

Services and care should be commissioned and provided based on sound evidence of effectiveness and from recognised sources, e.g. The National Institute for Health and Clinical Effectiveness (NICE).

Clinical and cost effectiveness should wherever possible be considered together.

Is there a robust evidence base, appropriate for the intervention, which shows the benefit of the proposed intervention? and does it translate into significant benefit for the patient? and does it translate into significant benefit for the patient (patient orientated outcomes)?

Methods to assess clinical and cost effectiveness are well established. The key success factors are the need to search effectively and systematically for relevant evidence, and then to extract, analyse, and present this in a consistent way.

Choice of appropriate clinically and patient-defined outcome needs are to be given careful consideration, and where possible the quality-of-life measures should be considered.

In the absence of National Guidance is the service/intervention recommended by accredited bodies e.g. Royal Colleges and what is the strength of their recommendations and are they underpinned by evidence?

How does the proposed service/intervention compare to other alternative service models/ existing or standard treatments or in terms of clinical effectiveness?

What are the overall clinical outcomes associated with the service/ intervention?

Consider use of business intelligence e.g. Model health, GIRFT, specific outcome data

Other examples of consideration:

A service may include a multiple of clinical interventions, these individually should follow best evidence practice, these may already be established e.g. NICE Quality Standards.

Data/ Health intelligence with poor clinical outcomes (outliers) should be used as a proxy for service review.

Is there comprehensive evidence supporting the service's effectiveness across various patient groups?

How does the service contribute to improving patient satisfaction and experience?

Patient satisfaction will not necessarily be taken as evidence of clinical effectiveness. Reliable evidence will often be available from good quality, rigorously appraised studies. Evidence may be available from other sources, and this will also be considered. Patients' evidence of significant clinical benefit is relevant and will be balanced against the strength of the available research.

Example of application in a prioritisation tool:-

- Evidence – There should be clear evidence that the service/intervention has shown to produce significantly higher benefits than alternatives as demonstrated by high level evidence. For example, reliable meta-analysis of Randomised Control Trials (RCTs) suggestive of good benefit would score '**Very High'**. Where only case-series reports or expert opinion without explicit critical appraisal exist score '**Very Low'**.
- Recommendations – Where a service is recommended by a NICE TAG these should be scored '**High'** to '**Very High'**, depending on the level of evidence used to produce them. Consensus evidence may include a significant healthcare body e.g. Royal Colleges, the Scottish Intercollegiate Guidelines Network (SIGN) or NICE Clinical Guidelines have recommended the service/intervention (but it is not a NICE TAG), the rating should reflect the level of evidence available in their production.

Cost Effectiveness

Maximising health benefits relative to the costs incurred including comparison to alternative models of care. Clinical and cost effectiveness should wherever possible be considered together.

Is there evidence or expectation of improved value for money?

Consider analysis of cost effectiveness of interventions to assess which yield the greatest benefits relative to the cost of providing them.

How does this compare, in terms of cost effectiveness, to alternative services/service models for the same patient group or conditions?

How does the service compare with other service models in terms of overall cost-effectiveness?

How well defined are service benefits and clinical outcomes – can these be measured?

Other examples of consideration:
Are there wider system alternatives or supporting service that improve cost-effectiveness e.g. social care, voluntary sector? Are there opportunities for cost savings without compromising quality?

Ways of measuring cost effectiveness may include

- cost-utility such as the Quality Adjusted Life Years measure (QALY). See NICE guidelines manual- assessing cost effectiveness
- Incremental cost-effectiveness over the long-term (invest to save).
- Direct support costs as a proportion of activity spend in comparison to other similar interventions.
- Cost comparison against examples of good/best practice form elsewhere.
- Comparative cost per unit of output/delivery or comparative cost per direct beneficiary (e.g. per patient)

What are the total costs associated with providing the service (setup, operational, and maintenance costs)? What health benefits are gained per unit cost over the long-term?

Example of application in a prioritisation tool:-

Services that have been proven to be highly effective and low cost should score **'High'** to **'Very High'** depending on the level of return expected and timescales. Services where the likelihood of cost-effectiveness has not been demonstrated in the published literature or similar NHS evaluation should score '**Low'** or **'Very Low'**.

Sustainability

Ensuring that the service is environmentally sustainable and viable in the long term.

Ensure the way our organisations operate reflect the needs of our staff, our communities and the environment, now and for future generations. The way we operate today must meet the needs of the present, without compromising the needs of future generations.

What is the environmental impact of the service?
How does the service contribute to the long-term sustainability of the healthcare services?

Are there sustainable practices incorporated in the service's implementation and operation?

How does the service or intervention meet the needs of the present, without compromising the needs of future generations?

Example of application in a prioritisation tool:-
Services that are fully sustainable have minimal ecological footprint and promote conservation would be scored as **'very high'**. Services that use excessive resource consumption, cause pollution or habitat destruction would score **'very low'**

Feasibility / Attainability

Due regard on the practicality of implementing services/interventions within available resources and constrains.

Balance of all the forementioned tests are best placed to Feasibility / Attainability

Do-ability
This will include considerations on the achievability of the service/ intervention e.g. time and resource for delivery, potential barriers/ level of challenge, unintended impact on other services.

What are the resource requirements for implementing and maintaining the service?
Are there any potential barriers to successful implementation?
What is the organisational capacity to deliver the service effectively?
How adaptable is the service to changing circumstances and needs?

Return on Investment (ROI)
The scale and timeliness of return of investment of each initiative can inform priority setting against similar requests.

What is the expected return on investment for the service/intervention?
What is the amount of cost savings anticipated to be achieved?
What is the ease or speed of delivery (service delivery friction)? Taking into consideration the ICB's statutory duties e.g. PPI, PSR.

Affordability
The ICB is duty-bound not to exceed its budget. Investing in one area of health care inevitably diverts resources from other uses or potential investments. This is known as opportunity costs and is defined as benefit foregone, or value of opportunities lost, that would accrue by investing the same resources in the best alternative way.

How much will the service or intervention cost per year/ per head of population that would potentially benefit?
Is this cost affordable within the current budget constraints?

Example of application in a prioritisation tool:-

If a service will result in a lower cost for the programme budget then rank it **'Very High'**.
Where the cost of implementing a service would require significant cuts to other services, or the inability to fund potential services of a similar or greater value, then the service should be ranked '**Very Low'**.

The size of the ROI e.g. £500k (threshold to be determined relative to service) should score "very high"

Service proposal that can be transacted quickly e.g. 1 year (threshold to be determined relative to service) should score "very high". Services which may for example require full decommissioning could take longer than one year and these would score "low". Services which may require formal public consultation, extensive comms engagement etc would score "**low"**

Savings which are realised quickly or provide a ROI within the financial year should score "**very high**"

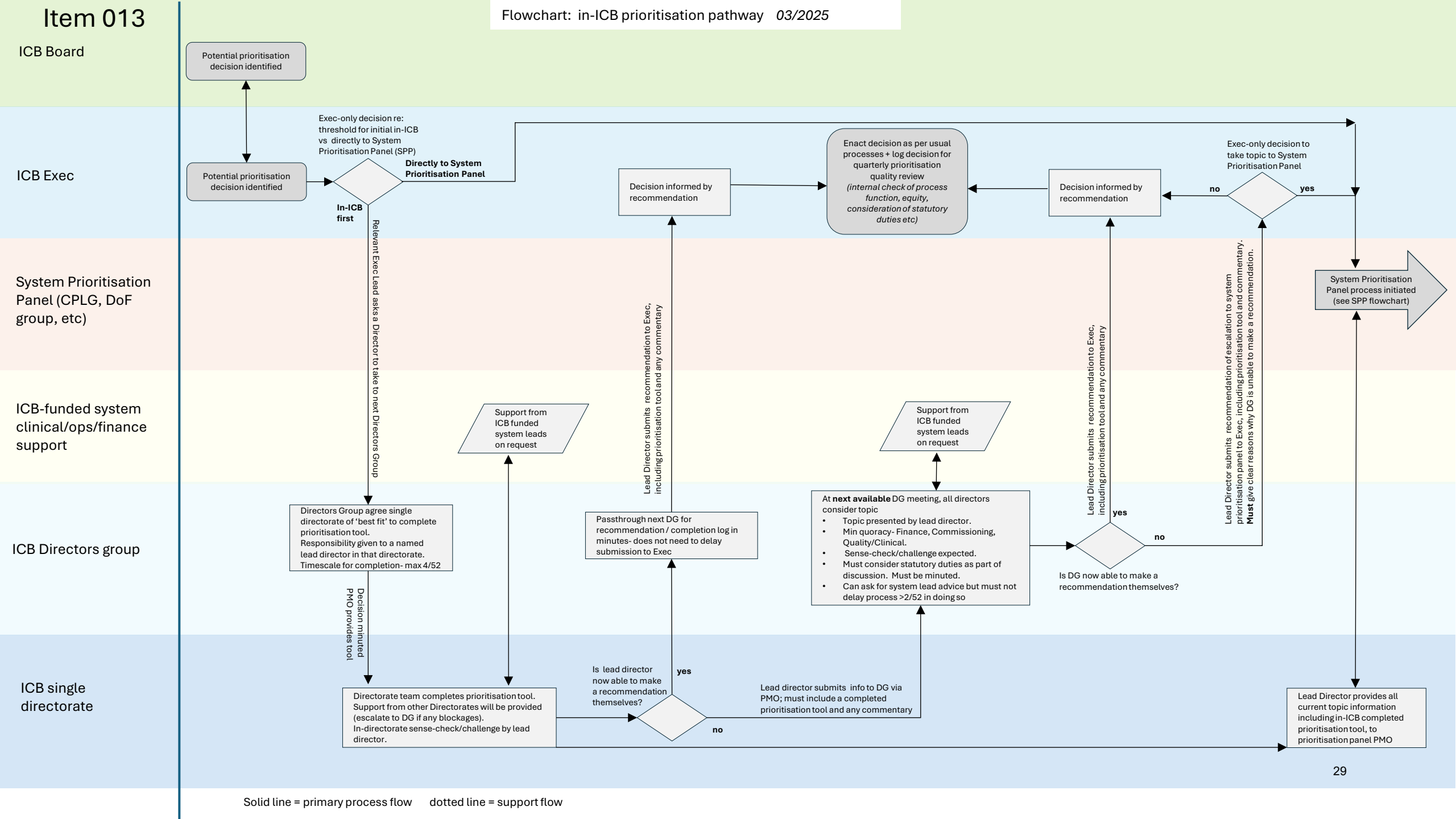
Summary of Key tests and example KLoE

Cross programme/ organisational impacts and interdependencies	Programmes and projects may affect other services. Commissioners should assess the impact on intended consequences and also explore unintended consequences on neighbouring services and mitigate its impact.	• What impact will the intervention have on other services? • To mitigate against unintended consequences, have all the appropriate stakeholders been identified and consulted with during the process? • Are there any other projects/programmes (including those in the ICB/ICS pipeline/plan) which is critically dependent on this service/ intervention?
Strategic Fit	Alignment with, and contribution to meeting the broader strategic objectives of the ICB/ICS, including long-term goals and policy priorities.	• How does the service/intervention align with National Health policies and priorities and support the strategic goals of the ICB and ICS? • How does the proposed intervention contribute to addressing any of the key aims or objectives set out in the ICB's plans and strategies?
Prevention and reduction & delay disease impact	Enhancing the overall health and well-being of the population through preventing, postponing or reducing health conditions. The key focus should be on the two high-level outcomes (healthy life expectancy and differences in life expectancy and healthy life expectancy between communities)	• Does the intervention prevent/delay the onset of a clinical condition? • What are the projected outcomes in terms of disease prevention, health promotion, and management of chronic conditions?
Anticipated Health Benefits	Overview of the scope/size of the potential benefits in health outcomes for patients and communities. Aim is to widen and increase the potential health benefits that the population accessing health services may attain relative to the current position. This may be measured in terms of increase in life expectancy and improving the quality of life. e.g. reducing morbidities, severity of morbidities.	• What is the added value that the service/ intervention brings to patients and communities? • Does the service/intervention demonstrate a proven health care or well-being benefit (physical and/or mental) to those who use it and to the wider population and communities? • Can the impact of the potential health benefits that the population accessing can expect be quantified relative to the current baseline?
Impact on Health Inequalities	People should have access to health care on the basis of need. Consider a demonstrable expected impact on reducing inequalities in the local area. (Consider access/ outcomes/ impact etc.)	• Does the service reduce known health disparities among different population groups? • Does the service ensure equitable access to groups/populations? • Does the service require a bespoke approach especially for hard to reach groups? • Does the service require a disproportionate approach for equitable outcomes?

Clinical effectiveness (evidence base)	Assessment of the existing evidence and strength of the evidence that the service may be effective compared to other existing or standard treatments. Services and care should be commissioned and provided based on sound evidence of effectiveness and from recognised sources e.g. NICE, SIGN, royal colleges.	• Is there a robust evidence base, appropriate for the intervention, which shows the benefit of the proposed intervention? and does it translate into significant benefit for the patient (patient orientated outcomes)? • How does the proposed service/intervention compare to alternative service models/ other existing or standard treatments or in terms of clinical effectiveness?
Cost effectiveness	Maximising health benefits relative to the costs incurred including comparison to alternative models of care.	• Is there evidence or expectation of improved value for money? • How does this compare, in terms of cost effectiveness, to alternative services/service models for the same patient group or conditions?
Sustainability	Ensuring that the service is environmentally sustainable and viable in the long term.	• What is the environmental impact of the service? • How does the service contribute to the long-term sustainability of the healthcare services? • How does the intervention contribute to meeting the health needs of the present, without compromising the health of future generations?
Feasibility/ Attainability	Due regard on the practicality of implementing services/ interventions within available resources and constrains. Balance of all the forementioned tests are best placed to Feasibility / Attainability Considerations on the achievability of the service/ intervention e.g. time and resource for delivery, potential barriers/ level of challenge, unintended impact on other services. • Do-ability. • Return on Investment (ROI) • Affordability (including opportunity costs)	• What are the resource requirements for implementing and maintaining the service? • Are there any potential barriers to successful implementation? • What is the organisational capacity to deliver the service effectively? • What is the expected return on investment for the service/intervention? • How much will the service or intervention cost per year/ per head of population that would potentially benefit? • Is the cost affordable within the current budget constraints?

Item 013

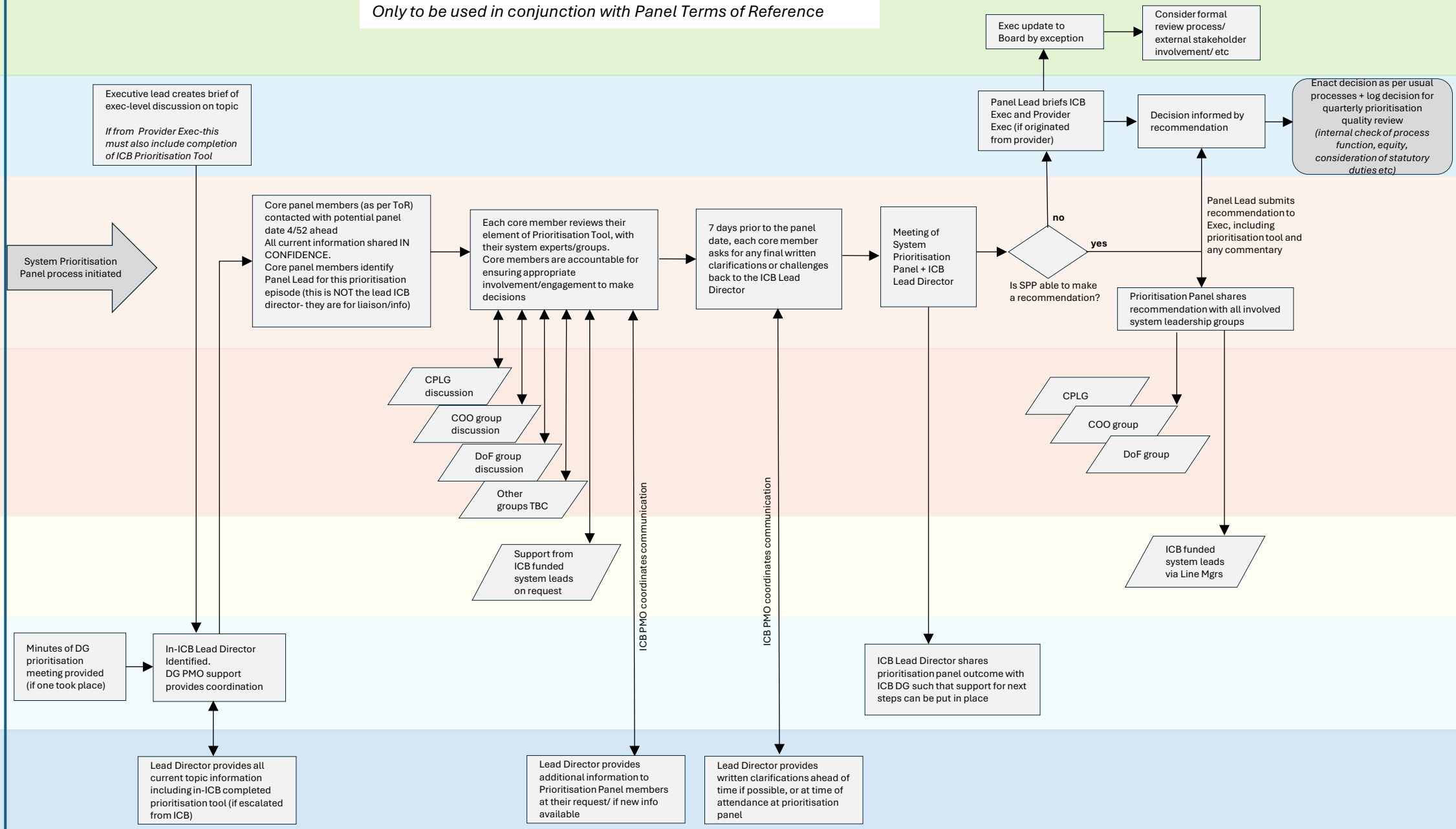
Flowchart: in-ICB prioritisation pathway *03/2025*



Solid line = primary process flow dotted line = support flow

Flowchart: System Prioritisation Panel pathway *03/2025*

Only to be used in conjunction with Panel Terms of Reference



Solid line = primary process flow dotted line = support flow

Derby and Derbyshire Integrated Care Board

Draft DDICB Framework for Prioritisation

To effectively commission, a prioritisation framework has been developed, which is informed by the various ICB plans and strategies. This framework will help assess the extent to which proposed interventions and investments contribute to the achieving ICB objectives.

For definitions of key tests/values, examples of Key Lines of Enquiry (KLoE), and example of triggers, refer to the Derby and Derbyshire ICB Prioritisation Framework - Key Tests explained document.

Project Description (to be completed by the service manager)

Name of the project / Service/ intervention:	
Trigger for prioritisation	
Footprint e.g. ICB/ Place/ PCN	
Organisation(s) involved	
Description of the proposal:	*Background/ current state* *Objectives/ desired state* *In/ Out of scope* *Deliverables/Success measures*

	Constraints/ Dependencies/ Assumptions *Risk and mitigation* *Stakeholder engagement/ Communication plan* *Additional information*
Due consideration for cross programme/organisational impacts and interdependencies **(e.g. does this affect other commissioned services or have unintended consequences)**	*What impact will the intervention have on other services?* *To mitigate against unintended consequences, have all the appropriate stakeholders been identified and consulted with during the process?* *Are there any other projects/programmes critically dependent on this service/ intervention?* *Are there any other projects/programmes in the ICB/ICS pipeline/plan which is critically dependent on this service/ intervention?*
Total Cost of Intervention or relevant cost description (e.g., PYE/ FYE/ one off) ***(further detail see Financial implications section below)***	

<table>
<tr><td rowspan="4">Strategic Fit</td><td colspan="4">Alignment with the broader strategic objectives of the ICB/ICS, including long-term goals and policy priorities.</td></tr>
<tr><td>Very low</td><td>Low</td><td>High</td><td>Very High</td></tr>
<tr><td></td><td></td><td></td><td></td></tr>
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</table>

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How does the service contribute to the long-term sustainability of the healthcare services?
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<table>
<tr><td rowspan="2">Overall Assessment</td><td>Very low</td><td>Low</td><td>High</td><td>Very High</td></tr>
<tr><td></td><td></td><td></td><td></td></tr>
<tr><td colspan="4"><u>Insert summary</u>
<table>
<tr><th>Key test</th><th>Very low</th><th>Low</th><th>High</th><th>Very High</th></tr>
<tr><td>Strategic Fit</td><td></td><td></td><td></td><td></td></tr>
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Do-ability
What are the resource requirements for implementing and maintaining the service? Are there any potential barriers to successful implementation e.g. infrastructure, workforce? What is the organisational capacity to deliver the service effectively?
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Financial implications	***Return on Investment (ROI)*** The scale and timeliness of return of investment of each initiative can inform priority setting against similar requests. *What is the expected return on investment for the service/intervention?* *Insert description/ evidence* ***Affordability*** *How much will the service or intervention cost per year/ per head of population that would potentially benefit?* *Is the cost affordable within the current budget constraints?* *Insert description/ evidence*

Recommendation from the Group

Summary

Reminder for service manager to complete Statutory requirements to relating to service changes e.g. QEIA, PPI

Appendix- Summary of Key tests and example KLoE

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Environmental Sustainability	Ensuring that the service is environmentally sustainable and viable in the long term.	• What is the environmental impact of the service? • How does the service contribute to the long-term sustainability of the healthcare services?

Feasibility/ Attainability	Due regard on the practicality of implementing services/ interventions within available resources and constrains. Balance of all the forementioned tests are best placed to Feasibility / Attainability Considerations on the achievability of the service/ intervention e.g. time and resource for delivery, potential barriers/ level of challenge, unintended impact on other services. • Do-ability. • Return on Investment (ROI) • Affordability (including opportunity costs)	• What are the resource requirements for implementing and maintaining the service? • Are there any potential barriers to successful implementation? • What is the organisational capacity to deliver the service effectively? • What is the expected return on investment for the service/intervention? • How much will the service or intervention cost per year/ per head of population that would potentially benefit? • Is the cost affordable within the current budget constraints?