Priority setting:
strategic planning

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Introduction

For primary care trusts (PCTs) the most important priority setting is done at the strategic level. It is here that the major decisions shaping local healthcare services are taken. This is done through the development of strategic plans which are then translated incrementally through serial resource allocation decisions.

Strategic planning involves priority setting because it determines which healthcare needs will be met and which will not. Developing an implementation plan involves priority setting because it determines when needs will be met.

Priority setting is as old as the NHS itself. It is surprising, therefore, that priority setting at these levels is most in need of development. It could be argued that the focus on health technology assessment has been to the detriment of the development of other tools. As a result, many challenges remain. These include:

- how to best manage a large number of decisions

- how to construct all decision making to ensure that the primacy of prioritisation is maintained (see the previous report in this series, *Priority setting: an overview)*

- how to fairly and efficiently compare very different sorts of interventions

- how to ensure that investments reflect priorities

- how to fully engage the wider NHS and the public and in doing so secure the trust of the local community.

To meet these challenges PCTs will need to network with fellow PCTs and other partner organisations, including academic institutions, to develop understanding, tools and skills. Particularly important is the need to verbalise, capture and therefore give full account of the decisions PCTs currently make and how these are shaped by their unique perspective and responsibilities (for example: knowledge of opportunity costs, legal duties to provide comprehensive healthcare and being a budget holder).

While this report acknowledges the developmental nature of priority setting at the strategic level, it sets out some well recognised considerations for the planning cycle and presents some tools which may be useful for PCTs to adopt and adapt.

> *'For PCTs the most important priority setting is done at the strategic level. It is here that the major decisions shaping local healthcare services are taken.'*

How to break down decision making

Many commissioners have been faced with the task of prioritising 30 out of 250 individual service developments. This is not made any easier when large numbers of these developments arise from provider trusts without reference to strategic plans. While this might represent an extreme case it raises the issue of how to 'cut' or group decision making in order to make it more manageable and in a way which is meaningful.

Priority setting has to be done in stages and the PCT, together with key partners, needs to give consideration to the 'building blocks' that will be used. Decision making can be grouped into *programmes* which can relate to disease areas (for example, cancer), specific diseases (for example, breast cancer), health problems (for example, hearing loss), patient/client groups (for example, the elderly) or a combination of these. When considering these programme areas two guiding principles are helpful:

1. Priority setting should, as a minimum, consider interventions related to programme goals across an entire patient pathway (see Figure 1).

2. The first and most detailed consideration of priorities should be undertaken by a group of individuals who are familiar with the area of interest.

Considering priorities within the context of the patient pathway is very important. For example, when a new cancer drug comes along, the key question which has to be answered is whether this drug is really the next most important investment.

It is self-evident that many of the interventions for protecting good health and managing long-term conditions fall outside the remit of services traditionally provided by the NHS. Strategic planning cannot, therefore, be done in isolation. The Local Government and Public Involvement in Health Act of 2007 ensures that joint strategic planning occurs between health and local government authorities, which between them share the responsibility for the health and well-being of the populations they serve.[2] As well as requiring closer collaboration on shared goals, this legislation also aims to realign the NHS towards preventing poor health in future generations.

Figure 1. Minimum range of objectives to be built into any programme area

Diagnosing ill health

Adjusting to chronic disability

Protecting good health

Restoring health

Easing the passing
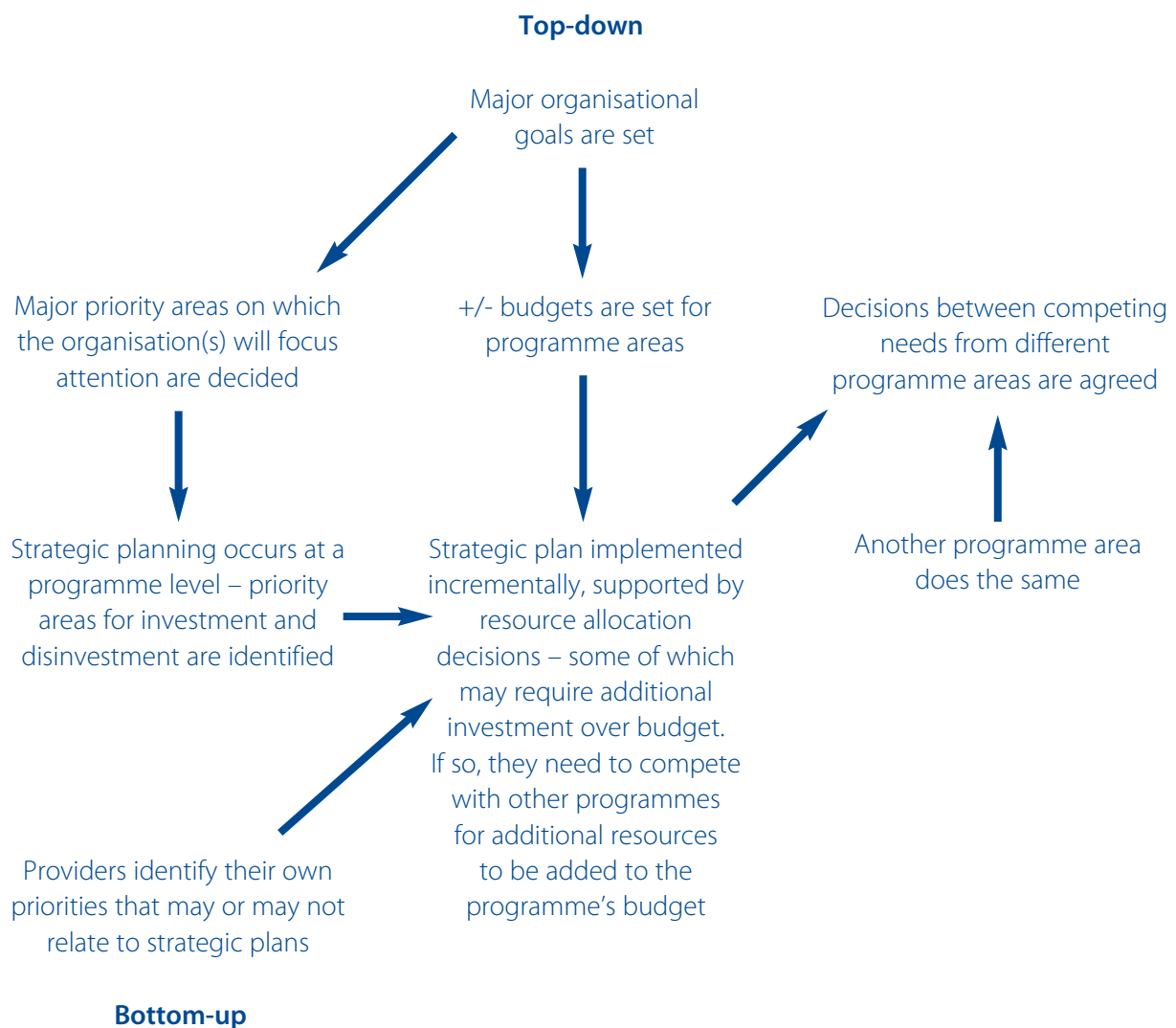
Source: Dr Peter Brambleby [1]

Priority setting results, therefore, from a complex set of interrelated groups of decisions, all aimed at identifying:

• What are the areas/issues to focus on?

• What are the needs and priorities of each particular service, patient group, condition?

• What is the next investment/disinvestment?

Figure 2 gives an example of how a series of decisions might contribute to overall priority setting.

Figure 2. Possible relationships between priority setting at different levels

Top-down

Major organisational goals are set

Major priority areas on which the organisation(s) will focus attention are decided

+/- budgets are set for programme areas

Decisions between competing needs from different programme areas are agreed

Strategic planning occurs at a programme level – priority areas for investment and disinvestment are identified

Strategic plan implemented incrementally, supported by resource allocation decisions – some of which may require additional investment over budget. If so, they need to compete with other programmes for additional resources to be added to the programme's budget

Another programme area does the same

Providers identify their own priorities that may or may not relate to strategic plans

Bottom-up

Strategic planning

Healthcare needs

Healthcare needs and their assessment were first fully described by Stevens.[3] A healthcare need is a health problem that would benefit from a known effective intervention. The term 'intervention' should not be restricted to the type of service provided by the NHS. This is particularly so in relation to primary prevention, where the intervention is aimed at preventing a health problem.

Healthcare needs assessment

Healthcare needs assessment (HNA)[4] is the process by which the need for services and other interventions are fully assessed. It is a vital analysis which underpins any strategic plan. It is comprised of three elements:

The epidemiological – this gives a picture of the condition of interest and potential interventions.

The comparative – this gives a picture of the existing services and interventions, comparing them with established standards or what is available to other populations. It also includes a strategic analysis of service issues and trends and identification of current spends and contracts used to commission those services.
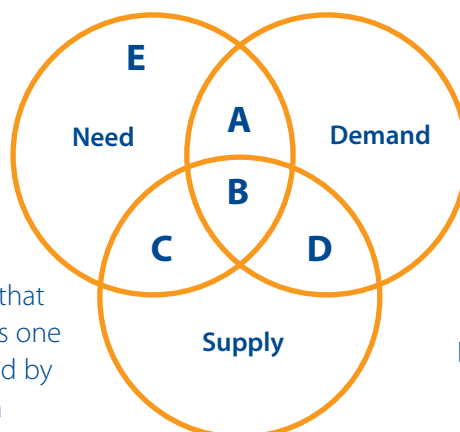
The corporate – this provides the views of stakeholders.

One objective of this exercise is to map out the relationships between need, demand and supply (also described by Stevens). Figure 3 shows the potential relationships that might exist. Every segment of the Venn diagram is of significance. Strategic plans should be designed to better align these elements.

Figure 3. Need, demand and supply of healthcare

Zone E represents unmet need that is not expressed for whatever reason (not recognised, neglected or not demanded).

The overlap between need and demand represents healthcare needs that are expressed. Zone B represents need which is met while Zone A represents need that is not.

Zone C represents a service that meets a legitimate need but is one which is not wanted or valued by patients. An example is a terminally ill patient being treated in an acute hospital setting.

Zone D represents services that are provided to meet a demand but do not meet a healthcare need. A classic example is prescribing antibiotics for a cold.

E Need A Demand B C D Supply

The outcome of a healthcare needs assessment should include:

- an understanding of the nature and size of the health problem and the current and future need for intervention and services

- a hierarchy of interventions arranged in terms of their ability to produce health gain and the costs incurred in doing so

- an understanding of the service currently being provided and an assessment of its quality

- a view on what a model service would look like and what changes and developments are potentially achievable in the short, medium, and long terms locally

- an analysis of constraints (for example, manpower shortages) and analysis of potential obstacles to implementation (for example, lack of commitment by a key organisation)

- minimum and target quality standards that might be introduced

- an understanding of the current spend and preliminary costs for key service developments and potential sources for releasing cash (for example, providing services more efficiently, service redesign, disinvestment)

- identification of any procurement/contracting issues.

Translating the healthcare needs assessment into a strategic plan

Once the information from a healthcare needs assessment is available, it needs to be translated into a strategic plan that maps out the desired shape of future services and the changes needed to deliver them. An indication of the order in which this should be implemented should also be included.

Involving stakeholders

The local authority will have been involved in the joint strategic needs assessment. Depending on how the programme areas have been developed, wider stakeholder engagement will have occurred, to a greater or lesser extent, through the healthcare needs assessment process itself.

Wider involvement in developing strategies (and therefore setting priorities) is important for many reasons, not least of which is that a better strategy is likely to result from having a richer experience and wider range of perspectives on which to draw. Other reasons for widening involvement are to build relationships, consensus and legitimacy.

PCTs need to carefully consider what structures they might need to help with strategy development at the programme level and how to involve the key perspectives: users, professionals, managers who run services, public health, the commissioning team, and other key agencies. Ideally, each programme area should have a supporting planning forum, chaired by a senior individual from either the PCT or the local authority. However, establishing and maintaining all the groups that are needed is an impossible task for any PCT at present and so a phased approach will need to be taken.

Unfortunately, public policy over the last 20 years has not delivered structures which bring together the key stakeholders in the right balance. In particular, PCTs have inherited a number of clinical networks established over the last ten years, and there is considerable confusion over the role of many of these. Functionally, there are three types of networks, listed on page 8.

Healthcare needs assessment – summary

Epidemiological assessment

- define the condition of interest
- describe the epidemiology – incidence, prevalence, changes in incidence and prevalence (over time, place and 'person'), associated mortality and morbidity
- establish which healthcare interventions are effective (primary, secondary and tertiary preventions) and their associated costs, including identification of patient subgroups for which treatments have differential benefits; and establish whether or not interventions are effective in all healthcare settings and subpopulations which experience higher prevalence of the condition of interest or its risk factors
- undertake a value for money assessment which should cover both cost-minimisation and cost-effectiveness wherever possible
- understand healthcare trends for this area (for example, emerging technologies, specialisation and skill-mix issues).

Comparative assessment

- identify national, professional and locally developed standards, guidelines, commissioning policies and specifications
- describe the services and interventions that are being provided:[5]
    - **structures/inputs:**
        - service configuration
        - manpower, including skill-mix
        - buildings
        - equipment
        - financial costs

    - **processes:**
        - activity
        - referral patterns
        - relationships between different services, including the patient pathway
        - professional practice
        - user perceptions

    - **outcomes:**
        - health outcomes
- assess relationships between need, supply and demand
- compare with other areas' services and interventions (access rates, quality and outcomes)
- look at existing contracts.

Corporate assessment

- check findings from the above two stages
- gain views from key stakeholders
- understand how providers and users want the service to develop and their priorities
- identify potential limitations and blocks to implementing healthcare strategies
- assess the major forces shaping the service, including technological developments, manpower trends and health policy.

Professional networks

Generally, these are informal networks of professionals who share the same interest, and often comprise of individuals coming from the same discipline. They are largely educational and support networks.

Clinical networks

These are more formal multi-disciplinary networks primarily, but not exclusively, comprised of healthcare professionals working across a patient pathway for a service area. They largely have an operational focus, concentrating on quality and ensuring that patients move between different parts of the service. A clinical network can be a subgroup of a strategic network.

Strategic networks

These are formal planning groups of the PCT or joint planning groups of the PCT and local authority. They are multi-disciplinary and multi-agency groups. Strategic networks should have responsibility for undertaking priority setting within a programme area. In the future it is both likely and desirable that they will also have some responsibility for the total budget for that programme.

Problems currently exist in a number of areas where a clinical network has been given or adopted a strategic function without sufficient accountability to local PCTs.

Patient and public involvement and the role of overview and scrutiny committees is a major area in itself and is not covered in this report. However, it is worth reiterating that the roles of the citizen and user should not be confused – it is the citizen's voice that is needed for high-level decision making. Users and carers should help shape priorities for the services they use. This also follows the principle of involving those who have detailed knowledge of an area involved in the early stages of priority setting.

Moving towards fair, open and fully informed priority setting

The capacity of the NHS to undertake fair and informed decision making requires a seismic shift in public, professional and political knowledge, understanding, attitudes and behaviours. Such change cannot be achieved by a one-off exercise or in one or two years but requires commitment to a long-term strategy at both local and national levels.

PCTs are encouraged to consider approaching priority setting in the same way they would a major public health programme. At least two of the three main strategies described by the World Health Organisation[6] can be adapted as follows:

Enabling – providing information and educating individuals and groups, and wide engagement in decision making.

Advocacy – combining individual and organisational actions to gain political commitment, policy support, social acceptance and systems support for fair and fully informed priority setting. This can involve activities such as lobbying, active engagement of the media and public debate.

Translating the strategic plan into a prioritised implementation plan

Having developed a strategic plan the PCT must then ensure that the annual investment decisions it takes reflect stated priorities. Because of external demands this can be a greater challenge than might be expected.

The annual commissioning round

In most PCTs investment decisions are made during the annual commissioning round. This often involves prioritising not only those developments that are linked to national and local strategies but frequently also lists of bids from provider organisations. The process currently rarely looks at disinvestment. As a result there is a question over whether or not the annual commissioning round, as currently constructed, is adequately meeting either the needs of the PCT or the requirements of fair priority setting. The answer may be that it does not and something different needs to take its place. There have been some initiatives which have attempted to address, at least in part, this issue.

Any solution must address four key problems:

- the constant diversion of funds to treatments which are of low priority but which have become politically hot issues

- the failure of the health economy and local communities to be sufficiently aware of or take into account opportunity costs

- the failure to address disinvestment

- clinical and public engagement.

Programme budgeting and marginal analysis [7, 8, 9, 10, 11]

A recent development has been the adaptation and promotion of programme budgeting and marginal analysis (PBMA) by the Department of Health. This is a long-established tool for decision making which has only recently been applied to healthcare. It could be considered the most important development within priority setting. Crucially, it has the potential to address all of the four problems identified above.

It is not possible to cover the subject in detail here but a few important features are highlighted below.

Programme budgeting refers to the task of breaking down what is currently spent into programme areas, with a view to tracking future expenditure in each programme area, in order to meet agreed programme objectives. **Marginal analysis** refers to an assessment of the added costs and added benefits when the resources in programmes are deployed in new ways.

This represents not an accounting method but a new way of thinking. In particular, it requires decisions to be taken with reference to a set of clear programme objectives. It also supports the principle that potential new investments are prioritised, in the first instance, within the programme area – i.e. assessed against that which is already being provided. Redeployment of resources is integral to the thinking of this methodology.

The current popularist framing of funding decisions in terms of 'Does this work?' and 'Is it good value for money?' fails to answer the key questions in relation to resource allocation. This series of reports to date has suggested that other factors need to be taken into account when assessing interventions. But even these do not go far enough. What is needed is a complete change in thinking. Ruta et al argue that priority setting must also consider five key questions which relate to public expenditure in the NHS:

1. What are the total resources available?

2. On which services are these resources currently spent?

3. Which services are candidates for receiving more or new resources (and what are the costs and potential benefits of putting resources into such growth areas)?

4. Can any existing services be provided as effectively but with fewer resources, so releasing resources to fund items on the growth list?

5. If some growth areas still cannot be funded, are there any services that should receive fewer resources, or even be stopped, because greater benefits would be reached by funding the growth options as opposed to the existing service?

This approach is relevant for priority setting at any level, both in provider and commissioning organisations. So this tool can, for example, be used to increase efficiency and focus resources optimally within a provider's departmental budget.

The major constraint in being able to answer these five questions is the lack of information on how existing budgets are spent. This should improve the more the tool is adopted within the NHS.

Currently, NHS decision making is often not constructed to fully address all five of the above questions. Strategic planning (or goal setting for a programme area) helps to answer question 3 and, in part, question 2. It does not, however, compare funding with other programme areas. Programme budgeting, however, aims to answer the first two questions and marginal analysis the remaining three.

The relationship between HNA and PBMA is an interesting one. Set in the context of PBMA, there should be greater emphasis on identifying areas for disinvestment and increasing efficiency. The emerging strategic plan should also be set within any financial constraints defined by the programme budget. Practically, PBMA can also operate in the absence of a strategy. Here the focus is on identifying more limited short-term goals or dealing with specific funding issues.

Priority setting using this approach re-emphasises the inappropriateness of singular decision making, as discussed in *Priority setting: an overview*.

Moving from reactive to proactive commissioning

Three years ago Birmingham East and North PCT planned to move to commissioning that was driven only by its own strategies and delivered by a continuous planning cycle. As a result, the PCT has moved away from the annual commissioning round as the main process for priority setting and decision making. Instead, this is the period of time when planning for priorities set at least one year earlier are crystallised and agreed. Critically, unsolicited bids from providers are no longer considered during the annual commissioning round. Instead, all investment proposals go through a gateway system to ensure they fit with the goals and commissioning strategy of the PCT, as well as a value for money assessment.

Source: Andrew Donald, Birmingham East and North PCT

Other tools to aid decision making

Paired comparison analysis [12, 13]

Paired comparison analysis (PCA) is a well-established tool for decision making which requires the ranking or prioritisation of options. Its main limitation is in the number of choices that can be compared – ideally, this should be no more than ten and preferably less. If used properly, it can be an efficient way of reaching consensus when decision making has stalled.

An essential requirement of paired comparison analysis is that everyone taking part in the exercise is very familiar with the subject area because they need to be able to make mental trade-offs quickly. The methodology involves each individual within the group making a series of paired choices where every option is compared to another. Usually, the decision-maker has to quickly decide which of the two options they prefer. The preferences are then scored and the group score added up (see Figure 4 for how rankings are obtained). There are variants of this method which involve making the choice against pre-agreed criteria or introducing weightings.

As with all tools, the outputs are meant to be an aid to decision making, not a substitute for it. Having undertaken the exercise and got a cumulative score for the group the stakeholders come together to discuss the ranking and negotiate, if necessary, any changes. These might be expected to be only minor – in the example shown in Figure 4 the group might decide to reverse the rankings of options 2 and 3.

It is critical when undertaking this exercise to ensure that the balance of representation from the stakeholder is correct, because each individual's score adds to the total.

Although the number of choices should generally be kept small, this tool has been successfully used to help priority setting at the strategic level for palliative care services. This was to break a deadlock in agreeing the emphasis to be given to developing key elements of the service (i.e. increase consultant numbers, beds, hospice at home, training etc.) Unusually, the exercise involved 20 options – an afternoon's work compared to the ten or 15 minutes it would normally take. The results were, as is often the case, surprising but when the group came together there was no dissent.

Figure 4. Results of a paired comparison exercise

	Stakeholder A	Stakeholder B	Stakeholder C
Option 1 versus Option 2	1	2	1
Option 1 versus Option 3	3	1	1
Option 1 versus Option 4	1	1	1
Option 2 versus Option 3	3	2	3
Option 2 versus Option 4	2	2	2
Option 3 versus Option 4	3	3	3

Scores: Option 1 = 7, Option 2 = 5, Option 3 = 6, and Option 4 = 0
Priority rankings: Option 1 is the highest priority, then Option 3, then Option 2, and the lowest priority is Option 4.

Scoring systems

Many organisations have developed systems for comparing service developments and virtually all of them use a scoring system. A scoring system aims to assess priorities against an agreed set of factors. Those most commonly used include:

- the nature of the health gain
- confidence in the clinical evidence
- the number of individuals benefiting
- cost-effectiveness/value for money
- the need to redress inequalities and inequities of access
- accessibility

- national priorities
- stated local priorities
- clinical risks
- service risks
- quality issues
- cost
- legislation and direction from the Secretary of State
- patient choice.

Factors are often weighted. So, factors considered most important may be given the maximum score of 100 while those of less significance only five or ten. A greater level of sophistication can be

Figure 5. The original Portsmouth Scorecard

PORTSMOUTH CITY PRIMARY CARE TRUST BALANCED SCORECARD

Group One	Group One			Group One
Strength of Evidence	NO (Strength)	MAYBE (Strength)	YES	out of 40
Magnitude of Benefit	10% Sx	100%Sx	Cure	out of 40
Number who Benefit	10	1000	10,000	out of 40
Total Cost	£500,000	£100,000	£1	out of 40
Patient Choice	Low	Medium	High	out of 40
Group Two	**Group Two**			**Group Two**
HIMP/NSF Priority	NIL	TWO	FOUR	out of 20
Hlth Ineq/Serv Ineq	NIL	TWO	FOUR	out of 20
Wider Benefits to Public	NONE	SOME	LOTS	out of 20
Only Rx or Alternative	SEVERAL	TWO	NONE	out of 20
Group Three	**Group Three**			**Group Three**
-	-	-	-	-
Public profile	NONE	HIGH	HUGE	out of 10

(Date of Analysis)	**(Name of Service/Therapy/Treatment)**	**(SCORE)** (Maximum of 290)

introduced if multipliers are used as this enables greater discrimination between interventions. So, for example, the scores for 'health gain', rather than being added to the score for 'number of individuals benefiting', is multiplied by the score.

As with paired decision analysis those assessing interventions need to be familiar with the topic area. They also need to understand and apply the scoring system in the same way.

One of the simplest scoring systems is the Portsmouth Scorecard, first developed by Dr Paul Edmundson-Jones at Portsmouth City PCT. His original scorecard is shown in Figure 5.

The Portsmouth Scorecard has been further developed by others. One such modification, overseen by Dr Khesh Sidhu, is summarised in the box below and illustrated in Figure 6.

A key issue for all scorecards is how the scoring is weighted; another is how they are assessed. A welcome development would be making the measures for determining the scores for each factor increasingly objective.

Development and local adaptation of the Portsmouth Scorecard

A modified version of the Portsmouth Scorecard was used as a starting point for two further modifications for use in Sandwell PCT's annual commissioning round.

The first, used in 2007/08 deliberations, involved changing the language for use in a practice-based commissioning (PBC) strategy meeting. This enabled doctors, nurses and practice managers to prioritise 11 options for their PBC strategy. Use of the scorecard led to a remarkable acceptance of the final ranks. A consistent approach in scoring was also confirmed during this process.

The second modification, for use in the 2008/09 annual commissioning round, was designed to address one of the problems of all existing scorecards – the relative weights for scores between the factors. To date, the weighting of the parameters had been relatively arbitrarily allocated. A two-stage Delphi exercise was undertaken which led to the version shown in Figure 6. A similar exercise will be run next year with the public to gauge their views on how the scorecard should be developed further.

Another problem encountered in the 2007/08 was that the quality of the information on each option wasn't consistent. This risked important interventions being given low rankings because they could not be assessed fully. This issue has been addressed by establishing a submission process that requires planning to start in April and discourages submissions late in the year.

There is no doubt that a measured logical approach to prioritisation has given Sandwell PCT and its practice-based commissioners a better understanding of local priorities. In addition, by engaging the public on how it compares submissions for funding, the PCT will in future be in a more defensible and robust position if its commissioning priorities are challenged.

Source: Dr Khesh Sidhu, Director of Clinical Services Development, Sandwell PCT

Figure 6. Sandwell PCT's modified Portsmouth Scorecard

Modified Portsmouth Scorecard Sandwell PCT WWB Cluster

Factor	Scale					Score
	Very Low	**Low**	**Mid scale**	**High**	**Top points**	
From your experience what is the strength of evidence that the service produces an effect	**Under 3 points** if still experimental, case series or opinion	**10 points**	**20 points** if you have modest evidence that the service works	**30 points**	**40 points** if you definitely have experience that the service works	
Magnitude of benefit	**Under 3 points** if negligible or no improvement in health or life expectancy	**10 points**	**20 points** if there are moderate improvement in health or life expectancy	**30 points**	**40 points** if there are large improvement in health or life expectancy	
Number of will **benefit** in your practice	**Under 3 points** if less than one person in your practice	**10 points**	**20 points** if there are 10 - 49	**30 points** there are 50 - 499	**40 points** if there are > 500 people in your practice who would benefit	
Total cost of the development	**Under 3 points** if the cost is more £,1000,000	**10 points** if the cost is between £,1000,000 & £500,000	**20 points** if the cost is between £500,000 – £250,000	**30 points** there the cost is between £250,000 – £50,000	**40 points** if the cost is less than £50,000	
Patient acceptability	**Under 3 points** if patients would find it highly unacceptable	**10 points** if patients would find it somewhat unacceptable	**20 points** if patients would have no view on acceptability	**30 points** if patients would find it somewhat acceptable	**40 points** if patients would find it highly acceptable	
National requirement or NHS target	**Under 3 points** if not a requirement	**10 points** if it addresses one target or national requirement	**20 points** if it addresses two targets or national requirements	**30 points** if it addresses three targets or national requirements	**40 points** if it addresses 4 targets or national requirements	
Addressing health inequality or health inequity – ie where patients have not had service in the past	**Under 3 points** if it doesn't address an inequality or inequity	**5 points**	**10 points** if it partially address's an inequality or inequity	**15**	**20 points** if it completely addresses an inequality or inequity	
Wider benefits to Society	**Under 3 points** if none	**5 points** if some benefit to society	**10 points** if moderate benefit to society	**15 points** if large benefit to society	**20 points** if major benefit to society	
Only treatment or alternative	**Under 3 points** if many other treatments options with best outcomes	**5 points** if other options with better outcomes	**10 points** if other options but equivalent outcomes	**15 points** if limited options with poorer outcomes	**20 points** if there are no treatment options at all	
Strength of local feeling	**0 points** if no local interest in favour	**5 points** if some local interest	**5 points** if moderate local interest in favour	**7 points** if large local interest in favour	**10 points** if massive local interest in favour	
TOTAL SCORE						

Source: Dr Khesh Sidhu, Director of Clinical Services Development, Sandwell PCT

Standardised business plans

Sandwell PCT's experience illustrates the problem of gathering all the relevant information on potential service developments needed to fully assess a development's priority. Most, if not all, PCTs have tried to address this at some time or other by establishing a standardised format for business cases or bids for service developments. Some have used online submission forms. It might be possible in the future to construct a computer programme which helps generate a scorecard, or part of a scorecard, from web-based submissions.

Live investment logs

Live investment logs have a number of useful functions in that they:

• are a simple method of documenting and tracking an organisation's priorities and investment plans

• ensure valued developments that have failed to gain funding are not lost to the planning process

• enable rapid assessment of opportunity costs

• provide organisational memory.

Figure 7. Part of an investment log for a palliative care programme

Service element	National priority	Local ranking of element	Development	Ranking of service development within area	Ranking of service development for coming year	Current status	Planned timescale	Various columns relating to financial planning…
Inpatient beds	Yes	1	Level 2 facility town A	–	–	Completed	Signed off 2006	Details
Inpatient beds	Yes	1	Level 2 facility town B	1	1	Business case completed and signed off by the PCT	2008	Details
Inpatient beds	Yes	1	Redesign of local community hospital beds C	2	Not planned	Business case requested from provider	2010	Await details…
Inpatient beds	Yes	1	Level 2 facility town C	3	Not planned	Dormant	2012	
Increased access to Marie Curie and night sitting	Yes	2	Increased capacity focusing on Zone X	1	2	Preliminary case from provider, revisions requested.	2009	Await details…
Increased access to Marie Curie and night sitting	Yes	2	Increased capacity focusing on Zone Y	2	Not planned	Dormant	2010	
Etc…								

They are best managed at a programme level, held and constantly updated by the programme lead, and can be set up in Excel. An example is shown in Figure 7.

All the tools presented above are useful when addressing different aspects or problems of decision-making. As such, they complement each other. In addition, PBMA, paired comparison analysis and scoring systems can both be used to identify priorities for investment and areas for disinvestment.

'The capacity of the NHS to undertake fair and informed decision making requires a seismic shift in knowledge, understanding, attitudes and behaviours.'

Resources

In the first report in this series, *Priority setting: an overview*, the need to consider the resources dedicated to priority setting was raised. Hopefully, the case for ensuring that the PCT has sufficient dedicated time and funds to support and develop this task has become apparent in the course of this series. Unfortunately, all too often responsibility for overseeing this function sits with the busiest people in an organisation. Priority setting should not be seen as an add-on but should command its own strategy, implementation plan and a dedicated team.

Conclusion

Priority setting is a complex but important task. As resources become more scarce, and both need and demand increase, PCTs will have to develop the best systems they can in order to allocate resources fairly and to optimum effect. This report – the last in the current series – has covered some of the important principles in relation to priority setting at the strategic level. It is not, however, meant to be a comprehensive guide and there are some notable areas that have been not been covered, such as patient and public involvement, practice-based commissioning, working with local authorities,

engaging with the media, strategies to influence the wider debate, disinvestment and the role of contracting in both delivering priorities and using resources most efficiently. It is hoped, nevertheless, that this series of reports has provided a useful guide for practitioners and introduced some key concepts.

If you would like to comment on any of the issues raised in this series, please contact **nigel.edwards@nhsconfed.org**

Key action points

Step 2: Develop and establish priority setting structures and processes
- Ensure there is dedicated manpower resource and funds to support priority setting.

- Review networks and ensure that those involved in strategic planning are sub-committees of the PCT with clear terms of reference.

- Agree and define programme areas.

- Consider instituting programme budgeting and marginal analysis at some level.

Step 3: Consider how to approach a range of issues related to key relationships
- Develop networks with other PCTs and key organisations which can help develop PCT priority setting.

- View engaging the local NHS and community as a long-term plan, gradually building understanding and capacity over a number of years. The process has to be sustainable.

- Develop a stronger national voice for PCTs.

Step 4: Produce key policy documents
- Describe in the overarching policy document how strategic planning (including that undertaken with the local authority) and incremental investment decisions will be carried out.

Step 5: Develop tools for decision making
- Experiment with and further develop existing tools and share results.

See *Priority setting: an overview* for a description of the steps.

The author

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Acknowledgments

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Glossary

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.

Healthcare needs assessment (HNA) – the process by which the need for services and other interventions is fully assessed. It is a vital analysis which underpins any strategic plan. It is comprised of three elements: the epidemiological, the comparative and the corporate.

Paired comparison analysis (PCA) – a well-established tool for decision making which requires the ranking or prioritisation of options. If used properly, it can be an efficient way of reaching consensus when decision making has stalled.

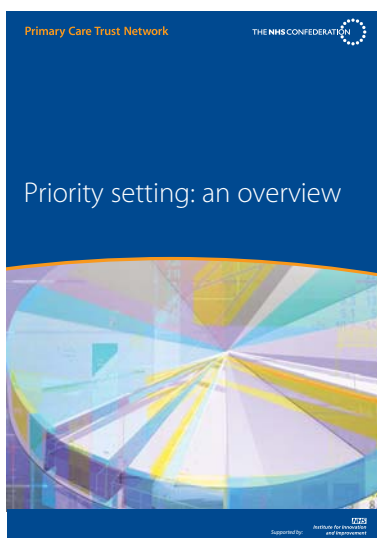**Programme budgeting and marginal analysis (PBMA)** – a long-established tool for decision making which could now be considered the most important development within priority setting. Redeployment of resources is integral to the thinking of this methodology.

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 thresholds; and quality improvements, such as reduced waiting times. It also refers to other types of investments 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.

The priority setting series

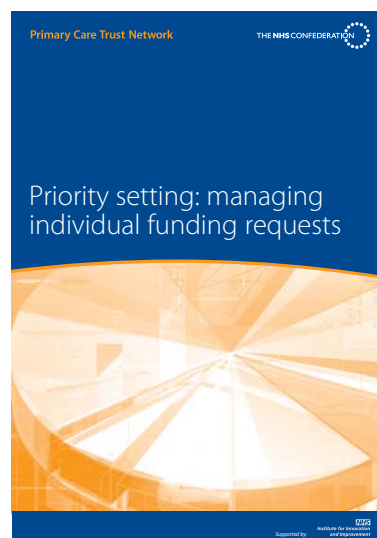All reports in the series are available at **www.nhsconfed.org/publications**

Priority setting: an overview

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Priority setting: strategic planning

This report is the fifth and last in a series of publications that 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.

Previous titles in this series: *Priority setting: an overview; Priority setting: managing new treatments, Priority setting: managing individual funding requests*, and *Priority setting: legal considerations*.

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

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