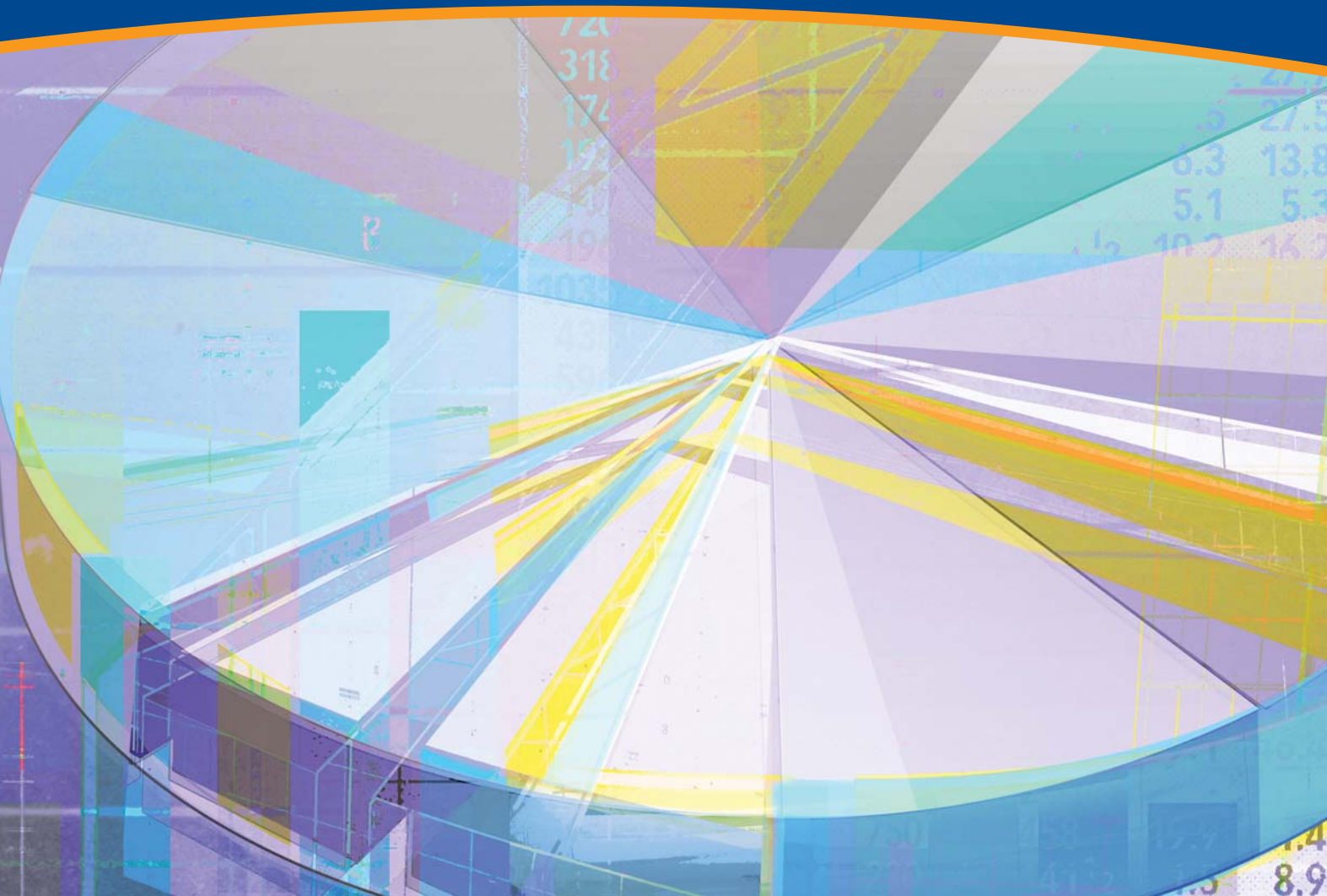


Priority setting: an overview



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Introduction

The Department of Health has begun a push to create “world-class commissioning” and is developing a range of tools, approaches, outcome measures and competences to support this. This initiative is the most serious attempt to reposition commissioning as central to the way the NHS operates since the introduction of the purchaser provider split in 1990. The NHS Confederation welcomes this initiative and the Primary Care Trust Network is fully engaged in influencing policy in this area.

One of the key skills that any commissioner will need is the ability to identify priorities. It is still the case that a large amount of the resources committed reflect historic patterns of provision, the particular approach of local providers or even individual clinicians. To change this there will be a need for high-quality, evidence-based and systematic decision making to support the development of the commissioning plan and to feed into the annual contracting round.

In addition, the number of high-cost treatments and increasingly vocal interest groups makes the task of allocating resources one of the most

politically sensitive and complex issues facing any part of the NHS.

The purpose of this report, and the series of *Briefings* that follows it, is to support the development of decision making in this difficult area. Although it is aimed primarily at those directly involved in resource allocation, the series should also be helpful to a wider audience including providers and policy makers.

The series has been written by practitioners in the field and so are based on experience in this evolving field. The evidence base is still in an early stage of development, so this should still be regarded as work in progress and primary care trusts will need to develop their own approach to this area.

Improving the quality and transparency of decision making, involving the public, patients, providers and other stakeholders, and building the capacity of commissioners to take and then implement these decisions will be an important task over the next few years as we work towards a more world-class vision of commissioning.

Why is priority setting so important?

Need and demand for healthcare always exceeds the funding that is available to the NHS. This requires PCTs to prioritise needs into those that will be met and those that will not. The challenge lies in arriving at fair decisions which properly balance competing needs. Being aware of the consequences, or the opportunity costs, of different funding options is crucial to this process. What is funded and what is not funded are different sides of the same coin and cannot be separated.

Rationale for achieving robust and fair resource allocation

- it improves the overall health and wellbeing of the population
- it aligns investment to pre-agreed strategies, priorities and policies
- it is more ethical because it gives competing needs a fair hearing
- it is a requirement of good corporate governance
- it increases public and patient confidence
- it adds legitimacy to decision making
- it helps achieve financial balance
- it provides better value for money
- it reduces the risk of successful legal challenge
- it is operationally more efficient.

Characteristics of robust priority setting

There are some characteristics which can be observed in commissioning organisations which have good priority setting processes. Organisations that demonstrate these characteristics are, in the experience of the author, better placed to cope with many of the challenges and threats to fair priority setting. The characteristics are outlined below.

1. A sound grasp of priority setting

Organisations which have a coherent understanding of priority setting, including knowledge of the law, reduce uncertainty and risk and are more robust to challenge.

2. Organisational cohesion

Cohesion results when there is a shared understanding of how priority setting will be done in the PCT and when all individuals and groups within the PCT act in accordance with that understanding. This leads to a high degree of consistency in decision making.

3. Consistent behaviour

A good way to influence clinicians and trusts is for the organisation to be predictable in its responses. This is particularly the case in relation to the management of individual funding requests. Organisations which have adopted consistent messaging and behaviours frequently report a fall in the number of requests.

The importance of consistency in priority setting

The need for consistency is one of the cornerstones of good practice.

Consistency in word – PCTs need to communicate consistent messages both internally and externally. To do this individuals and committees within the PCT should be familiar with their organisation's priority setting framework and adopt a common language in relation to priority setting.

Consistency in action – PCTs need to respond to the same situation in the same way every time. Becoming predictable to those outside the PCT is desirable and is achieved by the PCT doing what it says it is going to do. To deliver consistency in action, procedures need to be put in place and strictly adhered to. Procedures for dealing with emergencies or unusual circumstances can be agreed in advance so they need not be managed 'on the hoof.'

Consistency in decision making – PCTs need to apply the principles they have adopted and refer to the factors they have decided to take into consideration to all priority setting undertaken by the PCT.

4. The adoption of protocol-driven decision making

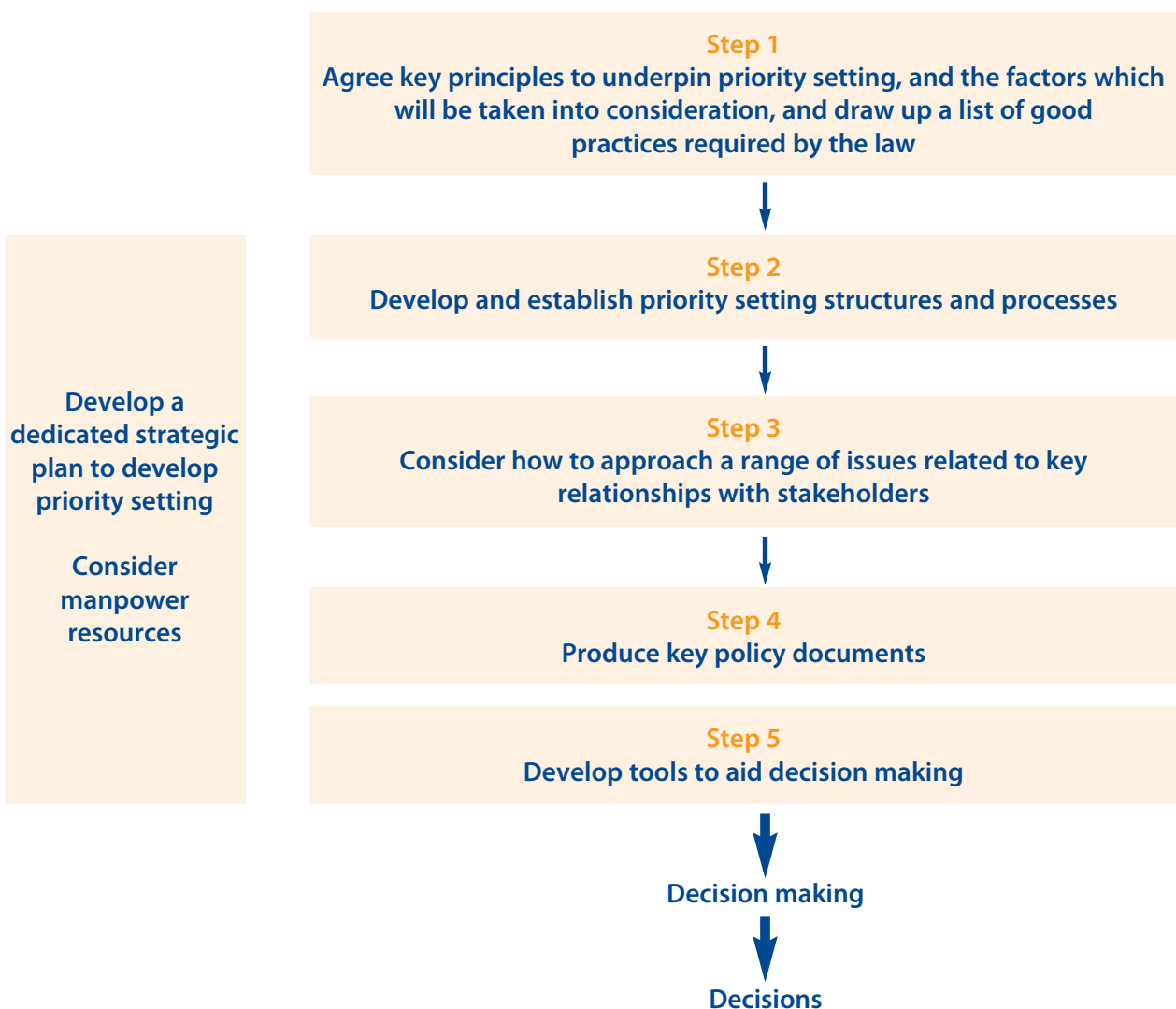
PCTs, like clinicians, come across the same scenarios time and again. Good commissioning practice, like good clinical practice, is policy and protocol-based. Organisations which adopt this approach have better documentation which leaves a more thorough audit trail. This all adds to consistent, efficient and timely decision making. Despite concerns that might exist to the contrary, protocol-based decision making does allow organisations to respond to unique and unusual individual need.

'Despite concerns to the contrary, protocol-based decision making allows organisations to respond to unique individual need.'

How to build up a priority setting framework

Figure 1 illustrates how, by taking a number of clearly defined steps, a PCT can build up a priority setting framework by ensuring each of the key elements is given careful consideration. Each step is described on the following pages.

Figure 1: Steps in developing a priority setting framework



Step 1: Agree key principles to underpin priority setting

The first step is to consider the *key principles* (values, rules and assumptions – for example, equity) and *key factors* (determinants, parameters and considerations – for example, clinical effectiveness) that the PCT will take into account when making decisions. Another task is to understand and set out good practice. Step 1 is heavily influenced by the law.

Step 2: Develop and establish priority setting structures and processes

The second step is to map out how the PCT will deliver decision making. This requires consideration of operational issues: the policies that are needed to support decision making, the structures and processes to be put in place and how decisions are to be documented. This is a detailed task. Things that might be covered include:

- which decisions individuals can make and which decisions groups should make
- the constitution of decision-making bodies
- the role of bodies such as overview and scrutiny committees, clinical networks and patient groups, and the status of their recommendations
- the role and responsibilities of provider trusts in relation to prioritisation and resource allocation
- setting out dates for key milestones of the annual commissioning round.

Step 3: Consider how to approach a range of issues related to key relationships with stakeholders

The third step is to consider a group of issues which can loosely be put under the umbrella of ‘relationships’. These include:

- patient and public engagement
- communications with patients and carers
- working with clinicians, providers and other PCTs, and the role of the NHS Contract
- responding to queries from politicians, the Department of Health and the media
- training and support for decision makers
- internal and external audit.

Step 4: Produce key policy documents

It is crucial that each PCT sets out in a single document how it will approach resource allocation. For the purpose of this series this will be called the ‘overarching policy document on priority setting.’ This should include the principles that the PCT has adopted, the factors which will be taken into account when making a decision, the structures which will support decision making and a scheme of delegation that sets out which decisions specific groups and individuals can make.

The overarching policy document should also set out the roles, responsibilities and status of the recommendations of networks, professional bodies, the National Institute of Health and Clinical Excellence (NICE) and the overview and scrutiny committee (OSC). It also needs to cover the full range of decision making related to priority setting,

including how the annual commissioning round will be handled. The author is aware of at least one PCT which had its overarching policy document approved by both the local OSC and all the local Members of Parliament.

There are a number of recurring issues to be usefully addressed as part of this step, through a series of policy statements. These statements can either be part of the overarching policy document or be addressed in a series of supplementary commissioning policies. Recommended policy statements include setting out the PCT's approach to:

- treatments under consideration in NICE's health technology programme
- requests seeking funding for patients coming off drug trials, and drug company sponsored funding
- requests from patients who have run out of private funds for private healthcare treatments not normally funded by the PCT
- patients seeking treatment abroad
- co-payment – which refers to private practice within the NHS
- experimental treatments
- funding research and development.

Step 5: Develop tools to aid decision making

The fifth step involves the actual decision making itself and relates mainly to strategy development and the annual commissioning round. The aim is to develop practical strategies and adopt tools to aid those making the decision. In particular, decision making in the annual commissioning round presents some major difficulties. These include:

- how to efficiently gather and process large quantities of information
- how to systematically assess and compare very different types of services
- how to ensure that all individuals contributing to the decision making have sufficient knowledge about all the services and treatments under consideration
- how to spread the information gathering and assessment across the whole year
- how to adopt wider involvement that is sustainable
- how to fairly and effectively disinvest and redistribute resources.

These are some of the most challenging issues PCTs currently face and as such are in need of urgent development.

A final consideration

Establishing and maintaining good priority setting requires an ongoing cycle of development, review and quality improvement. It should not be a one-off exercise. PCTs are encouraged to develop dedicated strategic and implementation plans for the development of resource allocation and assess the manpower and other resource requirements to run both operational and developmental aspects of priority setting.

The rest of this report will focus on aspects of Step 1.

'Establishing and maintaining good priority setting requires an ongoing cycle of development. It should not be a one-off exercise.'

Agreeing the key principles

Taking a whole-system approach

The current focus of priority setting is in relation to new treatments, particularly drugs, and individual funding requests. A whole-system approach is, however, needed. So, to begin with, the priority setting framework has to be relevant and applicable to *all areas of activity which involve prioritisation*. These are:

- developing healthcare strategies and timetabled implementation plans
- deciding how the budget will be allocated, including the redistribution of resources
- managing in-year service pressures and problems, including demand management
- dealing with individual funding requests.

The framework also needs to incorporate both *investment* and *disinvestment*.

The 'primacy of prioritisation'

One of the first and most fundamental issues to consider is how important is the process of prioritisation to achieve fair resource allocation. The obvious answer is that it is essential. But prioritisation is frequently bypassed in the NHS.

Currently, two very different approaches to decision making are used in the NHS. Take, for example, a newly licensed drug. The decision maker can either:

- focus only on the drug, assess it and make a decision to fund, partially fund or not fund. This type of decision making is referred to as **singular decision making**; or
- assess the drug against certain criteria and prioritise its importance by comparing it with existing services and other potential competing

service developments. Whether the drug is funded depends on the priority it is given and how much money is available to the PCT either through new money or disinvestment. This type of decision making is referred to as **prioritisation**.

These two approaches are profoundly different; they ask different questions and require different factors to be taken into account.

There are good grounds to argue that the second approach is the method that should be adopted by public authorities, because:

- it allows all needs to be given a fair hearing
- it discourages queue jumping and is better able to resist pressure from special interest lobby groups and pharmaceutical companies
- it requires the decision maker to look at the whole of healthcare and not just an isolated healthcare intervention
- it forces the decision maker to consider the consequences of their decisions, because it demands that the opportunity costs are considered.

Singular decision making is commonly applied to decision making around drugs and new technologies. Indeed, it is probably the case that clinicians, patients and the public expect decisions to be taken this way. But at the same time, funding issues related to such things as investments in specialist nurses or whole new services are generally referred to the annual commissioning round. This is the case even when they represent better health gain than any of the new drugs or technologies under consideration. This creates an ethical dilemma as it means that the system is allowing a subset of funding decisions to be taken on a completely different basis and one which is seen to sanction a disregard for opportunity cost.

If organisations strive to distribute resources fairly *and* if they are of the view that consideration of opportunity cost is essential to that process, then they *must* construct their decision making in ways that reflect this. It is suggested, therefore, that the primacy of prioritisation be a fundamental principle of public sector resource allocation. Currently this translates into the primacy of the annual commissioning round although as other vehicles for priority setting emerge this might change.

This principle has major implications for the management of individual funding requests (as opposed to dealing with unique individual circumstance) and the management of in-year service pressures as we will see in a later *Briefing* in this series. It also requires considerable organisational commitment to implement because of the external pressures to fund treatments to which all PCTs are subject to on a daily basis. But to fund requests for new treatments without regard to prioritisation seriously undermines both the PCT and fairness.

Understanding the legal framework within which PCTs operate

PCTs must understand the law within which they have to operate. The relevant acts are the National Health Service Act and the Human Rights Act. In addition, the PCT should be familiar with the relevant case law arising from judicial review.

While the law is commonly perceived to be absolute, it is very much a mixture of reasonable PCT discretion and judicial instincts about fairness and justice. The law is a complex and evolving area and PCTs should strive to understand their basic rights and duties to patients.

Openness and accountability

In considering what is required of the PCT by way of openness and accountability, the NHS Act and national policy in relation to patient and public involvement will need to be taken into account. Within this there are absolute requirements which PCTs are bound by law to implement. There are also more discretionary and developmental elements such as involving more stakeholders in the priority setting itself.

Do's and don'ts

A detailed knowledge of the law can enable an organisation to draw up a 'do's and don'ts' list for priority setting. Judicial review, in particular, is interested in reasonableness and procedural fairness and not necessarily the outcome of the decision.

Some aspects of good practice will be given in this series of publications but they cannot be comprehensive.

Agree a list of considerations which will be taken into account when making decisions

As well as key underpinning principles which might be set out in a PCT's mission statement and the primacy principle, the PCT will also need to generate a list of considerations which it will take into account when making a decision. There are no right or wrong answers but it has already been seen that this list is likely to be made up of a combination of principles and factors. This is a difficult task and some points of caution are needed.

Firstly, the PCT should resist any attempt to simply import this list from examples of good practice elsewhere. To become embedded in local commissioning culture it is vital that the principles and factors are owned by all members of the PCT and by wider stakeholders (especially patients and the public) in the local community. It is worth spending time and effort working with stakeholders to determine the values that they feel should underpin prioritisation and resource allocation given that resources are finite and difficult choices have to be made.

Secondly, the list has to apply in all settings; therefore, the PCT needs to take into account the full range of funding issues that it regularly faces. The risks of developing frameworks only in the context of individual funding requests is that these frameworks commonly omit key considerations such as clinical and service risks and quality issues (some of which might not represent any health gain at all). The role of risk assessment in decision making is probably more important than is commonly recognised. An example of a service risk which many commissioners will recognise is the need to invest in additional staff in a critical shortage specialty where a lack of investment would lead to a loss of staff, the result of which might lead to the population having no local service at all.

Finally, focusing only on individual funding requests risks developing a framework that does not retain a population perspective, thereby creating the ethical dilemma, once again, of having the organisation allocate resources using different criteria in different settings. For example, the case for funding individual patients is frequently presented in terms of medical ethics and the principle of the duty of care to individuals. However, it is questionable whether the principles

of patient autonomy (the right of patients to make decisions about their medical care), beneficence (provide benefit and not withhold benefit) and non-maleficence (do no harm) are appropriate in this situation. This is because the principles focus the decision on the patient's ability to benefit and give precedence to the values of the individual patient. Although these are relevant considerations, they cannot solely determine the outcome because the interests of other patients should also be considered.

A list of factors which frequently appear in PCT documents are listed in Figure 2, not necessarily in order of importance.

Figure 2. Common factors which PCTs take into account when allocating resources

- nature of the health gain
- confidence in the clinical evidence
- number of individuals benefiting
- cost effectiveness
- need to redress inequalities and inequities of access
- accessibility
- national priorities
- stated local priorities
- clinical risk
- service risk
- absolute cost of the development
- legislation and directives
- patient choice.

The list the PCT finally arrives at and the weightings which may be given to each item is a key output of Step 1. An example is shown in Figure 3.

Figure 3. An example of stated principles underpinning resource allocation

We will prioritise options for funding against the following framework:

1. **Health outcome** – we will prioritise interventions that produce the greatest benefit for our population.
2. **Clinical effectiveness** – we will prioritise interventions with sound evidence of effectiveness.
3. **Cost effectiveness** – we will prioritise interventions which yield the greatest benefit relative to cost of provision.
4. **Equity** – we will prioritise on the basis of clinical need, not on the basis of age, gender, ethnicity or lifestyle.
5. **Inequalities** – we will prioritise to ensure full access to existing pathways for the majority over funding for new or experimental technologies for the minority.
6. **Access** – we will prioritise delivery of care as close to the patient as possible, where this meets governance standards.
7. **Patient choice** will be considered whenever possible. Patients will be given informed access to appropriate options. We will not, however, fund treatment for one patient that could not be offered to all patients with equal clinical need.
8. **Disinvestment** – we will review existing services to ensure diversion of resources from less effective to more effective services wherever possible.
9. **Quality** – we will aim to commission and monitor services against agreed quality standards.
10. **Affordability** – we recognise that not all interventions with evidence of clinical and cost effectiveness will be affordable from fixed budgets. Further prioritisation may be necessary in line with national and local strategies and health needs assessment.

In addition, the PCT has adopted the primacy principle, expressed as follows:

- The local delivery plan (LDP) is the mechanism through which investment and disinvestment decisions are taken.
- Interventions recommended in NICE technology appraisals will be implemented only on publication of guidance unless previously prioritised through the LDP round.
- We do not expect to introduce any healthcare intervention in-year outside this process since to do so will take resources from identified priorities.

Adapted from Warwickshire Primary Care Trust, *Commissioning principles*, January 2007

Conclusion

Resource allocation and priority setting is a vital function, the responsibility for which rests with PCTs. Much progress has been made over the years and more can be anticipated. There is, more than ever, a need for PCTs to ensure that they carry out this task to the best of their ability and work in a

systematic way towards ongoing improvement. The challenges facing the NHS in relation to scarcity of resource are best met with PCTs working collaboratively, both between themselves and with their own local community.

Key action points

- When developing a priority setting framework be systematic, work through all elements and consider all equally important.
- Develop a framework which will be applied to all priority setting in the PCT.
- Make priority setting a major workstream of the PCT in its own right.
- Secure sufficient resources within the PCT to undertake both routine and developmental aspects of resource allocation.
- Draw up a set of good practice guidelines in relation to decision making or ask your lawyers to do it for you.
- Give very careful consideration to the primary principle and its implications. If adopted then commit to it.
- Agree the important principles and factors which will inform decision making.
- Produce a document that describes how resource allocation will be undertaken by the PCT and, if possible, get this approved by the overview and scrutiny committee and local MPs.
- Assess the PCT's knowledge and understanding of the law.
- Adopt the policy that legal training should be mandatory for certain posts and arrange training days as required.
- Contract with your lawyers to provide legal updates and make recommendations if changes to policies and processes are needed.
- Although legal advice is expensive, agree who can access legal advice, under what circumstances and the timing of access. The aim should be to prevent serious problems arising and therefore advice should always be sought sooner rather than later.

The author

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Dr Henrietta Ewart

Glossary

Resource allocation – the task of deciding how healthcare resources are to be allocated. This usually refers to financial resources but can also refer to the deployment of manpower.

Priority setting / prioritisation – the task of determining the priority to be assigned to a service, a service development or an individual patient at a given point in time. Prioritisation is needed because claims (whether needs or demands) on healthcare resources are greater than the resources available.

Service development – a catch-all phrase referring to anything that needs investment. It refers to all new developments including: new services; new treatments, including drugs; changes to treatment protocols which have cost implications; and changes to treatment thresholds and quality improvements, such as reduced waiting times. It also refers to other types of investments which existing services might need, such as pump-priming to establish new models of care, training to meet anticipated manpower shortages and implementing legal reforms.

Service disinvestment – the mirror image of service development.

Priority setting processes – all the things needed to support priority setting, such as structures, policies, protocols and processes.

Rationing – a consequence of priority setting. A patient can experience rationing in many ways, including being denied access to a treatment or service, experiencing a delay or poor quality services which impact on the clinical outcome. It is advisable not to use the term 'rationing' as a verb; to do so is to imply that rationing is an optional activity. All positive decisions to fund are inextricably linked with a rationing consequence somewhere in the system.

Affordability – the ability to do something without incurring financial risk or unacceptable opportunity cost. It is ultimately determined by the fixed budget of the PCT.

Opportunity cost – arises from alternative opportunities that are foregone in making one choice over another.

Annual commissioning round – the process by which new money coming into the NHS is allocated. The process has undergone many changes over the years but key elements of the process have remained unchanged. Funding decisions follow an annual cycle. Service developments are gathered and assessed during the autumn. Once PCTs are confident of the size of additional funding (usually known in December) priority setting intensifies. Final decisions have to be before the end of the year to ensure that new contracts can be placed with providers of healthcare for the new financial year which starts on 1 April. This annual process sits within a longer term strategic planning process. For the purposes of this series of publications this process will be known as the annual commissioning round.

Priority setting: an overview

This report is the first in a series of publications which aims to help organisations review their current priority setting processes and, if needed, provide a reference document for PCTs who still have to develop a comprehensive priority setting framework.

It is hoped that the series will also promote understanding and debate amongst a wider audience, particularly providers of healthcare who have always undertaken prioritisation, at both patient and service level, albeit less explicitly.

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