

|                            |                           |   |
|----------------------------|---------------------------|---|
| <b>MEETING DATE:</b>       | 12 December 2013          | <br><b>North Lincolnshire<br/>Clinical Commissioning Group</b><br><br><b>REPORT TO THE<br/>CLINICAL COMMISSIONING GROUP<br/>GOVERNING BODY</b> |
| <b>AGENDA ITEM NUMBER:</b> | Item 6.4                  |   |
| <b>AUTHOR:</b>             | Caroline Briggs           |   |
| <b>JOB TITLE:</b>          | Director of Commissioning |   |
| <b>DEPARTMENT:</b>         | CCG                       |   |

## ETHICAL COMMISSIONING POLICY

|   |  |
|---|--|
| <b>PURPOSE/ACTION REQUIRED:</b>                 | Decisions for Approval   |
| <b>CONSULTATION AND/OR INVOLVEMENT PROCESS:</b> | CCG Governing Body Workshop 14 November 2013   |
| <b>FREEDOM OF INFORMATION:</b>                  | <p><i>Is this document releasable under FOI at this time? If not why not? (decision making guide being developed)</i></p> <p>Yes</p> <p>Public</p> |

### 1. PURPOSE OF THE REPORT:

The Clinical Commissioning Group receives a fixed budget from NHS England and must arrange for the provision of healthcare to the extent it considers necessary to meet the reasonable requirements of its patients, subject to the duty to stay within its allocated resources.

The attached ethical framework and supporting prioritisation framework, is designed to underpin the CCGs priority setting processes and inform decision making by the Clinical Commissioning Group and its associated committees. In particular, it supports decision making in:

- i. the development of strategic plans for individual services
- ii. making investment and disinvestment decisions during the annual commissioning cycle
- iii. making in-year decisions about service developments or disinvestments
- iv. the management of individual funding requests

The Governing Body are asked to adopt the attached framework and agree to its use in supporting the development of the 2014/15 Commissioning Plan

**2. STRATEGIC OBJECTIVES SUPPORTED BY THIS REPORT:**

|   |   |
|---|---|
| Continue to improve the quality of services       | x |
| Reduce unwarranted variations in services         | x |
| Deliver the best outcomes for every patient       | x |
| Improve patient experience                        | x |
| Reduce the inequalities gap in North Lincolnshire | x |

**3. IMPACT ON RISK ASSURANCE FRAMEWORK:**

|     |                          |    |   |
|-----|--------------------------|----|---|
| Yes | <input type="checkbox"/> | No | x |
|-----|--------------------------|----|---|

**4. IMPACT ON THE ENVIRONMENT – SUSTAINABILITY:**

|     |                          |    |   |
|-----|--------------------------|----|---|
| Yes | <input type="checkbox"/> | No | x |
|-----|--------------------------|----|---|

**5. LEGAL IMPLICATIONS:**

|     |                          |    |   |
|-----|--------------------------|----|---|
| Yes | <input type="checkbox"/> | No | X |
|-----|--------------------------|----|---|

**6. RESOURCE IMPLICATIONS:**

|     |   |    |                          |
|-----|---|----|--------------------------|
| Yes | x | No | <input type="checkbox"/> |
|-----|---|----|--------------------------|

This framework supports the Clinical Commissioning Group in achieving its duty to stay within its allocated resources whilst arranging for the provision of healthcare to the extent it considers necessary to meet the reasonable requirements of its patients.

**7. EQUALITY IMPACT ASSESSMENT:**

|     |   |    |                          |
|-----|---|----|--------------------------|
| Yes | x | No | <input type="checkbox"/> |
|-----|---|----|--------------------------|

**8. PROPOSED PUBLIC & PATIENT INVOLVEMENT AND COMMUNICATIONS:**

|     |   |    |                          |
|-----|---|----|--------------------------|
| Yes | x | No | <input type="checkbox"/> |
|-----|---|----|--------------------------|

*Please explain briefly what involvement/communication has taken place or is planned*

It is proposed that this policy is used in the development of the 2014/15 commissioning plan, and tested with public and patients as part of that process.

*Does this paper need to be forwarded on to another Committee Group?*

No

**9. RECOMMENDATIONS:**

The CCG is asked to: -

- Approve and adopt the policy
- Agree to its use in supporting the development of the 2014/15 Commissioning Plan

# Ethical Commissioning Policy

|  |                                   |
|--|-----------------------------------|
| <b>Authorship:</b>                       | <b>Director of Commissioning.</b> |
| <b>Committee Approved:</b>               |                                   |
| <b>Approved date:</b>                    |                                   |
| <b>Review Date:</b>                      | <b>3 years</b>                    |
| <b>Equality Impact Assessment</b>        | <b>Completed - Screening</b>      |
| <b>Sustainability Impact Assessment:</b> | <b>Completed</b>                  |
| <b>Target Audience:</b>                  | <b>Public and stakeholders</b>    |
| <b>Policy Reference No:</b>              | <b><i>Commissioning</i></b>       |
| <b>Version Number:</b>                   | <b>1</b>                          |

The on-line version is the only version that is maintained. Any printed copies should, therefore, be viewed as 'uncontrolled' and as such may not necessarily contain the latest updates and amendments.

## POLICY AMENDMENTS

Amendments to the Policy will be issued from time to time. A new amendment history will be issued with each change.

| <b>New Version Number</b> | <b>Issued by</b> | <b>Nature of Amendment</b> | <b>Approved by &amp; Date</b> | <b>Date on Intranet</b> |
|---------------------------|------------------|----------------------------|-------------------------------|-------------------------|
|                           |                  |                            |                               |                         |
|                           |                  |                            |                               |                         |
|                           |                  |                            |                               |                         |
|                           |                  |                            |                               |                         |
|                           |                  |                            |                               |                         |

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## **1. POLICY STATEMENT**

- 1.1 The Clinical Commissioning Group receives a fixed budget from NHS England and must arrange for the provision of healthcare to the extent it considers necessary to meet the reasonable requirements of its patients, subject to the duty to stay within its allocated resources.
- 1.2 This ethical framework underpins priority setting processes and informs decision making by the Clinical Commissioning Group and its associated committees. In particular, it supports decision making in:
  - i. the development of strategic plans for individual services
  - ii. making investment and disinvestment decisions during the annual commissioning cycle
  - iii. making in-year decisions about service developments or disinvestments
  - iv. the management of individual funding requests

## **2. SCOPE**

This policy applies to decision making by the CCG and associated committees.

The Secretary of State has a duty to continue to promote a comprehensive health service.

Directly commissioned services include those provided through primary, secondary and tertiary care NHS providers, the independent sector, voluntary agencies and independent NHS contractors.

The mechanism through which investment and disinvestment decisions are taken is through a range of Clinical Commissioning Group processes. The Clinical Commissioning Group undertakes strategic planning, which leads to decisions made in its annual commissioning round. All decision making within the Clinical Commissioning Group is underpinned by this ethical framework. The Clinical Commissioning Group seeks to take decisions about which services to commission through a systematic approach which is centred on the needs of patients but which fairly distributes services across different patients groups. It can only do so if all decision making is based on clearly defined evaluation criteria and follows clear ethical principles.

Given resource constraints, the Clinical Commissioning Group cannot meet every healthcare need of all patients within its areas of responsibility. The fact that the Clinical Commissioning Group takes a decision not to commission a service to meet a specific healthcare need due to resource constraints is an inevitable fact of life in the NHS and does not indicate that the Clinical Commissioning Group is breaching its statutory obligations.

The purpose of setting out the principles and considerations to guide priority setting is to:

- provide a coherent framework for decision making;
- promote fairness and consistency in decision making; and to
- provide a means of expressing the reasons behind decisions that have been taken.

The ethical commissioning framework details the principles and the factors that will govern commissioning decisions and prioritisation in North Lincolnshire and is supported by a Prioritisation Framework at Appendix 3.

### **3. PRINCIPLES**

The core principles as set out below guide all decision making by the Clinical Commissioning Group both at the service and individual level. As with all Clinical Commissioning Group policies, this policy should be reviewed at regular intervals. However, core principles will guide all decision making unless and until the Clinical Commissioning Group decides to amend this policy.

The core principles will also be applied when dealing with individual funding requests, in conjunction with other general or treatment specific commissioning policies which might be relevant to the case.

#### **Principle 1**

The values and principles driving priority setting at all levels of decision making should be consistent.

#### **Principle 2**

The Clinical Commissioning Group has a legal responsibility to commission healthcare, within the areas for which it has commissioning responsibility, in a manner which is consistent with its legal duty not to overspend its allocated budget.

#### **Principle 3**

The Clinical Commissioning Group has a responsibility to make rational decisions in determining the way it allocates resources to the services it directly commissions and to 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 the Clinical Commissioning Group should have a fair chance of being considered, subject to the capacity of the Clinical Commissioning Group 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 and individual patients will be dealt within the agreed priority process).

#### **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 disadvantaged or unjustifiably advantaged or on the basis of age, gender, sexuality, race, religion, disability, 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, the CCG will adopt the Marmot principle of 'proportionate universalism'.

#### **Principle 6**

The Clinical Commissioning Group should only invest in treatments 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 clinical effectiveness, including where appropriate consideration of the cost per QALY (Quality Adjusted Life Years) as used by NICE of a healthcare intervention. Other forms of service developments

must represent value for money

**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 / value for money, and then prioritised in a way which supports consistent and affordable decision making.

**Principle 8**

The Clinical Commissioning Group 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**

No other body or individual, other than those authorised to take decisions under the policies of the Clinical Commissioning Group, has a mandate to commit the Clinical Commissioning Group to fund any healthcare intervention unless directed to do so by the Secretary of State for Health.

**Principle 10**

The Clinical Commissioning Group should strive, as far as practicable, to provide equal treatment to individuals in the same clinical circumstance. The Clinical Commissioning Group should therefore not 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**

Because the capacity of the NHS to fund research is limited, requests for funding to support research have to be subject to normal prioritisation processes.

**Principle 12**

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. The responsibility for this lies with the party initiating and funding the trial and not the Clinical Commissioning Group unless the Clinical Commissioning Group has either itself funded the trial or agreed in advance to fund aftercare for patients entering the trial.

**Principle 13**

Unless the requested treatment is approved under existing policies of the Clinical Commissioning Group, the Clinical Commissioning Group will not, save 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.

**Principle 14**

Over and above the clinical and value for money benefits, treatments or services will be expected to demonstrate that they will deliver public value as measured by the broader social, economic, and environmental impact on the community.

**Principle 15**

The CCG will ensure broader public and patient engagement in priority setting.

Five important themes can be found within these principles:

i. **Comprehensive and the Sole System** -The first is that, as budget holder for a defined population and the responsible commissioner for a defined range of clinical services, the Clinical Commissioning Group and its committees should ensure that all decisions are framed and considered in such a way that all options for investment are considered.

This means that there should not be a parallel system operating which allows individual treatments or patients to bypass prioritisation. The commissioning and operating policies that have been adopted by the Clinical Commissioning Group already allow for high priority service developments to be considered as a matter of urgency and for individuals who have unusual and high priority clinical needs to be funded.

The principles that require the Clinical Commissioning Group to consider competing demands when committing resources will help prevent situations in which whereby patients, patient groups and providers who lobby, being given undue priority.

ii. **Equality** -The second theme is that a commissioner should not give preferential treatment to a patient who is but one of a number of patients with the same clinical needs. Either a treatment or service is made available to all patients with equal clinical need or, if this cannot be afforded, it should not be commissioned for any patient. A decision to treat only some of the patients may be unfair because the decision about whom to treat would potentially be arbitrary and risks being discriminatory.

The Clinical Commissioning Group considers that if funding for a treatment cannot be justified as an investment for all patients in a particular cohort, the treatment should not be offered to only some of the patients *unless it is possible to distinguish on a rational basis between different sub-groups of patients on clinical grounds.*

A treatment policy approved by the Clinical Commissioning Group should therefore not be approved unless the Clinical Commissioning Group has made funds available to allow all patients within the clinical group identified in the policy to access treatment.

iii. **Clinical Effectiveness and Value for Money** - The need to demonstrate that a treatment is clinically effective or that a service development represents value for money is only the first stage in assessing priority, as other factors are relevant.

It is important to appreciate that being effective (or providing value for money) is a *minimum requirement* in order to be subject to prioritisation for funding and not **the** sole criteria that have to be met for funding to be agreed.

iv. **Accountability** - Commissioners are frequently asked to take on funding commitments made by another statutory body or other type of organisation (including pharmaceutical companies, research bodies or acute trusts) or indeed an individual who has funded the treatment themselves. While there might be instances where a commissioning body may choose to take on that responsibility for a number of reasons, another important principle is that the Clinical Commissioning Group cannot assume responsibility for a funding decision in which it played no part unless there is a legal requirement to do so

v. **Supporting Research and Development** - Related to point 4 is the issue of financial support provided to research and development. Commissioner support for R&D is highly desirable but it needs to be placed within appropriate constraints. These constraints should protect High priority treatments and services of

established value.

4. **Factors to be taken into account when prioritising competing needs for healthcare**

The NHS cannot possibly provide a service that meets the “best interests” of every patient and, indeed, does not have a legal obligation to do so. The Clinical Commissioning Group recognises that commissioners do not have a duty of care to the patients they serve but have an obligation to provide a fair system for deciding which treatments to commission, recognising that the Clinical Commissioning Group does not have the budget to fulfil every single need of the patients for whom it is responsible.

This means that the key task of priority setting is to choose between competing claims on the Clinical Commissioning Group’s budget. This requires the Clinical Commissioning Group to adopt policies that allow potential and existing demands on funds to be ranked, preferentially, in the context of a strategic plan for the service. However the Clinical Commissioning Group recognises that its internal resources will not allow every service to be assessed and ranked within every annual commissioning round.

The Clinical Commissioning Group will seek, within the resources available to it, to take rational decisions about which services to commission. As part of that process the Clinical Commissioning Group is committed to examining existing services and reserves the right to withdraw funding from existing services which are not determined to justify their funding since this will release resources to fund other services which have a higher ranking.

When prioritising both within and across Healthcare Programmes, a commissioner has to make complex assessments and trade-offs. This section of the policy sets out the common factors which are taken into account when making these decisions. This list is not exhaustive.

**Factors:**

1. Whether there is a Direction or other legal requirement which mandates the Clinical Commissioning Group to fund a particular treatment or service or an element of any service or treatment.
2. Whether or not the service and treatment and/or the benefits anticipated to be derived from the service or treatment have been identified as a priority within the strategic plan for that service. This includes the extent to which the service or treatment supports the delivery of the Clinical Commissioning Group’s Quality, Innovation, Productivity and Prevention Plan.
3. The anticipated effectiveness of the service or treatment particularly in reference to patient oriented outcomes.
4. The specific nature of the health outcome or benefit expected from the service or treatment.
5. The anticipated impact of the service or treatment on the population affected by the service or treatment.

6. Potential impacts of the service or treatment on one or more other services funded as part of NHS treatment (positive or negative).
7. The level of confidence the Clinical Commissioning Group has in the evidence underpinning the case for the service or treatment or the individual funding request (i.e. the quality of the evidence).
8. The level of confidence the Clinical Commissioning Group has in the robustness of the business case for the service or treatment.
9. Value for money anticipated to be delivered by the service or treatment (this includes cost-effectiveness where available).
10. The anticipated budgetary impact of the service or treatment including:
  - a. An assessment of the total budgetary impact of funding the service or treatment; and
  - b. Whether the service or treatment is cost saving in the short, medium or long term or cash releasing.
11. Any anticipated risks related to the service or treatment.
12. Whether the service or treatment will improve access to healthcare and for whom.
13. The effect of the service or treatment on patient choice.
14. The level of uncommitted funds that the Clinical Commissioning Group has at the time that it makes the decision and the affordability of the service or treatment.
15. Whether or not extraordinary circumstances are operating which justify variance from any original funding plan (e.g. the management of a major outbreak).
16. The degree to which the service or treatment will deliver public value as measured by the broader social, economic, and environmental impact on the community.

## **5. EQUALITY**

In applying this policy, the Organisation will have due regard for the need to eliminate unlawful discrimination, promote equality of opportunity, and provide for good relations between people of diverse groups, in particular on the grounds of the following characteristics protected by the Equality Act (2010); age, disability, gender, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, and sexual orientation, in addition to offending background, trade union membership, or any other personal characteristic. An Equality Impact Assessment has been undertaken (Appendix 1).

## **6. SUSTAINABILITY**

- 6.1 The policy has been assessed against the CCG's Sustainability themes. Please see Appendix 2.

## **7. BRIBERY**

7.1 The CCG follows good NHS business practice as outlined in the Business Conduct Policy and has robust controls in place to prevent bribery. Due consideration has been given to the Bribery Act 2010 in the development of this policy document and no specific risks were identified.

## **8. MONITORING & REVIEW**

8.1 This policy and procedure will be reviewed periodically by the Executive Team. Where review is necessary due to legislative change, this will happen immediately.

## 9. Glossary

| TERM  | DEFINITION   |
|---|--|
| <b>Clinical effectiveness</b>               | <i>Clinical effectiveness</i> is a measure of how well a healthcare intervention achieves the pre-defined clinical outcomes of interest in a real life population under real life conditions.  |
| <b>Clinical trial</b>                       | <i>A clinical trial</i> is a research study in human volunteers to answer specific health questions. Clinical trials are conducted according to a plan called a protocol. The protocol describes what types of patients may enter the study, schedules of tests and procedures, drugs, dosages, and length of study, as well as the outcomes that will be measured. Each person participating in the study must agree to the rules set out by the protocol. The ethical framework for conducting trials is set out in the Medicines for Human Use (Clinical Trials) Regulations 2004 (as amended). It includes, but does not refer exclusively to, randomised control trials.  |
| <b>Cost effectiveness</b>                   | <i>Cost effectiveness</i> is an assessment as to whether a healthcare intervention provides value for money. A specific methodology is adopted using evaluation criteria appropriate to the context of the service/healthcare intervention under consideration.  |
| <b>Effectiveness -clinical</b>              | <i>Clinical effectiveness</i> is a measure of the extent to which a treatment achieves pre-defined clinical outcomes in a target patient population.   |
| <b>Experimental and unproven treatments</b> | <i>Experimental and unproven treatments</i> are medical treatments or proposed treatments where there is no established body of evidence to show that the treatments are clinically effective. The reasons may include the following: <ul style="list-style-type: none"> <li>• The treatment is still undergoing clinical trials for the indication in question.</li> <li>• The evidence is not available for public scrutiny.</li> <li>• The treatment does not have approval from the relevant government body.</li> <li>• The treatment does not conform to an established clinical practice in the view of the majority of medical practitioners in the relevant field.</li> <li>• The treatment is being used in a way other than that previously studied or for which it has been granted approval by the relevant government body.</li> <li>• The treatment is rarely used, novel, or unknown and there is a lack of evidence of safety and efficacy.</li> <li>• There is some evidence to support a case for clinical effectiveness but the overall quantity and quality of that evidence is such that the commissioner does not have confidence in the evidence base and/or there is too great a measure of uncertainty over whether the claims made for a treatment can be justified.</li> </ul> |

|                                    |  |
|------------------------------------|--|
| <b>Healthcare intervention</b>     | <i>A healthcare intervention</i> means any form of healthcare treatment which is applied to meet a healthcare need.  |
| <b>Treatable Health Care need</b>  | <i>Healthcare need</i> is a health problem which can be addressed by a known clinically effective intervention. Not all health problems can be addressed.  |
| <b>In-year service development</b> | An <i>in-year service development</i> is any aspect of healthcare, other than one which is the subject of a successful individual funding request, which the Clinical Commissioning Group agrees to fund outside of the annual commissioning round. Unplanned investment decisions should only be made in exceptional circumstances because, unless they can be funded through disinvestment, they will have to be funded as a result of either delaying or aborting other planned developments.   |
| <b>Normally commissioned care</b>  | <i>Normally commissioned care</i> is healthcare which is routinely funded by the patient's responsible commissioner. The Clinical Commissioning Group has policies which define the elements of healthcare it is and is not prepared to commission for defined groups of patients.   |
| <b>Priority setting</b>            | <i>Priority setting</i> is the task of determining the priority to be assigned to a service, a service development, a policy variation or an individual patient at a given point in time. Prioritisation is needed because the need and demands for healthcare are greater than the resources available.   |
| <b>Prioritisation</b>              | <i>Prioritisation</i> is decision making which requires the decision maker to choose between competing options.  |
| <b>Public Value</b>                | <i>Public Value is the benefit provided to the community as a whole as measured by economic, social, environmental improvements or the avoidance of degradation.</i>   |
| <b>Service Development</b>         | A <i>Service Development</i> is a proposal to amend what is normally commissioned by the Clinical Commissioning Group. The term refers to all new developments including new services, new treatments (including medicines), changes to treatment thresholds, and quality improvements. It also encompasses other types of investment that existing services might need, such as pump-priming to establish new models of care, training to meet anticipated manpower shortages and implementing legal reforms. Equitable priority setting dictates that potential service developments should be assessed and prioritised against each other within the annual commissioning round. However, where investment is made outside of the annual commissioning round, such investment is referred to as an <i>in-year service development</i> . |

**Equality Analysis Initial Assessment**

| <b>1. Equality Impact Analysis: Local Profile Data</b>                      |  |
|---|--|
| <b>Local Profile/Demography of the Groups affected</b> (population figures) |  |
| <b>General</b>  | Total Population for North Lincolnshire is approx 161,000  |
| <b>Age</b>  | 0-15 = 30,000    16-29 = 25,000    30-44 = 30,500    45-64 = 46,000<br><br>65+ = 30,000 <b>All figures are approximate</b> |
| <b>Race</b>   | Local BME population is estimated at 7% of the resident population   |
| <b>Sex</b>  | 49.3% Male    50.7% Female   |
| <b>Gender reassignment</b>  | No reliable data available   |
| <b>Disability</b>   | Those living with a declared disability ages 16-65 is 21,100   |
| <b>Sexual Orientation</b>   | No reliable data available   |
| <b>Religion, faith and belief</b>   | No reliable data available   |
| <b>Marriage and civil partnership</b>                                       | No reliable data available   |
| <b>Pregnancy and maternity</b>  | Approx 2000 births per annum   |

## 2. Equality Impact Analysis: Equality Data Available

|  |   |
|--|---|
| <p><b>Is any Equality Data available relating to the use or implementation of this policy, project or function?</b></p> <p>Equality data is internal or external information that may indicate how the activity being analysed can affect different groups of people who share the nine <i>Protected Characteristics</i> – referred to hereafter as ‘<i>Equality Groups</i>’.</p> <p>Examples of <i>Equality Data</i> include: (this list is not definitive)</p> <ol style="list-style-type: none"> <li>1. Application success rates <i>Equality Groups</i></li> <li>2. Complaints by <i>Equality Groups</i></li> <li>3. Service usage and withdrawal of services by <i>Equality Groups</i></li> <li>4. Grievances or decisions upheld and dismissed by <i>Equality Groups</i></li> <li>5. <i>Previous EIAs</i></li> </ol> | <p style="font-size: 24pt;">No</p> <p>Where you have answered yes, please incorporate this data when performing the <i>Equality Impact Assessment Test</i> (the next section of this document).</p> |
| <p><b>List any Consultation e.g. with employees, service users, Unions or members of the public that has taken place in the development or implementation of this policy, project or function</b></p>  | <p>None, but to be tested during 14/15 for review</p>   |
| <p><b>Promoting Inclusivity</b><br/> <b>How does the project, service or function contribute towards our aims of eliminating discrimination and promoting equality and diversity within our organisation</b></p>   | <p style="font-size: 24pt;">Yes</p>   |

### 3. Equality Impact Analysis: Assessment Test

What impact will the implementation of this policy, project or function have on employees, service users or other people who share characteristics protected by *The Equality Act 2010* ?

| Protected Characteristic:  | No Impact: | Positive Impact: | Negative Impact: | Evidence of impact and if applicable, justification where a <i>Genuine Determining Reason</i> exists     |
|--|------------|------------------|------------------|--|
| <b>Gender</b><br>(Men and Women)                                     |            | ✓                |                  | The policy sets the decision making framework to ensure all decisions are made with an ethical framework |
| <b>Race</b><br>(All Racial Groups)                                   |            | ✓                |                  |  |
| <b>Disability</b><br>(Mental and Physical)                           |            | ✓                |                  |  |
| <b>Religion or Belief</b>  |            | ✓                |                  |  |
| <b>Sexual Orientation</b><br>(Heterosexual, Homosexual and Bisexual) |            | ✓                |                  |  |

## Equality Impact Analysis: Assessment Test (continued)

What impact will the implementation of this policy, project or function have on employees, service users or other people who share characteristics protected by *The Equality Act 2010* ?

| Protected Characteristic:      | No Impact: | Positive Impact: | Negative Impact: | Evidence of impact and if applicable, justification where a <i>Genuine Determining Reason</i> exists     |
|--------------------------------|------------|------------------|------------------|--|
| <b>Pregnancy and Maternity</b> |            | ✓                |                  | The policy sets the decision making framework to ensure all decisions are made with an ethical framework |
| <b>Transgender</b>             |            | ✓                |                  |  |
| <b>Marital Status</b>          |            | ✓                |                  |  |
| <b>Age</b>                     |            | ✓                |                  |  |

### 4. Action Planning

**As a result of performing this analysis, what actions are proposed to remove or reduce any risks of adverse outcomes identified on employees, service users or other people who share characteristics protected by *The Equality Act 2010* ?**

| Identified Risk: | Recommended Actions: | Responsible Lead: | Completion Date: | Review Date: |
|------------------|----------------------|-------------------|------------------|--------------|
|                  |                      |                   |                  |              |
|                  |                      |                   |                  |              |
|                  |                      |                   |                  |              |
|                  |                      |                   |                  |              |

|  |  |  |  |  |
|--|--|--|--|--|
|  |  |  |  |  |
|--|--|--|--|--|

## 5. Equality Impact Analysis Findings

| Analysis Rating: | Red | Red/Amber | Amber | Green |
|------------------|-----|-----------|-------|-------|
|------------------|-----|-----------|-------|-------|

## SUSTAINABILITY IMPACT ASSESSMENT

Staff preparing a Policy/Board Report/Committee Report/Service Plan/Project are required to complete a Sustainability Impact Assessment. Sustainability is one of the Trust's key Strategies and the Trust has made a corporate commitment to address the environmental effects of activities across Trust services. The purpose of this Sustainability Impact Assessment is to record any positive or negative impacts that this activity is likely to have on each of the Trust's Sustainability Themes. For assistance with completing the Sustainability Impact Assessment, please refer to the instructions below.

| <b>Policy / Report / Service Plan / Project Title:</b>  |                        |                        |                           |  |
|---|------------------------|------------------------|---------------------------|--|
| <b>Theme (Potential impacts of the activity)</b>  | <b>Positive Impact</b> | <b>Negative Impact</b> | <b>No specific impact</b> | <b>What will the impact be? If the impact is negative, how can it be mitigated? (action)</b> |
| Reduce Carbon Emission from buildings by 12.5% by 2010-11 then 30% by 2020                                    |                        |                        | ✓                         |  |
| New builds and refurbishments over £2million (capital costs) comply with BREEAM Healthcare requirements.      |                        |                        | ✓                         |  |
| Reduce the risk of pollution and avoid any breaches in legislation.   |                        |                        | ✓                         |  |
| Goods and services are procured more sustainability.  |                        |                        | ✓                         |  |
| Reduce carbon emissions from road vehicles.   |                        |                        | ✓                         |  |
| Reduce water consumption by 25% by 2020.  |                        |                        | ✓                         |  |
| Ensure legal compliance with waste legislation.   |                        |                        | ✓                         |  |
| Reduce the amount of waste produced by 5% by 2010 and by 25% by 2020  |                        |                        | ✓                         |  |
| Increase the amount of waste being recycled to 40%.   |                        |                        | ✓                         |  |
| Sustainability training and communications for employees.   |                        |                        | ✓                         |  |
| Partnership working with local groups and organisations to support sustainable development.                   |                        |                        | ✓                         |  |
| Financial aspects of sustainable development are considered in line with policy requirements and commitments. |                        |                        | ✓                         |  |

## **NHS NORTH LINCOLNSHIRE CLINICAL COMMISSIONING GROUP PRIORITISATION FRAMEWORK**

### **Purpose**

1. The CCG has a responsibility to use its available resources effectively to provide and continually improve care which is high quality, safe and accessible. The financial strategy identifies the following in support of this aspect of delivering the CCG's overall objectives:
  - A realistic approach to planning, balancing delivery of commissioning priorities with meeting statutory financial duties
  - Continual testing of spend against strategic objectives to ensure it is directed towards obtaining the most effective services at the best obtainable value
  - Use of investment to support timely and successful change, with structured testing and prioritisation of investment proposals
2. A prioritisation framework is an important tool for enabling the CCG to achieve this. It provides an effective, structured and defensible approach to making decisions and choices on the use of resources, and where there are insufficient resources to meet every request.
3. The Prioritisation and Investment Framework is expected to be used primarily in the context of annual planning decisions. It can however be applied in any situation where available resources do not allow all desired activities to be undertaken, requiring an effective and defensible choice to be made. Both the principles of prioritisation and some or all elements of the assessment process can be used where beneficial to support decision-making.

### **Commissioning and Planning Cycle Context**

4. The diagram at Annex 1 shows how the Prioritisation and Investment Framework fits into the overall annual planning process.

### **Prioritisation Approach**

5. Stage 1 – High Level Groupings. Proposals are identified as belonging to one of the following groups, which are in decreasing order of priority:
  - Group 1 – Unavoidable schemes required to deliver statutory compliance, mandatory NHS Commissioning Board requirements, or to respond to an issue of immediate and high risk patient safety

- Group 2 – Schemes which contribute to delivery of national or local priority objectives or targets for service or quality improvement or financial benefit in the next 3 years
  - Group 3 – Schemes which contribute to longer term goals or low priority shorter-term goals (i.e. desirable but not directly aligned to strategic or in-year priorities)
  - Other – The expectation is that resource will not be expended in submitting proposals which do not deliver any of the above
6. Stage 2 – Priority Assessment and Mapping. This is applied to Group 2 and 3 proposals on the basis that all Group 1 proposals will be supported. The relative priority of each proposal within Group 2 and Group 3 is assessed using weighted criteria and a prioritisation map for ease of comparison. Each proposal is assessed for importance and practical deliverability, with a weighted score allocated to a number of individual criteria. The outcomes for all proposals in the Group are then summarised on a single map. The criteria are attached at Annex 2 and a blank prioritisation map is provided at Annex 3.
7. Stage 3 – Recommendation. Prioritised proposals are matched against available funding and resource for delivery to determine which should be recommended for implementation. A review of the overall set of recommendations which emerges is undertaken to ensure no anomalies have been created e.g. interdependent proposals not all being approved, all investment unintentionally targeted to one area of care.

## **Process**

8. The exact process and timescales to be followed during the annual planning round and at other times will be determined locally in the context of any relevant wider processes and timetables e.g. NCB national planning guidance.
9. It is expected that any process will include the following stages to an extent proportionate to the scale of the decision.
- Development of proposals. For investment and QIPP proposals this will be by commissioner leads and service redesign teams working closely with GP leads and with other clinical and supporting professional input as required
  - Completion of a template for each scheme capturing the information required to inform prioritisation decisions.
  - Initial completion of Stage by a specifically convened group, to include clinical and senior level commissioning and finance representation
  - Opportunity for clarification and requesting further information or additional advice e.g. HR, public engagement
  - Final review and sign off of recommendations by the specifically convened group, including a sense check of the overall package
  - Approval by the CCG Engine Room

## **Implementation of Approved Proposals**

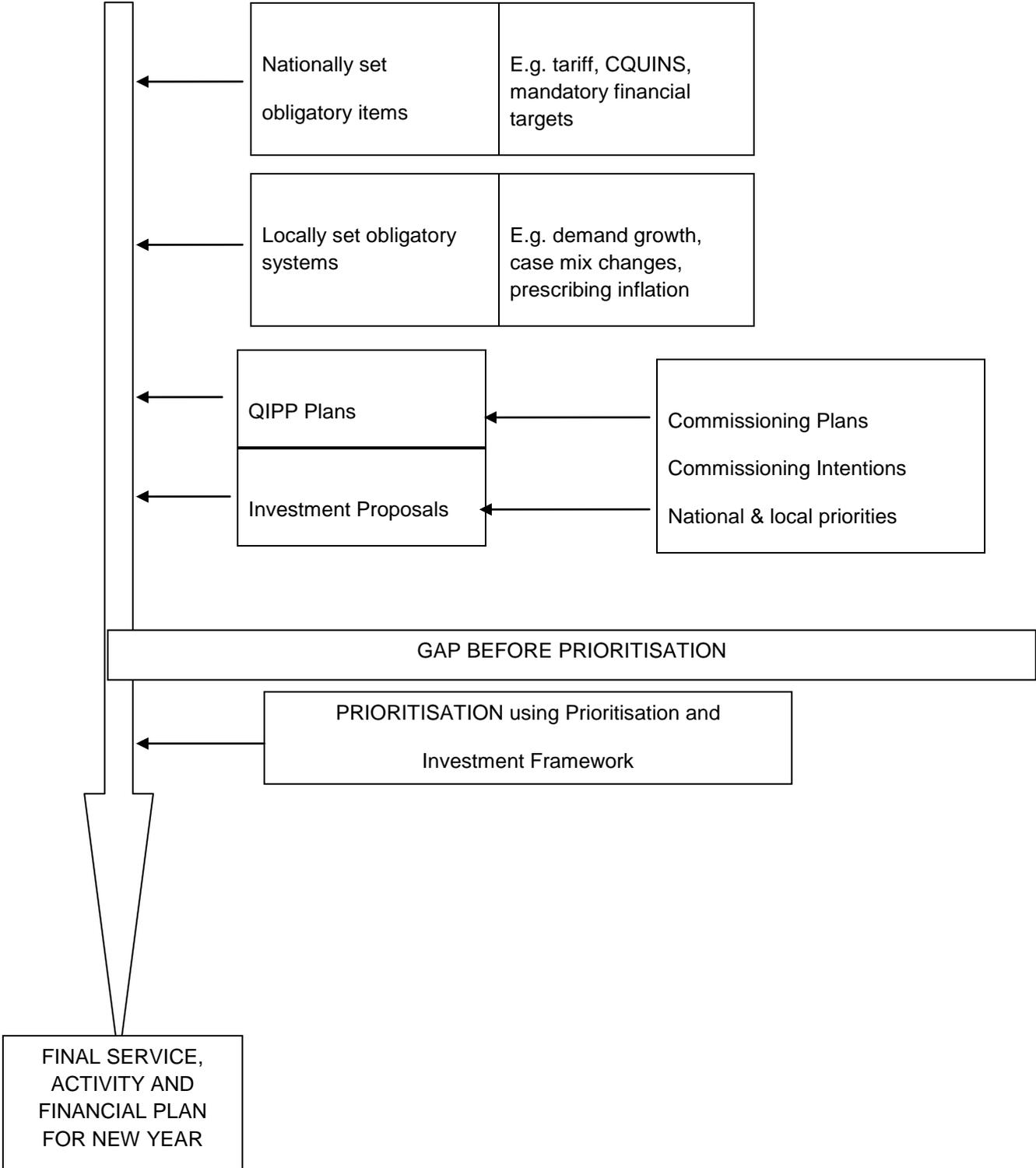
10. Following approval of individual proposals a named lead will be confirmed for each scheme to be implemented, who will hold delegated authority equivalent to that of a budget holder in respect of the scheme. This individual will have authority to progress the scheme subject to the following:
  - No material variation from the scheme as originally agreed. Material variation will require approval from the individual or body approving the original proposal
  - Approval of high value spend or contractual agreements in line with normal delegated financial limits
  - Compliance with other requirements e.g. procurement, choice and competition rules; due process for significant service change
  - Compliance with any request from the approving individual or body that further information on the scheme be provided prior to implementation e.g. where a high level investment has been agreed but detail of specific schemes is not yet worked up

## **Review**

11. This Framework will be reviewed by December 2014 at the latest, in preparation for the 2015/16 planning round.

**ANNUAL PLANNING PROCESS OVERVIEW**

BASELINE – starting point of service, activity and finance plans based on expected future position before changes



## PRIORITISATION CRITERIA - IMPORTANCE

| Criterion                                  | Key Considerations  | Weight    |
|--|---|-----------|
| <b>Patient /service user/carer benefit</b> | <ul style="list-style-type: none"> <li>• Does this proposal deliver improvements in the quality of services?</li> <li>• Does the proposal deliver improvements in the timelines or accessibility of the services?</li> <li>• Does the proposal enable services to be used more effectively?</li> <li>• Does the proposal deliver improvements in patient/service user /carer experience?</li> <li>• Does the proposal contribute to reducing health inequalities?</li> <li>• Are there wider community benefits arising from the proposal?</li> </ul> | <b>25</b> |
| <b>Innovation and transformation</b>       | <ul style="list-style-type: none"> <li>• Does the proposal address an area where the CCG performs less well than others?</li> <li>• Does the proposal use innovative approaches to deliver change?</li> <li>• Does the proposal contribute to large scale, long-term transformational change?</li> <li>• Does the proposal support research or the expansion of knowledge or of the evidence base?</li> </ul>   | <b>15</b> |
| <b>National priority</b>                   | <ul style="list-style-type: none"> <li>• Does the proposal support delivery of a national priority?</li> <li>• Does the proposal contribute to delivery of an existing programme or project?</li> </ul>   | <b>20</b> |
| <b>Local priority</b>                      | <ul style="list-style-type: none"> <li>• Does the proposal support delivery of the CCG's strategic objectives?</li> <li>• Does the proposal contribute to delivery of an existing programme or project?</li> <li>• Does the proposal support delivery of wider local objectives such as the Health &amp; Wellbeing Strategy or Council plans?</li> <li>• Does the proposal enable the CCG to function more effectively?</li> <li>• Does the proposal address a specific issue of local concern or risk?</li> </ul>                                    | <b>20</b> |
| <b>Financial benefits</b>                  | <ul style="list-style-type: none"> <li>• Does the proposal deliver financial savings?</li> <li>• Does the proposal deliver productivity or efficiency benefits or otherwise improve value for money?</li> <li>• Does the proposal support delivery of provider CIP's?</li> <li>• Does the proposal deliver wider economic benefits?</li> </ul>  | <b>20</b> |

**PRIORITISATION CRITERIA – DELIVERABILITY**

| Criterion                            | Key Considerations  | Weight    |
|--------------------------------------|---|-----------|
| <b>Stakeholders</b>                  | <ul style="list-style-type: none"> <li>• To what extent are stakeholders within the local health and wellbeing community supportive to this proposal?</li> <li>• Is formal public engagement or consultation likely to be required?</li> <li>• What is the likely strength of any adverse reaction to the proposal?</li> <li>• Does the proposal have support from clinicians?</li> </ul>   | <b>20</b> |
| <b>Infrastructure</b>                | <ul style="list-style-type: none"> <li>• Would the proposal require change to buildings and equipment?</li> <li>• Are there any likely barriers to change?</li> <li>• Would the proposal require the current provider workforce to be redeployed or reduced?</li> <li>• Are the skills to deliver any new or additional service readily available?</li> </ul>   | <b>10</b> |
| <b>Service delivery</b>              | <ul style="list-style-type: none"> <li>• Does the initiative represent a significant or complex service change?</li> <li>• Would this proposal adversely affect the viability of other services?</li> <li>• Would this proposal enhance the viability of other services?</li> <li>• Will this destabilise the market and risk service continuity?</li> <li>• Are the providers willing and able to engage in delivering the proposal?</li> </ul>  | <b>20</b> |
| <b>Resources required</b>            | <ul style="list-style-type: none"> <li>• Does the proposal require financial investment?</li> <li>• What is the skills and capacity required to implement the proposal?</li> </ul>  | <b>20</b> |
| <b>Risk and confidence</b>           | <ul style="list-style-type: none"> <li>• Has this proposal been undertaken successfully elsewhere?</li> <li>• Are the desired outcomes clear and measurable?</li> <li>• Is there confidence that the proposal will deliver the desired outcomes?</li> <li>• Is it possible to cease implementation and withdraw investment if the proposal does not deliver?</li> <li>• Are there any risks in proceeding not identified in the other criteria?</li> <li>• Are there any risks in not proceeding not identified in the other criteria?</li> </ul> | <b>20</b> |
| <b>Timescales for implementation</b> | <ul style="list-style-type: none"> <li>• How long will it take for the service to start?</li> </ul>   | <b>10</b> |

**PRIORITISATION MAP**

**ANNEX 3**

