NHS
Nottingham and Nottinghamshire

Strategic Decision-Making Framework

October 2022 - October 2025

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Final</td><td colspan="2">Author
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Contents

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.

1.2. They exist to achieve four aims:

i. Improve outcomes in population health and healthcare;

ii. Tackle inequalities in outcomes, experience and access;

iii. Enhance productivity and value for money;

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

1.3. Integrated Care Boards (ICB) are regularly required to make decisions on the best use of NHS resources on behalf of their local population.

1.4. The NHS is facing a huge task following the COVID-19 Pandemic against a backdrop of long waiting times and growing demand for services coupled with a challenging financial position. 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.

1.5. 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.

1.6. The decision tree "Flowchart for Decision-Making" sets out the decision-making process. Consideration should be paid to NHSE guidance for major service change to assess requirements for consultation.

2. Process

2.1. Changes to currently commissioned services should be assessed using the prioritisation framework. This will provide a consistent methodology that can be kept on record to support the decisions made by the ICB. 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.

2.2. A standard template for assessment of proposals against the prioritisation framework will be used alongside the Service Change documentation. This is supported by a flowchart outlining the use of the prioritisation framework in the broader process. A final draft priority rating should be decided upon according to the guidance within this flowchart.

2.3. Assessment of equity and quality is a statutory requirement and guidance should be followed accordingly, an Equality and Quality Impact Assessment (EQIA) will be required for all proposed service changes. The EQIA process will be completed as a separate document for all changes to services. This process is used to fully identify and mitigate any impact on quality or equality.

2.4. 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.

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

2.6. 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.

2.7. The Service Change Review Group (SCRG) will be reconstituted as a working group of the Strategic Planning and Integration (SPI) Committee, and all proposed service changes will be required to follow the process set out below. The SCRG will review all proposals ahead of submission to the SPI Committee. The SCRG will be a multi-discipline group allowing all aspects of the review process to be confirmed and challenged. The SCRG will keep a formal record of proposals reviewed and the feedback given.

3. Decision-Making Triggers

3.1. There are several reasons why a decision would need to be made. Decision triggers are a critical part of the overall assurance process.

3.2. 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 Notice Services
Quality Issue
Feedback from people and communities
Annual Planning
Other

4. Process for Relative Prioritisation

4.1. 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, 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.

5. Prioritisation Elements

5.1. 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.**

5.2. 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.

5.3. Each element will require evidence as to why the rating has been applied. This will also form the structure and content of the service change paper.

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 plan (including planned shifts of services/ activity to community/self-care/management)?*

Very Low	Low	High	Very High
Insert description/ evidence			

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.*

Very Low	Low	High	Very High
Insert description/ evidence			

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.*
- *Consideration to Personal Health Budgets?*

Very Low	Low	High	Very High
Insert description/ evidence			

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?*
- *Would Personal Health Budgets benefit this proposal?*

Very Low	Low	High	Very High
Insert description/ evidence			

Cost effectiveness (inc. 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?*

- *Have Personal Health Budgets been considered?*

Very Low	Low	High	Very High
Insert description/ evidence			

Affordability (inc. opportunity costs)

- *How much will the service or intervention cost per year?*
- *What is the cost per head of population that would potentially benefit?*
- *Is this cost affordable within the ICB's overall budget?*
- *Is there an opportunity for releasing resources for alternative uses? (Resources include staff time, estate, and finance).*
- *What are the opportunity costs for other services or interventions?*
- *Does this affect system finances / other partners?*

Very Low	Low	High	Very High
Insert description/ evidence			

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?*

Very Low	Low	High	Very High
Insert description/ evidence			

6. Prioritisation Framework Weightings

6.1. 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.

6.2. 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.

Element	**Weighting**
Strategic Fit	**1**
Improve outcomes in population health and healthcare	
Clinical effectiveness	**2**
Anticipated Health Benefits/Health Gain	**3**
Impact on Health Inequalities	**3**
Enhance productivity and value for money	
Cost effectiveness (inc. comparison to alternative models of care)	**2**
Affordability (inc. opportunity costs)	**2**
Help the NHS support broader social and economic development.	**2**

7. Prioritisation Rating Matrix

		Prioritisation Points				
Element	**Weighting**	**Very Low = 1**	**Low = 2**	**High = 3**	**Very High = 4**	**Score = Weighting x points**
Strategic Fit	**1**					
Clinical effectiveness	**2**					
Anticipated Health Benefits/Health Gain	**3**					
Impact on Health Inequalities	**3**					
Cost effectiveness	**2**					

Affordability (inc. opportunity costs)	**2**					
Help the NHS support broader social and economic development.	**2**					
Numerical Score						

7.1. Based on the weighting, the range for the prioritisation rating is between 15-60. The following table shows how the individual weighted points drive the final prioritisation rating:

Very Low	Low	High	Very High
15 - 22.5	22.5 - 37.5	37.5 - 52.5	52.5 - 60

7.2. 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.

8. Scheme of Reservation and Delegation

8.1. 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.

8.2. 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 re-constituted 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, Area Prescribing Committee is a good example of where subject matter expertise should be used and evidenced in the submitted paper. This will not remove the need for involvement of these functions in the development of the proposal.

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

9. NHS Nottingham and Nottinghamshire ICB Scheme of Reservation and Delegation

Disinvestments

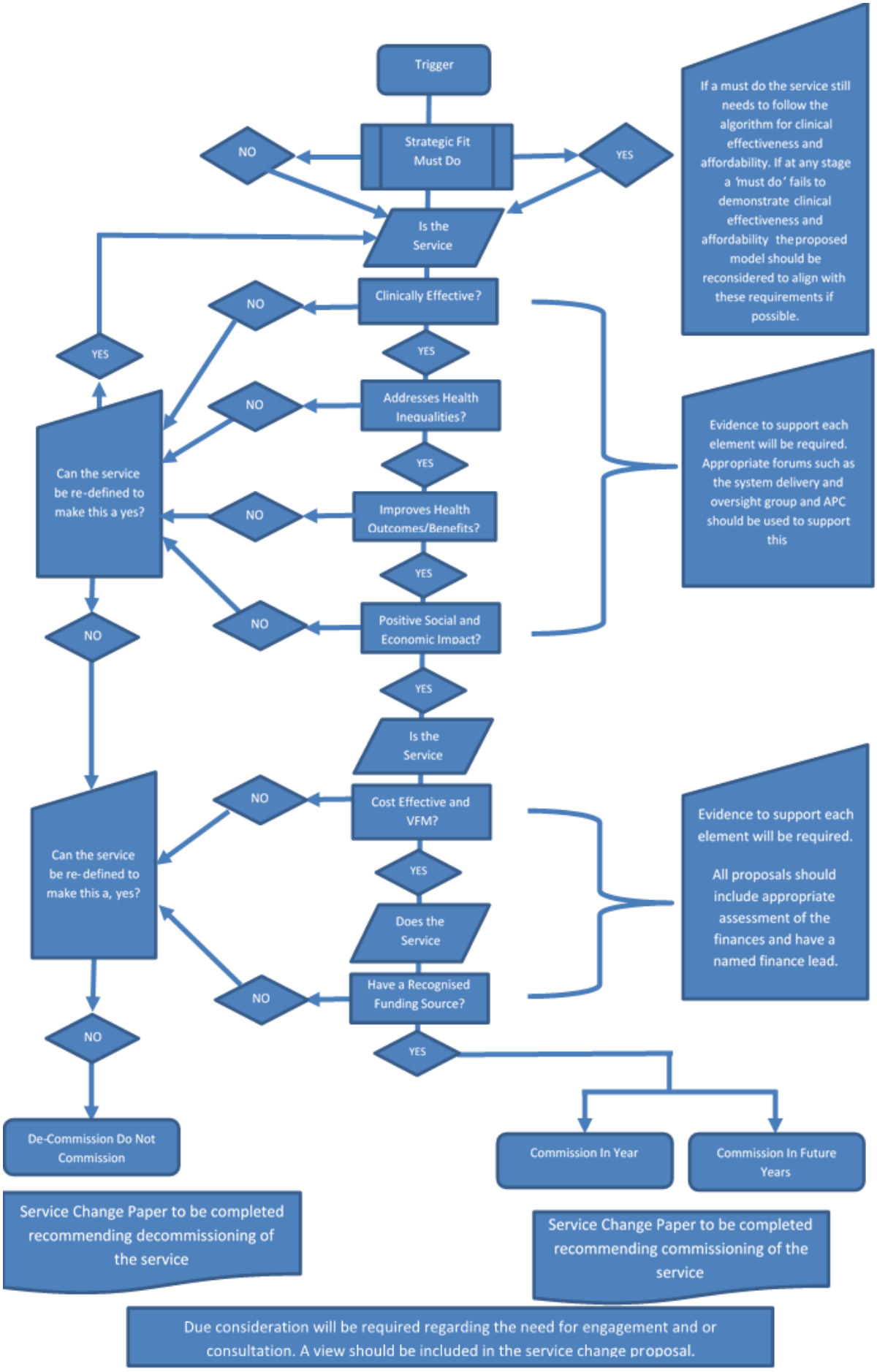
Annual value (£)	Delegated to	Additional information
Up to £100,000	Chief Executive (or Deputy Chief Executive in their absence)	Retrospectively reported to Strategic Planning and Integration Committee. Decisions that are considered to set precedent, or are novel, contentious or repercussive in nature can be escalated to the Strategic Planning and Integration Committee.
£100,001 to £5,000,000 or where proposals below this value are considered to set precedent, or are novel, contentious or repercussive in nature	Strategic Planning and Integration Committee	Decisions that are considered to set precedent, or are novel, contentious or repercussive in nature can be escalated to the Board.
£5,000,001 and above, or where proposals below this value are considered to set precedent, or are novel, contentious or repercussive in nature	Board	

Investments

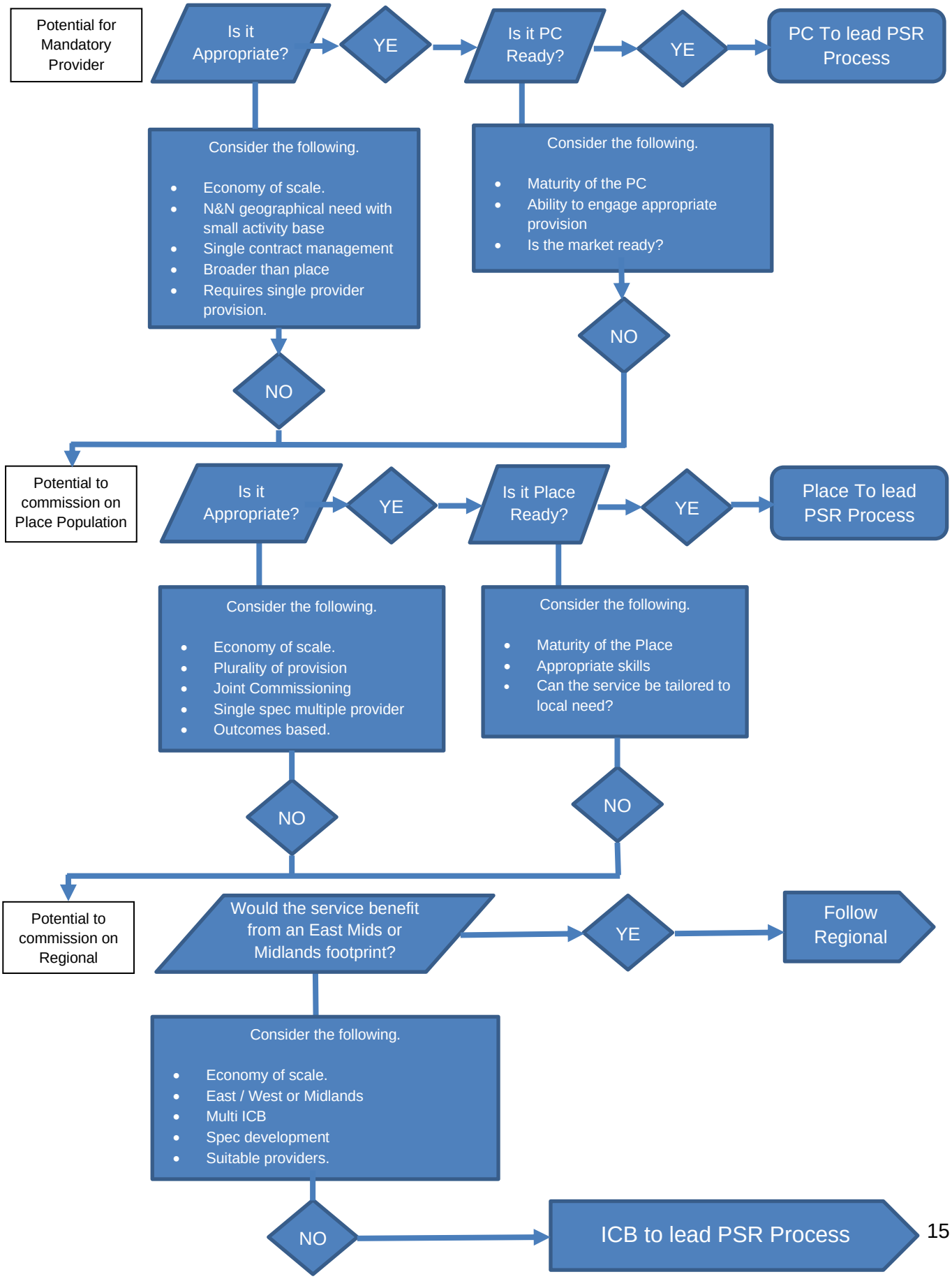
Annual Value	Delegated to	Additional information
Up to **£100,000**	Director of Finance Director of Integration Director of Nursing Medical Director	Retrospectively reported to Strategic Planning and Integration Committee. Decisions that are considered to set precedent, or are novel, contentious, or repercussive in nature can be escalated to the Strategic Planning and Integration Committee.
Up to **£500,000**	Chief Executive (or Deputy Chief Executive in their absence)	Retrospectively reported to Strategic Planning and Integration Committee. Decisions that are considered to set precedent, or are novel, contentious, or repercussive in nature can be escalated to the Strategic Planning and Integration Committee.
£500,001 to £5,000,000 or where proposals below this value are considered to set precedent, or are novel, contentious, or repercussive in nature.	Strategic Planning & Integration Committee	Decisions that are considered to set precedent, or are novel, contentious, or repercussive in nature can be escalated to the Board.
£5,000,001 and above, or where proposals below this value are considered to set precedent, or are novel, contentious, or repercussive in nature	Board	

10. Flowchart for Decision-Making

10.1. The below flowchart will be used to finalise the commissioning decision. The evidence used to rate the elements above will also be used to make the decisions required in the flowchart. See below:


Trigger
Strategic Fit Must Do
NO
YES
If a must do the service still needs to follow the algorithm for clinical effectiveness and affordability. If at any stage a 'must do' fails to demonstrate clinical effectiveness and affordability the proposed model should be reconsidered to align with these requirements if possible.
Is the Service
Clinically Effective?
NO
YES
Addresses Health Inequalities?
NO
YES
Improves Health Outcomes/Benefits?
NO
YES
Positive Social and Economic Impact?
NO
YES
Evidence to support each element will be required. Appropriate forums such as the system delivery and oversight group and APC should be used to support this
Can the service be re-defined to make this a yes?
YES
NO
Is the Service
Cost Effective and VFM?
NO
YES
Does the Service
Have a Recognised Funding Source?
NO
YES
Evidence to support each element will be required.
All proposals should include appropriate assessment of the finances and have a named finance lead.
Can the service be re-defined to make this a, yes?
YES
NO
De-Commission Do Not Commission
Commission In Year
Commission In Future Years
Service Change Paper to be completed recommending decommissioning of the service
Service Change Paper to be completed recommending commissioning of the service
Due consideration will be required regarding the need for engagement and or consultation. A view should be included in the service change proposal.

10.2. The above flowchart is used to confirm whether a service should be commissioned / continued or not. The following flowchart is used to determine the appropriate basis for the service to be commissioned on.



11. Provider Selection Regime

The Provider Selection Regime (PSR) will come into force following government direction, until this legislation has been passed the existing procurement rules remain extant.

11.1. NHSE recognises that collective decision-making between different bodies is the best way to arrange services. Therefore, a new Provider Selection Regime (PSR) is being proposed.

11.2. The current competition and procurement rules are not always well suited to the way healthcare is arranged and can create barriers to consultation on proposals for integrating care, disrupt the development of stable collaborations, and cause protracted processes with unnecessary legal and administration costs.

11.3. The new 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.

11.4. The central requirement of the proposed 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.

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

- Seeking continuation of existing arrangements using the existing provider.
- Selecting the most suitable provider when a service is new or changing substantially, but a competitive procurement is not appropriate.
- Running a competitive procurement.

11.6. **Continuation of existing arrangements.** There will be many situations where the incumbent provider is the only viable provider due to the nature of the service in question, and a change of provider is not feasible or necessary – many NHS services are already arranged in this way. There will be other situations where the incumbent provider/group of providers is doing a good job and the service is not changing, and there is no value in seeking another provider. In these situations, it needs to be straightforward to continue with the existing arrangements.

11.7. **Identifying the most suitable provider** for new/substantially changed arrangements. There will be situations where existing arrangements need to change – for example, when a service is changing considerably; when a new service is being established; when the incumbent is no longer able/no longer wants to provide the service; or when the decision-making body wants to use a different provider. In these situations, the decision-making body should consider a set of key

criteria. If after having done so they have reasonable grounds for believing that one provider/group of providers is the most suitable provider (which may or may not be the incumbent), they may award the contract to that provider without conducting a tendering process. This must be done in a way that is fully transparent and stands the test of scrutiny.

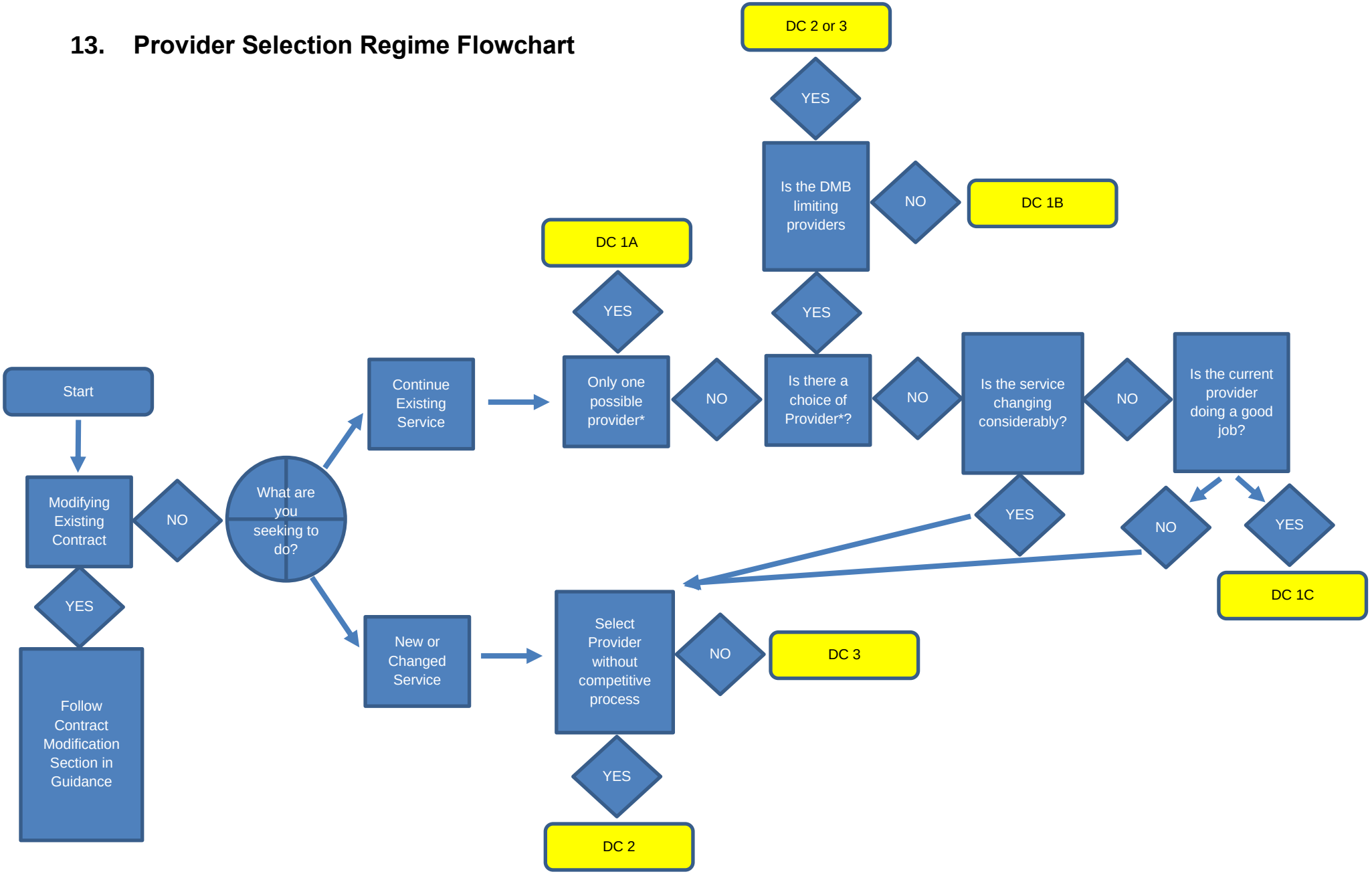
11.8. **Competitive procurement** – for situations where the decision-making body cannot identify a single provider/group of providers that is most suitable without running a competitive process, or the decision-making body wants to use a competitive process to test the market.

12. Decision Circumstance (DC) Definitions

12.1. This table should be read in conjunction with the flow diagram.

DC 1A	Continuation of existing arrangements. This type of service means there is no realistic alternative to the current provider.
DC 1B	Continuation of existing arrangements. Alternative providers are already available to patients.
DC 1C	Continuation of existing arrangements. The incumbent provider is doing a good job and the service is not changing.
DC 2	Identify the most suitable provider for the new / substantially changed arrangements.
DC 3	Competitive tender.
*	If decision making body are seeking to continue with the incumbent provider using DC 1A and 1B, they should not have made or be intending to make changes to the service requirement and / or the contract / sub-contract that result in the service being materially different in comparison to when awarded originally.

13. Provider Selection Regime Flowchart



14. Formal Decision-Making

14.1. 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.

14.2. 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. 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.

14.3. The Scheme of Reservation and Delegation will be applied based on the financial impact and whether the proposal is considered novel, contentious, or repercussive.