Lincolnshire COUNTY COUNCIL
Working for a better future

# LINCOLNSHIRE HEALTH AND WELLBEING BOARD

Open Report on behalf of Dr Tony Hill, Executive Director of Public Health

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| Report to | **Lincolnshire Health and Wellbeing Board** |
| Date: | **27 September 2016** |
| Subject: | **Prioritisation Framework for the Development of the Joint Health and Wellbeing Strategy** |

**Summary:**
A report was presented to the HWBB in June 2016 setting out some proposed principles for developing the next JHWS as well as a draft prioritisation framework which the HWBB agreed should be further reviewed and tested as part of its informal session on 12th July 2016.

On the 12th July a workshop was held with members of the HWBB alongside wider partners and stakeholders. The objectives of the session were to:

1. Agree the key criteria for use within the prioritisation framework for the next JHWS
2. Weight the criteria to reflect the varying importance each one has in prioritising JSNA evidence
3. Test the prioritisation framework with a JSNA topic commentary (the draft Breastfeeding topic commentary was used for this purpose due it already having been completed)

The workshop successfully reviewed the criteria and made recommendations for amendments, agreed a weighting for and assigned a score to each criterion within the framework. Following the workshop the framework has been amended along with a proposed weighting of criteria based on feedback and weighting from individual tables at the workshop.

The HWBB is therefore asked to agree the prioritisation framework at Appendix A and that final refining is undertaken following further testing

**Actions Required:**
The Health and Wellbeing Board is asked to:

- Consider the feedback from the workshop on the prioritisation framework for the

next Joint Health and Wellbeing Strategy for Lincolnshire; and
- Agree the Prioritisation Framework for developing the next Joint Health and Wellbeing Strategy for Lincolnshire.

## 1. Background

Currently the JHWS produced by the Health and Wellbeing Board for Lincolnshire (HWBB) is due to end 2018 and the review of the JSNA which is being undertaken will be expected to form the basis upon which a new JHWS will be developed.

A report was presented to the HWBB in June 2016 setting out some proposed principles for developing the next JHWS as well as a draft prioritisation framework which the HWBB agreed should be further reviewed and tested as part of its informal session on 12th July 2016.

The HWBB agreed in June were that adopting a prioritisation framework will assist with the prioritisation process in a systematic way, ensuring a clear, rational approach and a defensible, transparent process for local decision making, whilst ensuring the active engagement of key stakeholders in the development of the JHWS. In order to achieve this the following core principles for developing the next JHWS were agreed as follows:

1. Stakeholder engagement (that builds public and patient confidence in the process)
2. A clear and transparent process
3. Careful information management
4. Decisions based on clear value choices (underpinned by a sound evidence base)
5. Selection of an agreed prioritisation methodology that takes into account the ranking/scoring of a range of factors, or 'criteria'.

The initial criteria the HWBB agreed to review in a workshop session were as follows:

- **Strategic fit** with national and/or local policy and outcome frameworks
- Potential to reduce or improve **health inequalities/equity**
- **Strength of evidence** demonstrating better outcome or being receptive to change
- Consideration of any economic evaluations undertaken to ensure **value for money**
- Likely **magnitude of benefit** relating to improved clinical and social outcomes
- Scale of impact in terms of the **number of people benefiting**
- **Public acceptability** based on wider recognition of the priority by the population
- Unintended consequences based on **risk of not investing/prioritising**
- Impact and likelihood to delay and prevent need through **supporting prevention**

### Workshop Session

On the 12th July a workshop was held with members of the HWBB alongside wider partners and stakeholders. The objectives of the session were to:

4. Agree the key criteria for use within the prioritisation framework for the next JHWS
5. Weight the criteria to reflect the varying importance each one has in prioritising JSNA evidence
6. Test the prioritisation framework with a JSNA topic commentary (the draft Breastfeeding topic commentary was used due it already having been completed)

These objectives formed the basis of three separate exercises in the workshop.

### Feedback

In total 31 people attended the workshop and were placed across five tables. Each table worked through each objective in turn. A full summary of feedback for each of the individual objectives/exercises above is provided at Appendix A.

Some key messages from the session included the following points:

- Framework needs to incorporate a time component to reflect the length of time over which outcomes or impacts might be realised.

- The JSNA commentaries need to be effectively peer reviewed before being used as the basis for prioritisation to ensure they contain all the necessary information upon which scoring judgements can be made

- Whilst the criteria are not in any order of importance as set out, it was felt that prevention criteria should appear at the top of the framework rather than the bottom.

- Magnitude of benefit (regarding outcomes) and scale of benefit (regarding numbers of people benefitting) should be merged into one criterion.

The resultant draft prioritisation framework to support the HWBB in developing the next JHWS for Lincolnshire is attached at Appendix B to this report.

**Next Steps**

The JSNA continues to be reviewed and the assurance and peer review process has been made more robust to ensure the JSNA commentaries provide the evidence required to enable to HWBB to undertake the JHWS prioritisation.

It is planned that the prioritisation work will be undertaken between January and March 2017 and workshops will be arranged to enable both the HWBB and stakeholders to take part in this work.

Further engagement will then be undertaken with the wider public prior to the JHWS being drafted in line with the current strategy coming to an end in March 2018.

## 2. Conclusion

All tables at the workshop successfully reviewed the criteria and made recommendations for amendments, agreed a weighting for and assigned a score to each criterion within the framework. Following the workshop the framework has been amended along with a proposed weighting of criteria based on feedback and weighting from individual tables at the workshop. There are some limitations to the framework however with some further testing and refinement it is expected that these can be addressed.

The framework itself performed in a fairly consistent way following sensitivity analysis and so is judged to be fit for purpose from this perspective.

The HWBB is therefore asked to agree the prioritisation framework at Appendix A and that final refining is undertaken following further testing.

## 3. Consultation

A full consultation and engagement plan is being developed to ensure that statutory requirements are met in the development of the JHWS for Lincolnshire.

## 4. Appendices

Appendix A – Feedback from workshop held 12 July 2016

Appendix B – Draft Prioritisation Framework for the development of the Joint Health and Wellbeing Strategy for Lincolnshire

## 5. Background Papers

No background papers within Section 100D of the Local Government Act 1972 were used in the preparation of this report.

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**Appendix A – Feedback from workshop held 12 July 2016**

Exercise 1: Agree the key criteria for use within the prioritisation framework for the next JHWS

| Criteria | Summary Feedback | Recommended Action |
|---|---|---|
| 1. Strategic Fit | Local policy context was felt to be of greater importance so statements can be amended to reflect this. | Wording has been amended to that scoring favourably weights the alignment and 'fit' of the JSNA topic area with local policy priorities/ measures, as opposed to solely being a national priority/indicator. |
| 2. Health inequalities/equity | Difference between health inequality and equity requires explaining and reflecting in scoring statements | Wording of criterion and scoring statements has been amended |
| 3. Strength of evidence | Scoring statements need to reflect a less strict academic framework to allow for impact of wider knowledge and softer evidence | This amendment has been made to provide a balance of qualitative and quantitative evidence within the scoring |
| 4. Value for money | Scoring statements need to reflect a time component and also incorporate the potential value for money benefit as well as any evidence of actual VFM calculations already undertaken | Potential for value for money and timeframes have been incorporated. |
| 5. Magnitude of benefit (clinical and social) | Need to clarify difference between clinical and social outcomes. Scoring statements need to reflect qualitative and quantitative scales. Potential for double counting across number of people benefitting so perhaps these criteria could be combined. | Statements and criterion amended to remove any differentiation between clinical and social outcomes. Criterion merged with number of people benefitting and incorporating qualitative and quantitative component. |
| 6. Number of people benefitting | Need to incorporate qualitative element to scoring statements | See above |
| 7. Public acceptability | Change heading to reflect the criterion is about "Public understanding and engagement". Current wording is vague and changing would enable evidence to be drawn from the Local Views section of the JSNA commentary | Heading changed with further definition provided and JSNA process strengthened to ensure that where views have been sought as part of topic that these are captured in the JSNA commentary. |
| 8. Risk of not prioritising | Remove reference to "unintended consequences" from criterion and include inter-dependencies to other services within statements | Removed "unintended consequences" and amended statements to reflect interdependencies |
| 9. Supporting prevention | Remove reference to "call for action" and define what is meant by prevention as well as review statements to ensure they are quantifiable. Move prevention criterion to the top of the list. An element of time is required for this criterion. | Reference to "call for action" removed and statement reviewed. Criterion moved to top of list. Time has not been included in the amended framework. Given the scope of the JSNA it would be difficult to define this explicitly. However, clearer definition has been built in which focuses criteria more clearly around primary, secondary and tertiary prevention. |

Exercise 2: Weight the criteria to reflect the varying importance each one has in prioritising JSNA evidence

| Criteria | Weighting by workshop table | | | | | Proposed Weighting |
|---|---|---|---|---|---|---|
| | Table 1 | Table 2 | Table 3 | Table 4 | Table 5 | |
| Strategic fit | High | Low | High | Medium | Low | **Medium** |
| Health inequalities/equity | High | Medium | High | High | High | **High** |
| Strength of evidence | High | Medium | High | High | High | **High** |
| Value for money | High | High | High | Medium | Medium | **High** |
| Magnitude of benefit (clinical and social) | Low | High | High | High | High | **High** |
| Number of people benefitting | Medium | High | High | Low | Low | |
| Public acceptability | High | Low | Medium | Medium | Low | **High** |
| Risk of not prioritising | Medium | Medium | Medium | Low | Low | **Medium** |
| Supporting prevention | High | Medium | High | High | High | **High** |

Tables were consistent in 6 of the 9 criteria resulting in a clear majority in favour for one weighting. The most consistent criteria were "Health inequalities/equity", "Strength of evidence", "Magnitude of benefit" and "Supporting prevention" all of which received a weighting of high from 4 of the 5 tables.

For 3 of the 9 criteria there was not a majority opinion:

- For "Strategic fit" the median weighting was used as 2 tables selected it as high, 2 as low and 1 as medium.

- Applying the proposal from Exercise 1 to merge the "Magnitude of benefit" and "Number of people benefitting" criteria this provided a majority across the two for high priority. Had these two criteria not been merged "Magnitude of benefit" would have been weighted as high and "Number of people benefitting" would have been weighted as medium using the same rationale as for "Strategic fit".

- "Public Acceptability" did not demonstrate a clear majority decision or an obvious median position to take as 2 voted for a medium weighting of this criteria and 2 for low (with 1 voting it a high weighting). Given there were concerns raised about the vagueness of the criteria in earlier discussions and that this may have affected the weighting some tables gave it has been proposed that in the final criterion this is given a medium weighting.

The proposed weightings in the table above have also been included in the draft prioritisation framework at Appendix B.

Exercise 3: Test the prioritisation framework with a JSNA topic commentary

Each table was given the Breastfeeding JSNA topic commentary and was asked to systematically work through the framework scoring each of the criteria within the prioritisation framework. Where a criteria was judged to be low, the score was multiplied by a factor of 1; where the criteria was judged as medium, the score was multiplied by 2 and where they were judged as high they were multiplied by a factor of 3.

Due to tables having weighted the criteria independently of each other during Exercise 2, there were wide variations in the resultant scores which could be misinterpreted as meaning that the prioritisation framework was not robust enough.

To test this, sensitivity analysis of the results was performed by applying each tables scores for each criteria to both the proposed weighting and the weighting each table applied to see what effect this had on the final ranking of each tables results.[1]

Substituting individual table weightings with that of the proposed weighting to the scores resulted in a slight shift in the ranked order between tables 2, 3 and 5. However the difference between weighted scores for these three was not greater than 10% under the proposed weighted criteria. Table 1 and table 4 were ranked highest and lowest respectively regardless of whether their own table weighting or the proposed weighting was applied.

| Criteria | Table 1 | Table 2 | Table 3 | Table 4 | Table 5 |
|---|---|---|---|---|---|
| Strategic fit | 4 | 4 | 3 | 2 | 4 |
| Health inequalities/equity | 3 | 4 | 4 | 2 | 4 |
| Strength of evidence | 5 | 5 | 4 | 3 | 4 |
| Value for money | 4 | 1 | 3 | 1 | 1 |
| Magnitude of benefit (clinical and social) | 5 | 4 | 4 | 1 | 5 |
| Number of people benefitting | 5 | 5 | 4 | 5 | 5 |
| Public acceptability | 4 | 3 | 3 | 1 | 3 |
| Risk of not prioritising | 3 | 2 | 2 | 2 | 3 |
| Supporting prevention | 5 | 3 | 4 | 3 | 5 |
| **TOTAL** | **38** | **31** | **31** | **20** | **34** |

*Scores by criteria and table when assessing Breastfeeding JSNA topic commentary*

| Workshop Table | Unweighted | | Table weighting | | Proposed weighting | |
|---|---|---|---|---|---|---|
| | Score | Rank | Score | Rank | Score | Rank |
| No. 1 | 38 | 1 | 96 | 1 | 98 | 1 |
| No. 2 | 31 | 3 | 65 | 4 | 79 | 4 |
| No. 3 | 31 | 3 | 88 | 2 | 81 | 3 |
| No. 4 | 20 | 5 | 42 | 5 | 50 | 5 |
| No. 5 | 34 | 2 | 71 | 3 | 87 | 2 |

*Score and rank of workshop tables when assessing Breastfeeding JSNA topic commentary*

Summary

All tables at the workshop were able to review the criteria, agree a weighting and assign a score to each criterion despite the feedback provided on the criteria themselves at Exercise 1. However, due to the need to refine and clarify the criteria and the statements attached to them it is possible that attendees/tables applied different interpretations to the same criterion which would explain the variance in the scores given. The proposed weighting has resulted in 6 criteria being weighted as high and 2 as medium. Due to this lack in range within the weighting there is a risk of "clustering" of scores which may lead to difficultly in differentiating between JSNA topics when prioritising them. Evidence from another area, whose prioritisation framework this tool was based on, was that it not result in this "clustering" happening. However, further refinement of the tool might be required once the first cohort of JSNA topics have been tested within the tool.

[1] Wilson, E. C., Rees, J., & Fordham, R. J. (2006). Developing a prioritisation framework in an English Primary Care Trust. Cost Effectiveness and Resource Allocation, 4(1), 1

## Appendix B – Draft Prioritisation Framework for the development of the Joint Health and Wellbeing Strategy for Lincolnshire

| JHWS Prioritisation Framework Criteria | Weighting of criteria | Very Low (Score = 1) | Low (Score = 2) | Mid-scale (Score = 3) | High (Score = 4) | Very High (Score = 5) |
|---|---|---|---|---|---|---|
| **Supporting prevention** Does addressing the topic area (i) improve the overall health and wellbeing of the population; (ii) reduce the escalation of health and care needs in future, e.g. through identifying individuals at risk of health conditions or events; (iii) maximise peoples independence through effective treatment and recovery of health conditions? | Medium | No evidence of improvement to health, delay or prevention in the use of healthcare services and/or improvement treatment and recovery | Slight evidence of improvement to health, delay or prevention in the use of healthcare services and/or improvement treatment and recovery | Moderate evidence of improvement to health, delay or prevention in the use of healthcare services and/or improvement treatment and recovery | Significant evidence of improvement to health, delay or prevention in the use of healthcare services and/or improvement treatment and recovery | Strong evidence of improvement to health, delay or prevention in the use of healthcare services and/or improvement treatment and recovery |
| **Strategic fit:** National requirement or Outcome Framework indicator (PH, NHS, ASC) or local policy priority. | High | Not a national requirement or indicator and no clear local policy priority | Addresses one or more national requirements or indicators but is not a local policy priority | Addresses one/two national requirements or indicators and is a local policy priority | Addresses three national requirements and/or indicators and is a local policy priority across two or more partners | Addresses four or more national requirements and/or indicators and is a policy priority across multiple partners (three plus) |
| **Health inequalities/equity:** The criteria incorporates both health inequity (an unfair or unjustifiable difference in health) and health inequality (differences in health arising from social inequalities in the conditions in which people are born, grow, live, work & age). The criteria assesses the scale of inequalities (defined as inequalities in access and outcomes) as relevant to the JSNA topic area. | High | No evidence of inequalities/inequity amongst different groups of individuals, as relates to the topic area. | Limited amount of evidence of inequalities/inequity affecting a small number/group of individuals, as relates to the topic area. | Evidence of geographic or population-based inequalities, affecting a moderate number/group of individuals | Significant evidence of geographic or population-based inequalities, affecting multiple groups of individuals | Strong documented evidence exists demonstrating the impact of persistent & wide-scale geographic or population-based health inequalities/inequity affecting a large section of the community. |
| **Strength of evidence:** How strong is the evidence of need contained within the topic commentary? Does it include a mixture of both qualitative & quantitative data sources to provide a broader context around the topic area? | High | Evidence of need is poor | Evidence of need is limited to one type of data source | Evidence of need includes a combination of qualitative & quantitative data sources but there | Evidence of need includes a combination of qualitative & quantitative data sources with a | Evidence of need is robust containing strong and consistent evidence of need derived from |

| JHWS Prioritisation Framework Criteria | Weighting of criteria | Very Low (Score = 1) | Low (Score = 2) | Mid-scale (Score = 3) | High (Score = 4) | Very High (Score = 5) |
|---|---|---|---|---|---|---|
| | | | | is no consistent 'message' regarding needs | coherent & consistent 'message' regarding needs | multiple & diverse data sources. |
| **Value for money:** The criteria assesses the extent to which value for money considerations regarding service/activity interventions are evidenced in the JSNA topic area. Have any calculations been undertaken, e.g. Spend and Outcome (Return on Investment) Tools (SPOT)? | High | No VFM calculations available | VFM calculations available and demonstrate poor value for money | VFM calculations available showing cost effective service interventions (or the potential for them to be delivered) across a short timeframe only (1-2 years) | VFM calculations showing cost effective service interventions that deliver (or the potential to deliver) sustained value for money across a short and medium term period (3-5 years) | VFM calculations and/or good programme budgeting intelligence to support investments that deliver (or have the potential to deliver) VFM across short, medium and longer term |
| **Magnitude & scale of benefit :** What is the scale of the benefit in terms of quality of life improvements and size of population (potentially) affected? The criteria incorporates (i) scale of improvements in health or life expectancy and (ii) number of people benefitting/affected. | High | Negligible improvement in health or life expectancy with <1% of the population (approximately 700-800 people) affected/benefiting | A small improvement in health or life expectancy with 1%-3% of the population (approximately 800 to 20,000 people) affected/benefiting | Moderate improvements in health or life expectancy with 3%-5% of the population (approximately 20,000 to 35,000 people) affected/benefiting | Significant improvements in health or life expectancy with between 5%-7% of the population (approximately 35,000- 50,000) people affected/benefiting | Large and proven improvements in health or life expectancy with >7% of the population (approximately >50,000 people) affected/benefiting |
| **Public Understanding & Engagement:** This criteria considers the extent to which there is consistent and robust evidence regarding the local views and priorities from stakeholders incl. residents and/or service users. | Medium | No evidence of views from stakeholders, patients, residents and/or service users | Weak evidence of views from stakeholders, patients, residents and/or service users | Evidence of views from stakeholders, patients, residents and/or service users is provided but no consistent 'messages' are evident | Some evidence of strong views from stakeholders, patients, residents and/or service users | Comprehensive engagement leading to evidence of strong & informed views from stakeholders, patients, residents and/or service users. |

| JHWS Prioritisation Framework Criteria | Weighting of criteria | Very Low (Score = 1) | Low (Score = 2) | Mid-scale (Score = 3) | High (Score = 4) | Very High (Score = 5) |
|---|---|---|---|---|---|---|
| **Risk of not prioritising:** This criteria considers the risk of not prioritising the topic area having considered the level of need (incorporating trend, severity of need, comparator data, etc.) evidenced in the topic commentary. | High | No risk | Risk is low. Available evidence suggests low risk (i.e. because data demonstrates needs are stable & in-line with regional, national or comparator area data) | Risk is fairly high. Available evidence suggests fairly high risk (i.e. because data demonstrates above-average prevalence/need relative to regional, national or comparator areas and/or a gradual worsening trend) | Risk is high. Available evidence suggests high risk (i.e. because data demonstrates need is worse when compared to regional, national and/or comparator areas and/or a worsening trend that is predicted to continue). | Risk is very high. Available evidence suggests very high risk (i.e. because data demonstrates need is significantly worse than regional, national and/or comparator areas, with a rapid worsening of need over time if the topic need is not addressed.) |