Staffordshire CCGs Prioritisation framework

Factor	Scale					Score
	Very Low	**Low**	**Medium**	**High**	**Very High**	
1 Strength and quality of evidence* **Is there a robust evidence base, appropriate for the intervention, which shows the benefit of the proposed intervention? Scores will reduced from the indicative hierarchy scores where the studies are of low or moderate quality (see below).**	**< 10 points** if poor quality evidence **OR** strong evidence it does **NOT** work =0	**10 points**	**20 points** if there is modest evidence for benefit	**30 points**	**40 points** if there is very strong evidence that the service or intervention **DOES** work	
2 Magnitude of health improvement for the patient group or population* **To what extent does this intervention increase the health gain or life expectancy for the patients/population? Appraise outcome measures eg improvement in functionality, clinical markers, QoL, HLE ***	**<10 points** if **negligible** or **no** improvement in health or life expectancy (<10% improvement)	**10 points**	**20 points** if there is **moderate** benefit (20 – 30% improvement)	**30 points**	**40 points** if there are **large** health improvement benefits (≥50% improvement in outcome measures such as QoL, HLE)	
3 Prevention of future illness or disability* **Does this intervention contribute to prevention of future new health conditions?**	**0points** if it does **not** prevent future illness	**10 points**	**20 points** if there is a **moderate** prevention benefit	**30 points**	**40 points** if it has a **very high** prevention benefit	
4 Supports people with existing health problems **Does this intervention prevent or reduce complications in people with ongoing conditions?**	**0 points** if it does **not** support people with health problems	**10 points**	**20 points** if there is a **moderate** benefit for people with health problems	**30 points**	**40 points** if it is **highly** supportive of people with health problems	
5 Cost effectiveness ratio* **What is the cost per ICER or QALY of this intervention?** **If no information, default score =10**	**0 points** >£30000	**5 points** £>20000 - £30000	**10 points** £>10000 - £20000	**15 points** £5000 - £10000	**20 points** <£5000	

6 Opportunity costs **What is the cost per head for the population that might benefit potentially from this intervention? Cost per annum, one-off or recurring.**	**>£20K** 5 points	**£>10 - 20K** 10 points	**£>5 - 10K** 15 points	**£1 - 5K** 20 points	**<£1K** 30 points	
7 Addresses health inequality or health inequity* **Does this intervention reduce or narrow identified inequalities or inequities in the local population?**	**0 points** if it does **not** address any inequality or inequity	**5 points**	**10 points** if it **partially** addresses an identified inequality or inequity	**15 points**	**20 points** if it **completely** addresses an identified inequality or inequity	
8 Delivers national or local requirements and targets **Does this intervention support the CCG in delivering identified national requirements or local priorities/targets?**	**0 points** if **not** a requirement	**10 points** if it addresses **one** target or requirement	**20 points** if it addresses **two** targets or requirements	**30 points** if it addresses **three** targets or requirements	**40 points** if it addresses **four or more** targets or requirements	
TOTAL SCORE						

Maximum score = 270

***= subject to further notes below**

Notes on the criteria and interpretation

1 Strength & quality of evidence

1. Where the evidence can be readily categorised, usually because it is clinical, the NICE hierarchy is used:

Hierarchy of Evidence	Grading of Recommendations	score
Ia Evidence from systematic reviews or meta analysis of high quality randomised controlled trials	A Based on hierarchy I evidence	40
Ib Evidence from at least one high quality randomised controlled trial		30
IIa Evidence from at least one good quality controlled study without randomisation	B Based on hierarchy II evidence or extrapolated from hierarchy I evidence	20-30
IIb Evidence from at least one other type of quasi experimental study of good quality		
III Evidence from non experimental descriptive studies, such as comparative studies, correlation studies and case control studies	C Based on hierarchy III evidence or extrapolated from hierarchy I or II evidence	10-20
IV Evidence from expert committee reports or opinions and/or clinical experience of respected authorities	D Directly based on hierarchy IV evidence or extrapolated from hierarchy I, II or III evidence.	0-10

The quality of the study may be assessed in regard to the criteria recommended in Cochrane handbook:

1. risk of bias
   - random sequence generation.
   - allocation concealment.
   - blinding of participants and personnel.
   - blinding of outcome assessment (assessed separately for self-reported and objectively assessed outcomes).
   - incomplete outcome data.
   - selective reporting.
   - other sources of bias (specifically, baseline imbalance).
2. measurement of treatment effects
3. assessment of heterogeneity

4. assessment of reporting biases

Another set of quality criteria for assessing experimental studies (RCTs) is:

i. Was the assignment to the treatment groups really random?
ii. Was the treatment allocation concealed?
iii. Were the groups similar at baseline in terms of prognostic factors?
iv. Were the eligibility criteria specified?
v. Were outcome assessors blinded to the treatment allocation?
vi. Was the care provider blinded?
vii. Was the patient blinded?
viii. Were the point estimates and measure of variability presented for the primary outcome measure?
ix. Did the analyses include an intention to treat analysis?

Source: Report 4 of the NHS Centre for Reviews and Dissemination (NHSCRD, 2001)

Score deductions:
where studies are of **moderate** quality 5-10 points may be deducted,
where studies are of **low** quality 10-20 points may be deducted.

Usually the assessment of quality will have been made by reviewers in a systematic review. As a guide only:
If a systematic review looked at 7 studies and all were judged to be moderate quality a deduction of 5 points might be considered.
If 5 studies were judged to be moderate quality, and 2 were judged to be low quality, 10 point deduction might be appropriate.
If 5 studies were low quality and 2 were moderate quality a deduction of 15 points might be considered.

2. where the above categorisation is not applicable the strength of evidence definitions can be used:

Strength-of-evidence	Definition	score
High	**High confidence that the evidence reflects the true effect.** Further research is very unlikely to change our confidence in the estimate of effect.	30
Moderate	**Moderate confidence that the evidence reflects the true effect.** Further research may change our confidence in the estimate of effect and may change the estimate.	20
Low	**Low confidence that the evidence reflects the true effect.** Further research is likely to change the confidence in the estimate of effect and is likely to change the estimate.	10
Insufficient	Evidence either is unavailable or does not permit a conclusion.	0

2. magnitude of health improvement for the patient group/population

The second criterion in the Portsmouth scorecard is key and is concerned with the magnitude of health improvement benefit. The explanatory question is:

To what extent does this intervention increase the health gain or life expectancy for the patients/population?

In considering the magnitude of health improvement benefit CPAG needs to be clear what can be included.

To be consistent with commissioning policy as expressed in the IFR policy, social factors are not included. The Human Rights Act does not engage, as emphasised in the judicial review of 2011.

Physical health is presumed to be included, and most interventions considered by CPAG have been concerned with physical diseases and their consequences. Pain, functional impairment and threat to life expectancy are common issues.

Mental health is also presumed to be included. If not, then all interventions for mental health problems would have to be prioritised by another scoring process. However issues such as functional impairment, quality of life and threat to life are as relevant.

What can we measure?

Two aspects of the measurement of health are important in assessing magnitude of benefit.

- Measures of improvement in functionality, or of clinical markers relevant to the condition.
- Measures of quality of life, and increase in life expectancy

The latter are required to estimate the incremental cost-effectiveness ratio, or cost per QALY.

What are the questions to be satisfied?

In order to score the relative magnitude of benefit a number of questions should be satisfied. For example:

Are there appropriate measures relevant to the particular condition or patient group?

Is there evidence of impact of the condition on generic measures such as the General Health Questionnaire, SF-36, EQ5D etc. All these instruments include domains which are about mental health.

Is there evidence that the intervention leads to improvement in any of those measures?

Has the effect size been calculated?

3.Prevention

This criterion considers whether the service/intervention is aimed at people without an ongoing condition.

This includes health & wellbeing interventions that may prevent the onset of illness in the future e.g. diet, exercise, not smoking, education, immunisation.

It includes measures taken to manage risk factors that already exist.

It includes systematic testing of a population to identify a condition that is not yet symptomatic, and may still be treated with an early intervention (screening).

4 Existing health problems

This criterion concerns people with an ongoing condition.

It includes measures taken to manage the condition with the aim of preventing, or reducing the risk of, complications including critical events, limitations to activities of daily living, and mental health problems.

5 Cost effectiveness ratio					
5.1 How does this service compare with alternatives? **ICER** = Incremental Cost-Effectiveness Ratio. The ratio of change in costs: change in effects**	**0 points** >£30000>£30000	**5 points** £>20000 - £30000£>20000 - £30000	**10 points** £>10000 - £20000£>10000 - £20000	**15 points** £5000 - £10000 £5000 - £10000	**20 points** <£5000
5.2 What is the cost per QALY of this intervention? **QALY** = Quality-Adjusted Life Year. NICE uses range £20K - £30K	**0 points** >£30000	**5 points** £>20000 - £30000	**10 points** £>10000 - £20000	**15 points** £5000 - £10000	**20 points** <£5000
5.3 What is the cost per QALY SORI of this intervention? **SORI** = Social Return on Investment. Use if known, and ICER and QALY unknown	**0 points** Worse than 1:1	**5 points** 1.1 – 2:1	**10 points** 2.1 – 5:1	**15 points** >5:1	**20 points** Not allocated

*The change in effects is usually measured in terms of the number of life-years gained or quality-adjusted life years gained by the intervention.

If there is no information relevant to this criterion the default score is 10.

7 Addresses health inequality or health inequity

Health inequalities are the differences in health and wellbeing which we can measure between different population groups and geographical populations. They are caused by social determinants and are a reflection of the strata of educational achievement and income levels in society.

Where health inequalities are attributable to the external environment and conditions mainly outside the control of the individuals concerned, such as difficulty in accessing services, the uneven distribution may be unnecessary and avoidable as well as unjust and unfair. The resulting health inequalities also lead to inequity in health, i.e. health inequity

For example., this would be relevant to provision or lack of a service that discriminates against a population group with high prevalence of a condition, or unfair lack of access to a relevant service for a particular group (e.g. haemoglobinopathy service for ethnic minority group)

Where an intervention does not specifically target a group affected by known health inequalities or health inequities then the score will be zero. CPAG does not take account of socio-economic gradients when the intervention is accessible by the population as whole.

7.1 Health inequality is the difference in health status or the distribution of health determinants between different population groups **7.2 Health inequity** is the uneven distribution of health determinants that may be avoidable, unjust and unfair, leading to inequity in health	**0 points** if it does not address any inequality or inequity	**5 points**	**10 points** if it partially addresses an identified inequality or inequity	**15 points**	**20 points** if it completely addresses an identified inequality or inequity

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Where there is no direct application, the questions could be framed differently to ask whether the intervention will enhance the standard interventions (such as early years programmes and lifestyle change) which are believed to work to reduce inequalities. The question might be aimed at understanding the likelihood the impact of the intervention on risk – population, occupational, or individual risk, using the best clinical and social evidence available.

What is the impact in terms of reducing risk?	0 points No evidence	5 points Evidence is weak	10 points Modest evidence	15 points Good evidence	20 points Strong evidence

The score is for the proposed or existing service. If the score may lead to a service being decommissioned then an Equality Impact Assessment and Quality Impact Assessment are required for the decision making committee.

Criterion 8 asks whether an intervention/service delivers national or local requirements and targets.

The supplementary question on the modified Portsmouth scorecard is:

does the intervention support the CCG in delivering identified national requirements or local priorities/targets?

This paper sets out pointers to CPAG members to ensure consistency in assessing interventions against this criterion.

National requirements

The national requirements which may be met by an intervention should fall into one of four categories:

i) requirements in the NHS planning guidance (currently Everyone Counts)

eg planned outcomes from taking the 5 steps recommended in the "commissioning for prevention" report

ii) national strategies published by the Department of Health

eg *Living well with dementia: A National Dementia Strategy*

iii) NICE guidance including Quality Standards (QS)

eg QS10 Chronic obstructive pulmonary disease (COPD)

As the Quality Standard is derived from the Clinical Guidance, this can only score once, but the QS may make it clearer how the intervention supports the CCG in delivering that guidance.

IPGs are not counted as guidance - they give an indication as to the acceptability of a procedure in terms of safety and efficacy, but do not constitute a NICE recommendation.

Mandatory requirements which are subject to a NICE TAG are not considered by CPAG.

iv) NHS national outcome frameworks

eg school readiness: the percentage of children achieving a good level of development at the end of reception

The Group will assess how far the intervention/service supports the CCG in delivering **specific** aspects of these requirements in deciding to allocate a score.

Guidelines and strategies from national bodies such as the Royal College of Physicians or British Thoracic Society and from international bodies such as the World Health Organisation are not considered in this criterion. However it will be the case often that these guidelines or strategies may provide the evidence summarised in the narrative for assessing the benefit of the intervention.

Local requirements

The local requirements which may be met by an intervention should fall into one of two categories, and be set out in the current CCG strategy:

i) Locally determined priority – including priorities identified through public engagement

   eg frail elderly

ii) Local planning trajectory

   eg Years of Potential Life Lost (YPLL) – addressing identified major causes of avoidable mortality such as cardio-vascular disease.

iii) Health and Wellbeing strategy

   eg best start in life

The Group will assess how far the intervention/service supports the CCG in delivering **specific** aspects of these requirements in deciding to allocate a score.

NB Where a local priority reflects national guidance it should not be counted twice.