

A study of English primary care trusts

Setting priorities in health

Research report

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September 2011

Acknowledgements

We would like to thank the Nuffield Trust for giving us the opportunity to undertake this research work, with particular thanks to the Efficiency research programme steering group for their expert advice and guidance, and the reviewers for their very helpful and detailed comments. We would also like to thank those who helped develop and pilot the electronic survey. Finally, we would like to thank all those NHS and public sector employees who took part in the survey and extend our gratitude to the five case study sites. We really appreciate the time and effort given to our research, especially during a very turbulent time for health and public sector services – without such support, studies like this would not be possible.

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Glossary

Accountability for Reasonableness (A4R)	A process-based model of decision making based on four 'conditions'
Allocative efficiency	Allocation of resources to maximise the level of population health
Cost-effectiveness analysis	Evaluation of the cost and effects of health care interventions
Disinvestment	The withdrawal or substitution of services and interventions on grounds that include considerations of efficiency
Efficiency	The concern to maximise benefit and minimise cost
Engagement/involvement	Enabling input from stakeholders and citizens into priority-setting decisions
Equity	The concern to distribute resources fairly among population groups
Multi-criteria decision analysis (MCDA)	A collection of formal approaches that seek to take explicit account of multiple criteria in helping individuals or groups explore decisions
Priority setting	Processes by which decisions about the allocation of scarce health care resources are taken
Programme budgeting and marginal analysis (PBMA)	Constructs relevant frameworks to see how resources are currently allocated and is used to assess the costs and benefits of potential changes from this current position
Rationing	Withholding potentially beneficial health care interventions on grounds that include considerations of cost
Scarcity	The condition of having limited resources, including natural and financial
Technical efficiency	Production of the maximum possible sustained output for any given set of inputs

Foreword

The exacting nature of the financial challenge facing the National Health Service (NHS), combined with increasing demand for NHS services, means that commissioners will have to make difficult decisions about how NHS resources are used. Processes for reaching and enacting these priorities will need to be robust and transparent, and capable of withstanding judicial review.

We know from research and experience that prioritising health care is difficult and often controversial, and although involving patients and the public is accepted as being vital to priority setting, this can be difficult to achieve and sustain. It was against this backdrop that we asked a team from the Health Services Management Centre at the University of Birmingham to undertake research into how the current NHS commissioners – primary care trusts (PCTs) – did their priority setting. The intention was to use this research to inform the next stage of development of NHS commissioning, and in particular the role of clinical commissioning groups and the NHS Commissioning Board.

The research reported here demonstrates that PCTs have made significant progress in establishing priority-setting processes and, although there are some key weaknesses from which we can learn, they have used many different methods, procedures and processes in seeking to prioritise health needs.

This report forms part of the Nuffield Trust's programme of work on health system efficiency, for we feel strongly that with the NHS facing the most significant financial challenge in its history, a robust evidence base is needed to help inform the difficult decisions that will need to be made by clinicians, managers and policy-makers. Further reports on other aspects of health system efficiency will be published in the coming months.

This report is accompanied by a research summary, *Setting Priorities in Health: The challenge for clinical commissioning*, which sets out analysis by the Nuffield Trust of the challenges facing a new generation of health commissioners who have to make difficult choices about health funding. This summary, together with further copies of this report, is available from www.nuffieldtrust.org.uk/publications

Judith Smith, Head of Policy, Nuffield Trust

Executive summary

Aims

The research reported in this document was designed to map the priority-setting activities taking place across the National Health Service (NHS) in England, and to explore and assess the effectiveness of these practices within specific local contexts.

The questions that provided the basis for the research were as follows:

- What priority-setting tools, processes and activities are practised currently as part of the commissioning processes of English primary care trusts (PCTs)?
- What barriers are experienced by PCTs seeking to implement explicit priority setting, and how are these being addressed?
- What other strengths and weaknesses can be identified in current priority-setting practice?
- What learning can be derived that will be instructive for future priority setting within the NHS and elsewhere?

Method

There were two core elements to the research. The first was a national, electronic survey sent to directors of commissioning (or equivalent posts) in all PCTs across the country. The second phase involved five case studies of priority-setting activities at a sample of PCT sites. Data were collected at the sites through a combination of documentary analysis, semi-structured interviews and observation of priority-setting-related activities.

Findings from the survey

Most PCTs have formal arrangements for priority setting, but these are geared primarily towards allocation of new monies and developments, rather than core PCT spend or disinvestment. The picture of priority setting across PCTs is one of a complex patchwork of different approaches and tools being adopted. Senior NHS managers and doctors were more involved in priority setting than other stakeholders. Those with the most involvement were: PCT chief executives; directors of public health; commissioning managers; PCT non-executive directors; and practice-based commissioners. The general population, carers and health care providers from the acute, mental health, private and voluntary sectors had much less input.

Needs assessment using population-level health data was the main approach employed as the basis for decisions about spending priorities. Strengths of priority-setting processes were considered to be in relation to them being simple and transparent, and entailing the use of evidence. Weaknesses were perceived to be related to: finding sufficient evidence for decisions; the tendency for priority setting to take place at just one point in the financial year; and the typically narrow focus of the activity, which fails to reach across health economies. The lack of involvement of local authorities, patient groups and the public was also considered to be a weakness.

Findings from the case studies

It is clear that local approaches to priority setting have been very much influenced by national policy, as set out in World Class Commissioning (WCC) and the Quality, Innovation, Productivity and Prevention (QIPP) agenda. There was also an awareness of the need to extend priority-setting work from just focusing on new investment to core funding services in order to meet the QIPP challenge.

Priority-setting tools were being used by PCTs not only to help with the process of decision making, but also as a route for promoting evidence-based debate with clinicians, patients and the general public about health spending and services at a local level. The case study PCTs struggled with engaging the public and patients in priority setting, although they realised that this would be important, particularly at a time when disinvestment will be required.

PCTs found acute trusts difficult to engage in priority setting, making it hard to implement decisions that affected acute services. Furthermore, Payment by Results was deemed by PCTs to incentivise providers to try and increase activity, rather than engage with commissioners in finding ways of reprioritising spending aimed at reducing hospital admissions. However, practice-based commissioning had helped with clinical engagement with priority setting, including across primary and secondary care.

Carrying out robust, transparent and inclusive priority-setting work in the NHS entailed the creation of a range of processes for considering evidence and making decisions, the provision of analytical, public health and project management support, and sustained attention to stakeholder engagement.

Key messages from the research

Many PCT commissioners have made notable strides in their priority-setting practices. This is reflected in the number of organisations with formal priority-setting processes and the extent to which survey respondents cited the routine use of decision tools and analysis.

However, the overall 'map' of PCT priority setting remains patchy, and there is much variation in the scale, aims and methodologies of priority-setting functions that currently exist. Many priority-setting challenges have been addressed only partially. In particular, there remain questions over how technical approaches to decision making can be incorporated into broader strategies of governance, implementation and legitimisation.

The arrangements have not generally been tested in respect of overall PCT spend, nor in making significant disinvestment decisions.

NHS priority setting has to move beyond new and marginal expenditure. PCT clusters and clinical commissioners will face the challenge of having to review their total expenditure with a view to making significant efficiency savings. These commissioners should be proactive about disseminating and learning from the experience that PCTs have amassed in priority setting and commissioning. They will, however, need sophisticated and robust evidence on which to base decisions, and will need to find new and convincing ways of working with local clinicians, provider organisations, patients and the public.

The research findings set out in this report have been used as the basis for analysis of the challenges facing a new generation of health commissioners, who will have to make difficult choices about funding in a highly constrained economic environment. This analysis is set out in a Nuffield Trust research summary that accompanies this research report: *Setting Priorities in Health: The challenge for clinical commissioning*, which is available from www.nuffieldtrust.org.uk/publications.

1. Background and context

This report presents the findings from research into PCT priority setting in the NHS in England. The study was funded by the Nuffield Trust and carried out by the Health Services Management Centre at the University of Birmingham and the Nuffield Trust. The report is intended to provide an insight into current priority-setting practice, and to inform future priority-setting functions in the NHS. It is intended to be of interest to government, other national agencies and local budget holders and decision-makers. Later chapters detail the research findings and discuss implications for policy and practice. The remainder of this chapter defines key terms, locates priority setting within the current commissioning landscape, and gives a brief summary of key themes from the wider priority-setting literature. These discussions of the policy environment and the wider literature provide a context for later discussion of the study's implications for future research, policy and practice.

Understanding priority setting

It is increasingly accepted that priority setting in publicly-funded health care systems is inevitable (Coast, 2004; Newdick, 2005). As demand for health care has increased – driven by an ageing population, advances in medicine and higher patient expectations – the need to establish procedures for allocating scarce resources has become more pressing. Developments in the field of priority setting have become especially urgent in the current context of economic austerity, in which the welfare system of England is subject to greater financial constraint. Although a number of other options are available to deal with the growing gap between demand and resources – such as increasing waiting times, improving system efficiency and so on – systematic approaches to the allocation of health care resources have become increasingly popular across the developed world.



As demand for health care has increased... the need to establish procedures for allocating scarce resources has become more pressing

There are varying definitions of priority setting in the published literature. For the purpose of this report, the term is used to refer to any explicit approach to the allocation of population resources in a context of scarcity. The term 'priority setting' clearly links to the notion of 'rationing'. In this report, the two terms are used to refer to different stages of the resource allocation process, with priority setting associated with decision making, and rationing referring to decision implementation (Klein, 2010). Explicit approaches to priority setting or rationing exclude the informal, 'bedside' rationing that traditionally has been a common feature of health care delivery (Mechanic, 1995; Klein and others, 1996). Although such practices may still be

present, they are not the focus of the research reported here. The range of resource allocation decisions that fall within the category of priority setting include:

- overall budget allocation (core budget spend)
- prioritising between service areas
- prioritising between patient groups
- prioritising between interventions
- substitution of, and disinvestment in, interventions and services.

Priority setting and commissioning

In this report, priority setting is considered as part of the broader commissioning role. Here, commissioning is defined as organisations and/or individuals using public resources to buy services for populations based on analysis of health needs (Smith and others, 2010). Based on Ovretveit's (1995) notion of the commissioning cycle (see Figure 1.1), priority setting takes place after public and patient engagement has been sought; population health needs have been identified; and current service provision has been mapped against these areas of need.

Figure 1.1: The commissioning cycle



Source: NHS Information Centre for Health and Social Care (2011)

Over the latter period of the New Labour administration, PCTs were firmly established as the principal commissioning agents in the NHS in England. The introduction of the WCC agenda set the expectation that PCTs will “deliver better health and well-being for all, better care for all and better value for all – adding life to years and years to life” (Department of Health (DH), 2008a: p2). Central to the delivery of WCC was the requirement for PCTs to reach a number of key competencies (DH, 2007a, 2007b, 2008a), two of which related directly to the priority-setting function. Competency 6 required demonstration of an evidence-based approach to investment decision making, and Competency 11 focused on efficiency and value for money across the whole health care expenditure of PCTs. In addition, the drive for explicit priority setting was enshrined in the NHS Constitution, which states that commissioners must be transparent in their decision-making criteria and processes (DH, 2009b).

Therefore, priority setting is integral to the commissioning role; however, in the NHS in England, as in all health care systems, priority setting and rationing involve a series of distributed tasks. Although commissioners invariably are expected to carry out priority-setting activities, they are rarely in a position to take full responsibility for all of its dimensions. For example, until very recently the National Institute for Health and Clinical Excellence (NICE) has produced guidance on the use of new technologies, and adherence to this has been mandatory for all local health organisations in England (Schmidt and Kreis, 2009). Although implementation of NICE guidance is now carried out on a voluntary basis, it remains a key feature of the English and Welsh priority-setting landscape. As well as national bodies such as NICE and the National Screening Committee, priority-setting decisions are also taken by, for example, provider organisations through formulary lists, assessment and eligibility regimes, medicines management and so on, and by other bodies discharging health and social care budgets. Clearly the rationing stage of the resource allocation process, in which priority-setting decisions are put into practice, also involves a range of other health care parties.

Overall, the need to make explicit and fair decisions over the targeting of resources has moved to the centre stage of government policy, and commissioning has emerged as a key vehicle for its delivery. The model adopted in the NHS in England has been one in which PCTs have been expected to lead the process of explicit priority setting, albeit within an overarching national framework set out by NICE and other national agencies.

Just as priority setting is not simply reducible to the commissioning function, neither does all commissioning activity require a formal priority-setting phase. For example, until recently in England, practice-based commissioning (PBC) has operated at levels which have not necessitated separate population-level priority setting, as the patient numbers and budgets involved have remained relatively small-scale (DH, 2008b). The reforms set out in the White Paper *Equity and Excellence: Liberating the NHS* (DH, 2010a) signal a shift in the scope and scale of clinician-led commissioning and a series of organisational changes for the wider NHS in England. The key changes include the abolition of PCTs, with the majority of their commissioning powers passing to clinical commissioning groups (CCGs) and a national NHS Commissioning Board (NHSCB),

and responsibility for public health relocating to local authorities (DH, 2010a). Although these planned changes do not diminish the importance of commissioning, they do cast some uncertainty over the priority-setting role in terms of how and by whom it is to be carried out.

“ Overall, the need to make explicit and fair decisions over the targeting of resources has moved to the centre-stage of government policy, and commissioning has emerged as a key vehicle for its delivery

The challenges facing priority-setters

The existing priority-setting and rationing evidence base suggests that those leading local processes face a number of challenges. These are summarised briefly in Box 1.1.

Box 1.1: The challenges facing local priority-setters

Pluralism

Priority-setting decisions are likely to be influenced by a range of considerations (for example, efficiency, equity and need) and by a range of interested parties (for example, professions, industry and patient groups). This means that simple algorithms for deciding on where to invest money are unlikely to be sufficient.

Processes

Priority-setters increasingly need to demonstrate that the decision-making processes followed are fair and reasonable. For example, the Accountability for Reasonableness (A4R) framework (Daniels and Sabin, 2008) holds that all priority-setting processes should meet four conditions in order to be rigorous and legitimate (see Box 1.2).

Public engagement

The need to have better awareness of, and input from, the public in priority setting is increasingly recognised, and there is a growing body of work which explores and assesses a range of engagement methodologies including citizens' juries, deliberative polling, citizen summits and consensus conferences (Abelson and others, 2003; Mitton and others, 2009).

Evidence

The need to draw on best evidence and analysis in making resource allocation decisions is widely recognised. Existing resources and frameworks can be useful, but also have limitations and can be resource-intensive. Evidence does not remove the need for deliberation and dialogue.

Leadership

As well as involving technical and procedural aspects, priority setting often requires skills in relationship management and consensus building so that tough choices can be taken and implemented. Therefore, priority-setting processes need to be carefully and effectively led at local levels.

Box 1.2: The four conditions of Accountability for Reasonableness**Publicity**

The extent to which decisions taken over the allocation of health care resources are made accessible to the public.

Relevance

The extent to which decisions are influenced by evidence that fair-minded people would consider relevant.

Appeals

The existence of mechanisms for the challenge and review of decisions and for resolving disputes.

Enforcement

The existence of effective mechanisms for ensuring that the other three conditions are implemented.

Source: Daniels and Sabin (2008)

These themes and challenges are likely to arise in any attempt to implement explicit priority setting and rationing. Therefore, the extent to which they are addressed is likely to influence the success or otherwise of the priority-setting enterprise. In particular, a balance is required between rules-based decision making informed by public values, evidence and analysis, on the one hand, and consensus-building and interest group engagement, on the other.

Research on local priority setting in England

Although there is an extensive body of literature on priority setting in health care, surprisingly little is known about what NHS priority-setters are actually doing in practice. In particular, there is a limited understanding of what priority-setting models and processes have been put in place by health care commissioners, and how these have fared in practice. Therefore, it is timely to investigate this topic in order to understand current PCT commissioning practice, and to identify areas for future support and improvement of priority-setting activities.

Research scope and aims

In conducting this study the authors sought to map the priority-setting activities of PCTs across England and to explore the activities of a subset of case study PCTs in more depth. Research questions included the following:

- What priority-setting tools, processes and activities are practised currently as part of the commissioning processes of English PCTs?
- What barriers are experienced by PCTs seeking to implement explicit priority setting, and how are these being addressed?
- What other strengths and weaknesses can be identified in current priority-setting practice?
- What lessons and learning can we derive that will be instructive for future priority setting within the NHS and elsewhere?

Summary

The current political and economic context has highlighted the need for explicit and fair priority setting, and until recently PCTs have been the primary decision-making agents within this process. It is important and timely to develop a broad and in-depth understanding of PCT priority-setting practices so that informed prescriptions for improvement can be formulated. The research reported here seeks to provide insights into current practice and to make recommendations for priority setting in the new NHS.

2. Methodology

There are two core elements to the research presented in this report:

- Stage 1 – National survey of PCTs in England
- Stage 2 – In-depth case studies of priority-setting activities at a sample of PCT sites.

This chapter sets out the data collection carried out as part of each of these stages.

Stage 1: National survey

The national survey was designed to provide a picture of the types of priority-setting activities and techniques that are in place in PCTs around the country, and to offer some indications of their perceived effectiveness. This took the form of an electronic survey that was sent to all 152 PCTs in England, addressed to the director of commissioning. The survey was developed in consultation with national commissioning experts from the NHS Confederation and the Nuffield Trust, and with current NHS commissioning managers. The survey was then piloted with NHS commissioning managers from four PCTs and refined to reflect feedback.

The survey focused on the following themes:

- formal priority-setting arrangements
- involvement in priority setting
- the tools and processes used to aid investment decisions
- disinvestment activity
- the tools and processes used to aid disinvestment decisions
- the effectiveness of priority-setting processes
- innovative practices.

The survey comprised a series of tick boxes and attitudinal questions that were rated according to Likert scales,* with additional opportunities to provide free-text responses. (A copy of the survey can be obtained from the authors.)

Quantitative data from the questionnaires were subjected to a range of descriptive statistical techniques. Qualitative free-text responses were categorised into emergent themes and are reported alongside the quantitative data.

* Psychometric scales used to measure attitude.

Stage 2: In-depth case studies

Stage 2 aimed to go beyond the macro-trends explored in Stage 1 and provide an in-depth investigation into how a range of priority-setting activities are operationalised in practice. A case study design was adopted for this stage as a technique suited to obtaining multiple perspectives and experiences of a wide range of different stakeholders (Yin, 1994). A decision was reached to undertake two waves of case study research: the first wave (Wave 1) being a 'deep dive' into priority-setting activities in two sites; and the second wave (Wave 2) a much lighter-touch investigation into three sites that were undertaking interesting or innovative activities in relation to priority setting.

Wave 1 (W1)

The first wave of case studies sought to include two sites that had been seen to demonstrate good practice in commissioning health services, particularly in terms of priority-setting activities. Sites were identified from a composite of data derived from the following sources:

- Peer review – sites which are cited as good practice examples in publications such as the *Health Service Journal*, or are recognised as leading examples of good practice or innovative commissioning of health care services by working bodies such as the NHS Confederation, the NHS Institute for Innovation and Improvement (Excellence in Commissioning award-winners and nominees) and the NHS National Prescribing Centre.
- Government – sites quoted as good practice examples in official documentation and through data obtained from assessment of WCC competencies.
- Academic literature – sites quoted as examples of good practice.

Wave 2 (W2)

Drawing on the national survey data, the authors sought case study sites in which prioritisation processes for disinvestment decisions were formalised and/or specific innovative practices had been indicated. These are issues for which there is little detail in the established literature, and which also have been raised by those involved in priority-setting activities as requiring support. Thus, our focus within W2 sites was more targeted, given the lack of high-quality data in relation to these areas.

Where the survey respondents indicated that they were demonstrating disinvestment activity and/or innovative practice, the authors investigated this further through telephone conversations with candidate case study organisations and other useful stakeholders, and this led to the selection of three case study sites.

In total, five sites were included in the study and Table 2.1 provides further detail in relation to the sites and the types of priority-setting activities under investigation at each one. For each case study site, the chief executive and/or senior commissioning leads were contacted to discuss the possibility of conducting the research. Following this, the research team produced a draft protocol for the proposed study. Further detail on the characteristics of each of the sites is provided in Chapter 4.

Table 2.1: Priority-setting activity at the case study sites

Type of priority-setting activities*	Wave 1 sites		Wave 2 sites		
	Morebeck	Donative	Nethersole	Chetwynd	Chatterton
Overall budget allocation (core budget spend)	✓	✓			
New resource allocation	✓	✓		✓	
Reprioritising across budget areas		✓	✓		
Disease care pathway redesign	✓	✓			
Disinvestment/decommissioning of existing service provision			✓		✓

*The Appendix to this report provides more detailed definitions of these different activities.

Data collection

Three main research methods were employed in the case studies: documentary analysis, interviews and non-participant observation. Opportunities for full use of each data collection technique varied across the case study sites: for example, observations were not conducted in W2 sites.

In terms of documentary analysis, the research team were provided with access to documents including:

- meeting agendas
- minutes
- policy documentation
- presentations and workshop notes
- ethical frameworks used in priority setting
- information prepared for WCC panels
- WCC panel assessments
- copies of paperwork relating to business cases
- applications for new interventions.

Further relevant literature, including strategy documents and annual reports, were accessed via websites. These documents provided a formal account of priority-setting processes and a context for the data derived from interviews and observation.

Semi-structured interviews were used to explore a range of issues in relation to priority setting. In most of the sites a first set of face-to-face interviews was conducted with senior management or executive teams, and took place early on in the study. The interviews explored the respondents' assumptions and experiences of priority setting in their locality, and provided insight into the planning, strategy and operation of priority setting.



The interviews... provided insight into the planning, strategy and operation of priority setting

Following the initial interviews and observational data collection, interviews with wider stakeholder groups were conducted. The primary aim of these interviews was to ascertain the views and experiences of all parties in relation to the priority-setting activity under study. All interviews were conducted by telephone and were audio-taped after assurance of confidentiality was provided.

The types of participant groups interviewed included:

- commissioners (at multiple levels: director, service leads, joint commissioning leads)
- chief executive
- finance director
- public health registrar
- information analyst(s)
- practice-based clinicians
- service providers.

Given the publication of the White Paper *Equity and Excellence: Liberating the NHS* (DH, 2010a) part way through the research, the authors explored interviewee perceptions on the following themes from a limited number of respondents across sites:

- the impact that the reforms might have on priority-setting activities in the localities
- the readiness of general practitioners (GPs) to take on the commissioning role
- the strength of current GP consortiums across localities
- how well equipped public health and local authorities were to respond to this agenda
- the impact of the reforms on public health, and health and wellbeing more generally.

Observation of priority-setting boards and meetings was undertaken in the Wave 1 case studies. The observation of meetings involved “the systematic detailed observation of behaviour and talking: watching and recording what people do and say” (Mays and Pope, 1995: p183).

An *overt* approach to observation was undertaken: that is, panel members were aware of the researcher's presence and the objectives of the evaluation exercise. However, beyond brief introductions at the start of the session, the research team adopted an unobtrusive approach to observation. A free note-taking approach was undertaken.

Data analysis and reporting

An inductive approach to analysis was adopted, generating categories in an iterative process of interpretation in which data are both an outcome and a shaper of the data fieldwork undertaken. The approach used in this study drew on the work of Miles and Huberman (1994). Analysis of data was performed by two researchers, who compared their findings and discussed any differences in the themes that each had identified.

In order to maintain confidentiality, the sites reported in this study have been given pseudonyms, and verbatim quotations were avoided when writing up the findings; however, verbatim interview data are used. Raw data are reported where they exemplify concepts within the inductive analysis, and thus may be included either due to their typicality, or where they provide an alternative perspective. Quotations are used to highlight key themes and salient points relevant to the research findings, and are presented in Chapter 4.

3. Priority setting: the national picture

A total of 121 individuals from across 80 of the 152 PCTs in England (53 per cent) responded to the survey, and a further 25 PCTs declined to take part. Comparing respondents and non-respondents using multiple factors (PCT size, index of multiple deprivation score, surplus/deficit position and proportion of population under 75), the authors found that PCTs in budgetary deficit were slightly under-represented in the survey. In other respects, however, respondents and non-respondents were broadly similar. In order to present data at a PCT rather than individual respondent level, when more than one individual from a PCT completed the survey, the authors aggregated their scores into a single score for each PCT.

Developments in local priority-setting processes

The respondents were asked if their PCT had made any significant changes to their priority-setting processes in the previous three years. The responses to this question indicate that: 50 per cent of PCTs had made changes; 14 per cent had not made any significant changes; 13 per cent were unsure; and 23 per cent did not respond to this question. Box 3.1 outlines some of the changes made and, as this illustrates, most are in relation to the introduction of scoring mechanisms or decision-making tools and structured processes around these. Many of the PCTs claim to have introduced these types of approaches in order to make priority setting more explicit. As one respondent commented:

Three years ago there was no explicit priority-setting process. We now have one, as we realised we had to have a transparent defensible process to cope with the changed financial position.

What this demonstrates is that priority-setting processes have not tended to be well embedded. However, for some PCTs, commissioning policy and financial pressures do seem to be changing this.

The survey also asked PCTs if they had planned to implement further changes to their priority-setting processes in the coming financial year. The responses suggest that 30 per cent of PCTs planned to make changes, 33 per cent had no such plans, 14 per cent were unsure and 23 per cent did not respond. Planned changes typically included:

- making changes to strategic plans and operational procedures around priority setting and resource allocation
- developing specific tools – including the development of multi-criteria decision analysis (MCDA) techniques such as the Portsmouth Tool

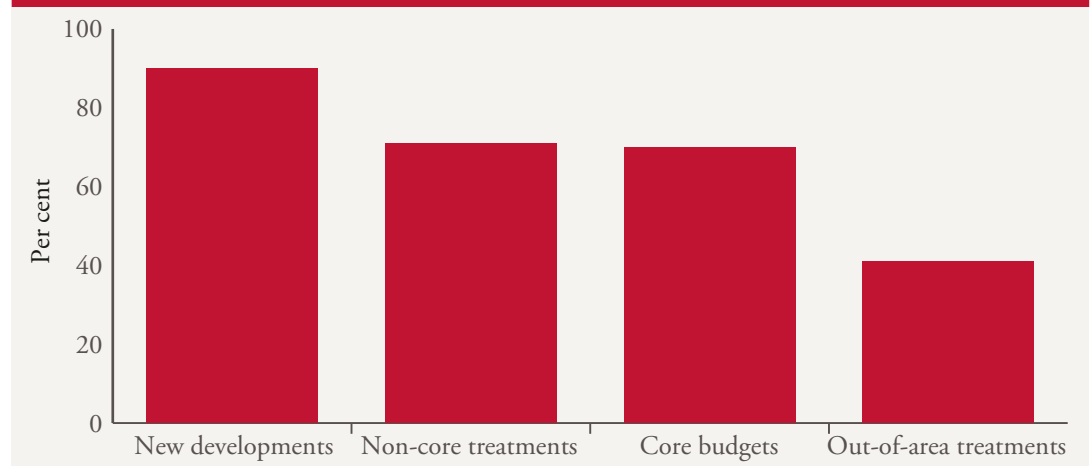
- increasing the involvement of different stakeholder groups – it was suggested that these changes had been largely driven by the current financial climate facing the NHS.

Box 3.1: Changes made to PCTs' priority-setting processes

Stakeholder engagement	<ul style="list-style-type: none"> • Processes to enhance public and patient involvement in priority setting • Public consultation processes • Processes to enhance clinical engagement
Developments and changes to operational strategies	<ul style="list-style-type: none"> • Develop overall operational strategies • Develop a priority-setting policy • Make priority-setting policy and process more in line with PCT strategic direction
Developments and changes to priority-setting processes	<ul style="list-style-type: none"> • Introduction of panel processes for investment and disinvestment decisions • More explicit scoring methodology • Changes to criteria and weighting of priorities to reflect changes to strategic goals and public consultation • Better use of information, including programme budgeting • Introduction and development of prioritisation tools including: <ul style="list-style-type: none"> - more sophisticated local tool - Lean prioritisation tool - McKinsey Dashboard Analysis - adaption of existing tools to other local settings including Portsmouth Tool and programme budgeting and marginal analysis (PBMA) • Process much more stringent and monitored

Remit and scope of priority-setting arrangements

The survey findings suggest that 86 per cent of respondent PCTs have formal priority-setting boards. The majority of these boards (90 per cent) make decisions on new developments, while 71 per cent make decisions on non-core budget treatments. Of the boards, 70 per cent make decisions on core treatments, while 41 per cent make decisions on out-of-area treatments. These results suggest that while most PCTs have formalised priority-setting procedures, more decision activity occurs on new service developments than core budget spend (these results do not include data on exceptional treatment panels). Graphical representation of these results can be found in Figure 3.1.

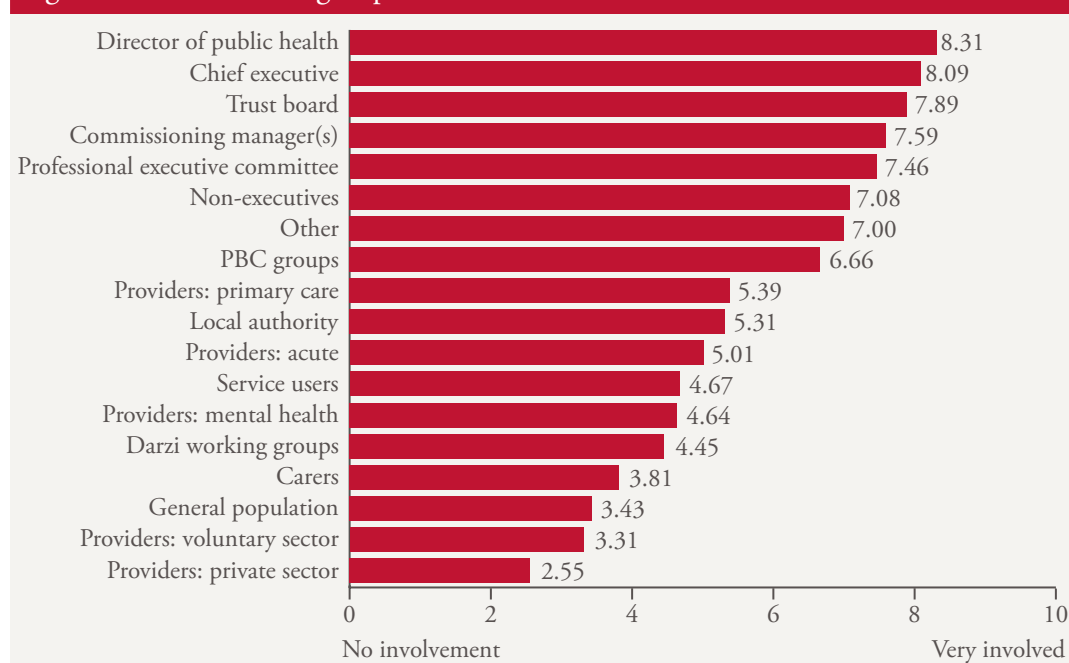
Figure 3.1: Remit of priority-setting boards

Most priority-setting boards were operating at the PCT level (81 per cent), with a further seven per cent at the strategic health authority level. Only a small percentage (seven per cent) indicated that they have boards working in collaboration with other PCTs, and four per cent have boards that operate at the local authority level. However, more than half of the respondents were aware of other priority-setting groups within their local health economy, including local authority groups, children's trusts and other PCT priority-setting boards.

Stakeholder involvement in decision making

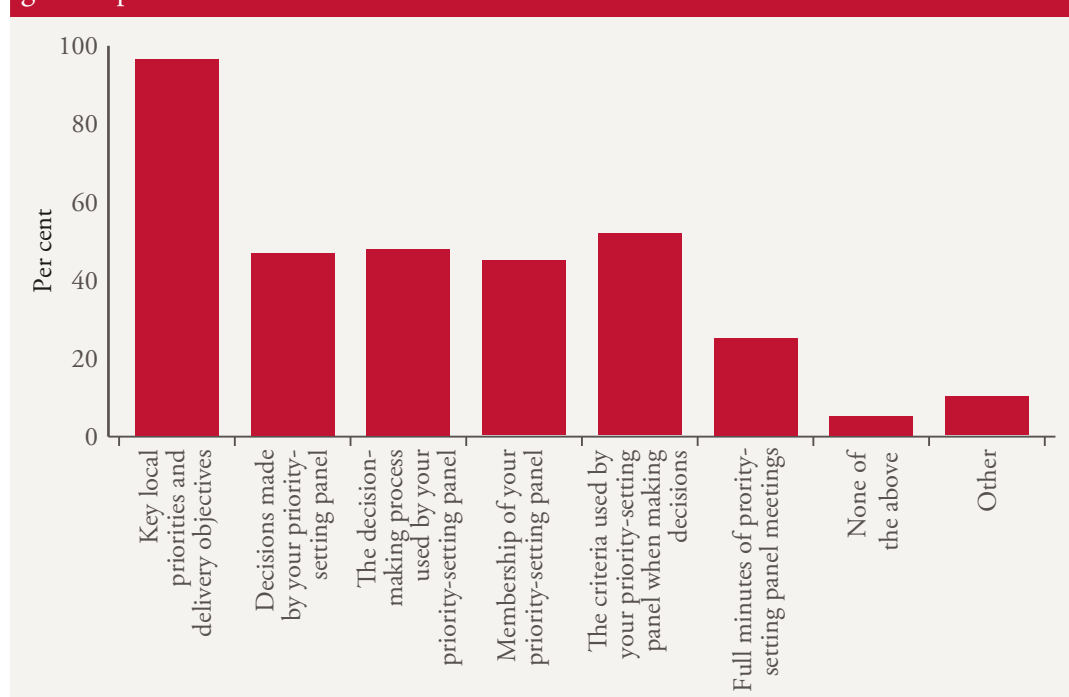
The survey sought to explore the level of involvement that different stakeholder groups have in decision-making processes. The respondents were asked to rate stakeholder groups' level of involvement on a ten-point scale (where 0 = 'no involvement' and 10 = 'very involved'). Figure 3.2 demonstrates the average scores for each individual stakeholder group. Those who were generally perceived to have the highest level of involvement were CEOs, directors of public health, commissioning managers, non-executives, professional executive committees and trust boards. Six respondents (seven per cent) also highlighted that directors of finance have a high level of involvement in priority setting within their PCT. Those stakeholder groups which were cited as having rather less involvement tended to include the general population, carers and providers (both voluntary and private).

Figure 3.2: Stakeholder group involvement



The survey also sought to capture information on how effective PCTs are in making their priority-setting processes explicit to the public. The respondents were asked to highlight which aspects of the priority-setting process their PCT makes known to the public, and 75 per cent provided a response to this question. Of these responses: 97 per cent suggested that key local priorities and delivery objectives are made known; 52 per cent stated that the criteria used by priority-setting panels when making decisions is made explicit to the public; and 35 per cent publicise the decisions made by the priority-setting panel. Figure 3.3 demonstrates all responses to this question.

Figure 3.3: Aspects of the priority-setting process which are made explicit to the general public

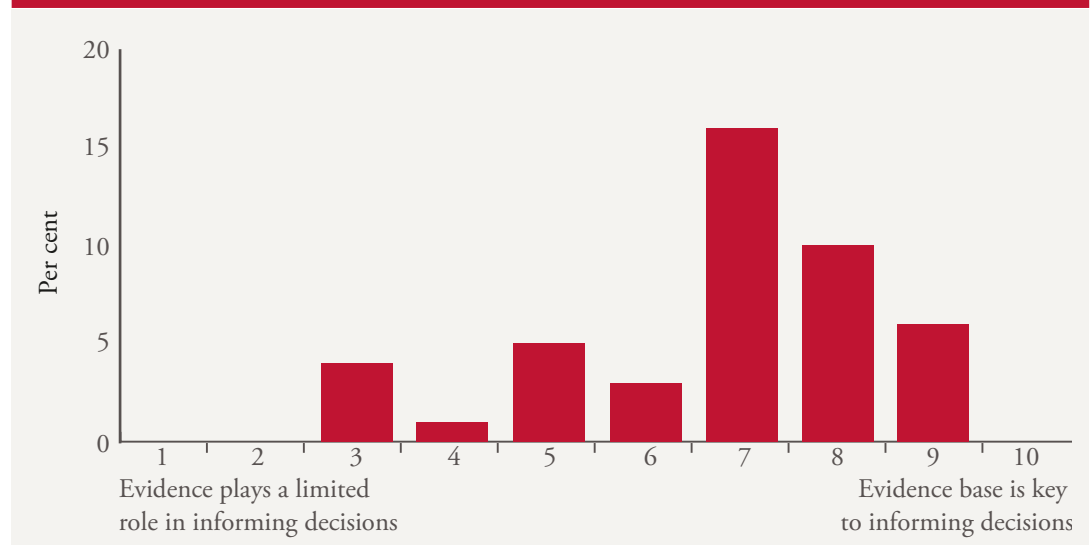


Use of evidence and decision tools

The respondents were asked their views on how well they perceived their PCT to be doing in drawing on evidence to support priority-setting decisions. The authors did not define evidence in detail in this question, but rather allowed the respondents to draw on their own perceptions of evidence and how that did or did not inform decision making. Again, the respondents were asked to rate their views on a scale of 0–10 (where 0 = ‘evidence plays a limited role’ and 10 = ‘evidence is key to informing decisions’). Of the PCTs, 56 per cent provided responses for this question, and the data suggest that the use of evidence to support decisions is generally seen as being strong, with 71 per cent (32) of PCTs rating the role of evidence in priority setting as seven or above. Figure 3.4 provides graphical representation of these results and, as this illustrates, the majority of respondents considered evidence to play an important role within decision-making processes.

“ the majority of respondents considered evidence to play an important role within decision-making processes

Figure 3.4: How well evidence-based practice supports priority-setting decisions



The survey also explored what types of information resources were available to support PCTs' priority-setting activities. Just over half of the respondents (51 per cent) stated that they had a dedicated information resource to support their priority-setting process, while 24 per cent said that they did not. A further 11 per cent responded that they were unsure what information resources were currently available, and 14 per cent did not respond to this question. The majority of information resources that were cited as being available were public health analysts and information teams within a PCT commissioning arm. Of all the responses received, only two PCTs suggested that they had access to a health economist.

Use of decision tools in priority setting

One important component of the survey asked the respondents about the different types of tools that PCTs use to aid priority setting. In addition, the respondents were asked for their perceptions of the usefulness of the different approaches in making effective decisions.

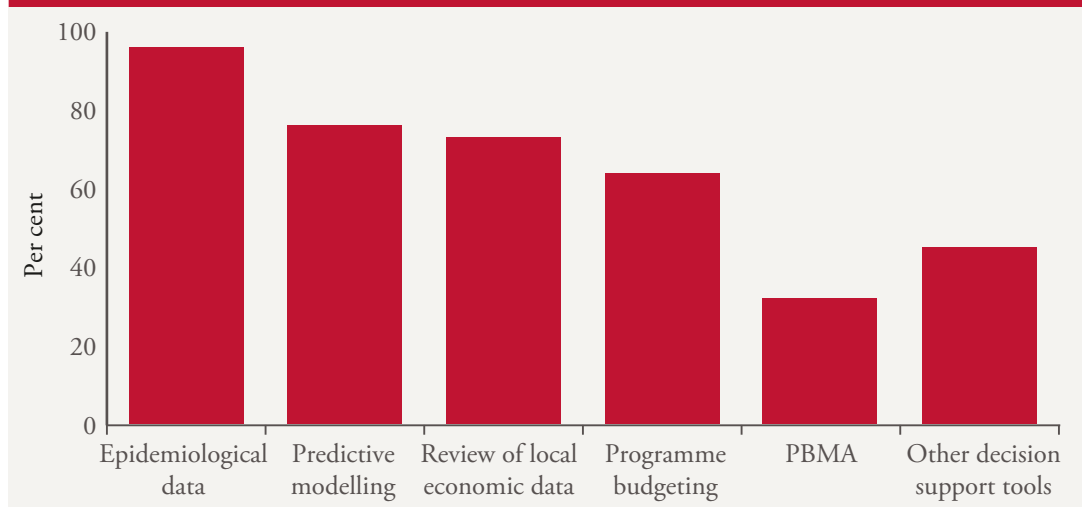
The responses to these questions indicated a range of different types of activity taking place across PCTs. The main activity used to inform priority-setting was needs assessment, with 96 per cent of responding PCTs suggesting that this helped make informed decisions locally. Other activities cited include predictive modelling (76 per cent), review of local economic data (73 per cent) and programme budgeting (64 per cent). Only 45 per cent of respondents suggested that they use PBMA to inform priority-setting activities. Of the respondents, 32 per cent suggested that they used other decision support tools, making reference to the following:

- Lean prioritisation tool
- prioritisation tool developed in partnership with stakeholders
- multi-criteria scorecards including the Portsmouth Tool (often a modified version) and locally-developed scoring tools
- SHAPE (Strategic Health Asset Planning and Evaluation) and NHS comparators
- population risk stratification tools
- surveys and patient questionnaires
- McKinsey Dashboard analysis
- cost-effectiveness analysis and cost–benefit analysis.

Table 3.1 and Figure 3.5 outline the different tools used by PCTs in their priority-setting work.

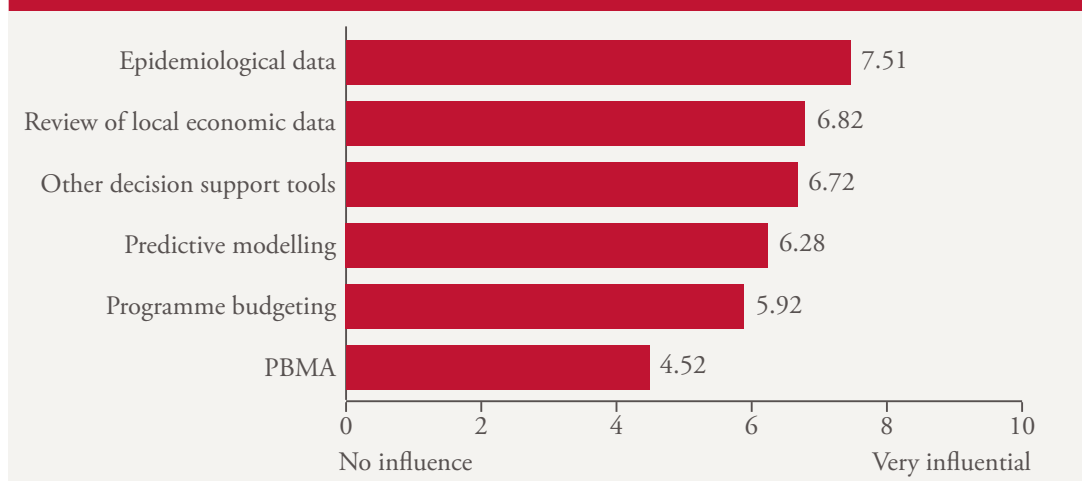
Table 3.1: Tools used by PCTs to aid priority setting		
Tool/process	Yes (%)	Number
Epidemiological data (for example needs assessment)	96%	77
Predictive modelling	76%	61
Review of local economic data	73%	58
Programme budgeting	64%	51
PBMA	45%	36
Other decision support tools (for example the Portsmouth Tool or paired tool)	32%	26

Figure 3.5: Different tools used to aid priority-setting processes and investment decisions



What seems clear from these responses is that there are a number of different types of priority-setting activities taking place at a local level. To explore the impact that these activities have on decision making, the respondents were asked to rate their perceptions of the influence that the various tools have on investment decisions. Again, the scale ranged from 0–10 (where 0 = ‘no influence’ and 10 = ‘very influential’). Figure 3.6 presents the average rating assigned by each PCT in relation to the influence that these different tools have on investment decisions. Data were collected only for PCTs which stated that they actually use these tools in their priority-setting processes. From this assessment it seems that the most influential, with an average score of 7.51, is the epidemiological data used in needs assessment, and the least influential is PBMA.

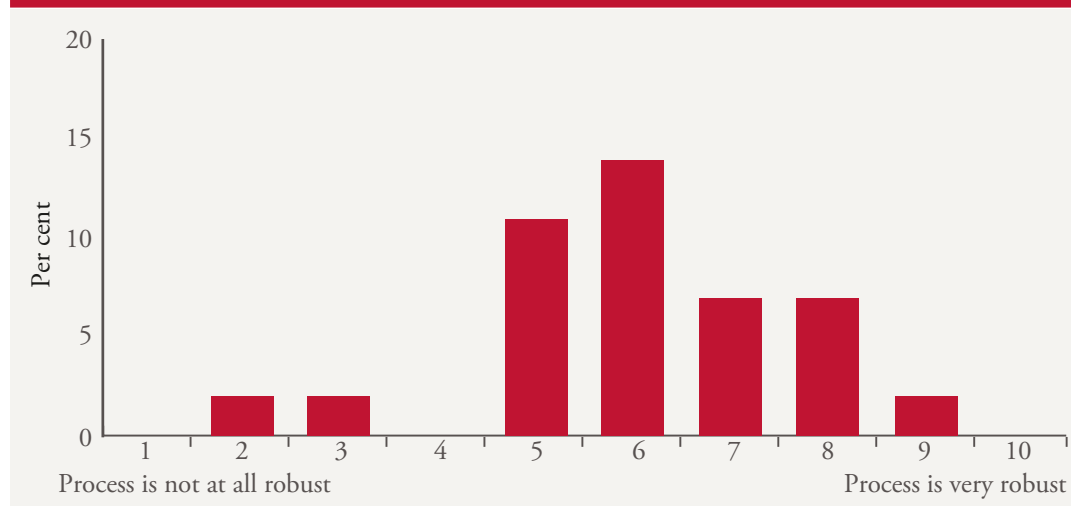
Figure 3.6: Respondents’ rating of the influence of different tools and processes on investment decisions



The study also sought to explore how robust PCT processes are for appealing and revising decisions in the light of new evidence, stakeholder challenge and other considerations, on a ten-point scale (where 1 = ‘process is not at all robust’ and 10 = ‘process is very robust’). Of the PCTs, 56 per cent responded to this question, with the majority of respondents judging their PCT’s process as being robust.

Only four PCTs (seven per cent) claimed to have a weak process for revising decisions. Figure 3.7 is a graphical representation of these scores.

Figure 3.7: Respondents' perceptions of the revisions and appeals processes used in priority setting



Strengths and weaknesses of priority-setting processes

The respondents were asked how effective priority-setting processes were within their PCT. In terms of the types of strengths that were highlighted by the respondents, we can broadly assign these strengths into three main groups: evidence, process and stakeholder involvement. The use of effective evidence from a range of sources was seen as a crucial component of effective priority setting; other reported strengths related to the types of processes put in place to facilitate priority setting. From the responses, it seems apparent that recently a number of PCTs have sought to develop new or enhanced priority-setting processes. For many, current strengths were considered to be the visibility, transparency and simplicity of processes, and enabling communication to stakeholders. A further strength for some was around the issue of stakeholder involvement or understanding of priority-setting processes, which was an important and valued aspect of priority-setting work.

The respondents typically identified a greater number of weaknesses than strengths. These often related to the three themes identified above (evidence, process and stakeholder involvement). A recurrent weakness cited was the way in which evidence was used in priority setting, with a number of respondents highlighting the difficulties involved in benchmarking and finding sufficient evidence for decisions. Other concerns related to the times at which evidence was generated and employed within processes of priority setting. Many respondents saw it as a negative that priority-setting processes predominantly take place at one point within the financial year, rather than throughout the year. One of the most commonly suggested weaknesses in this category relates to priority-setting processes not being as 'rational' as they might be, and therefore subject to other, more political considerations. In addition, there were concerns raised over the issues of boundaries and these tended to relate to priority setting and decision making across disease or geographical areas. Again, the issue of involvement was raised, and this was seen as a weakness for a number of PCTs. A

lack of meaningful involvement was identified most often in relation to patient and public stakeholders, although in some cases it was not insufficient involvement, but an attempt to involve too many stakeholders which, it was argued, got in the way of decision making. Figures 3.8 and 3.9 outline some of the key aspects mentioned in relation to the strengths and weaknesses of the priority-setting process for each of the three themes identified.



A lack of meaningful involvement was identified most often in relation to patient and public stakeholders

Figure 3.8: Perceived strengths of priority setting

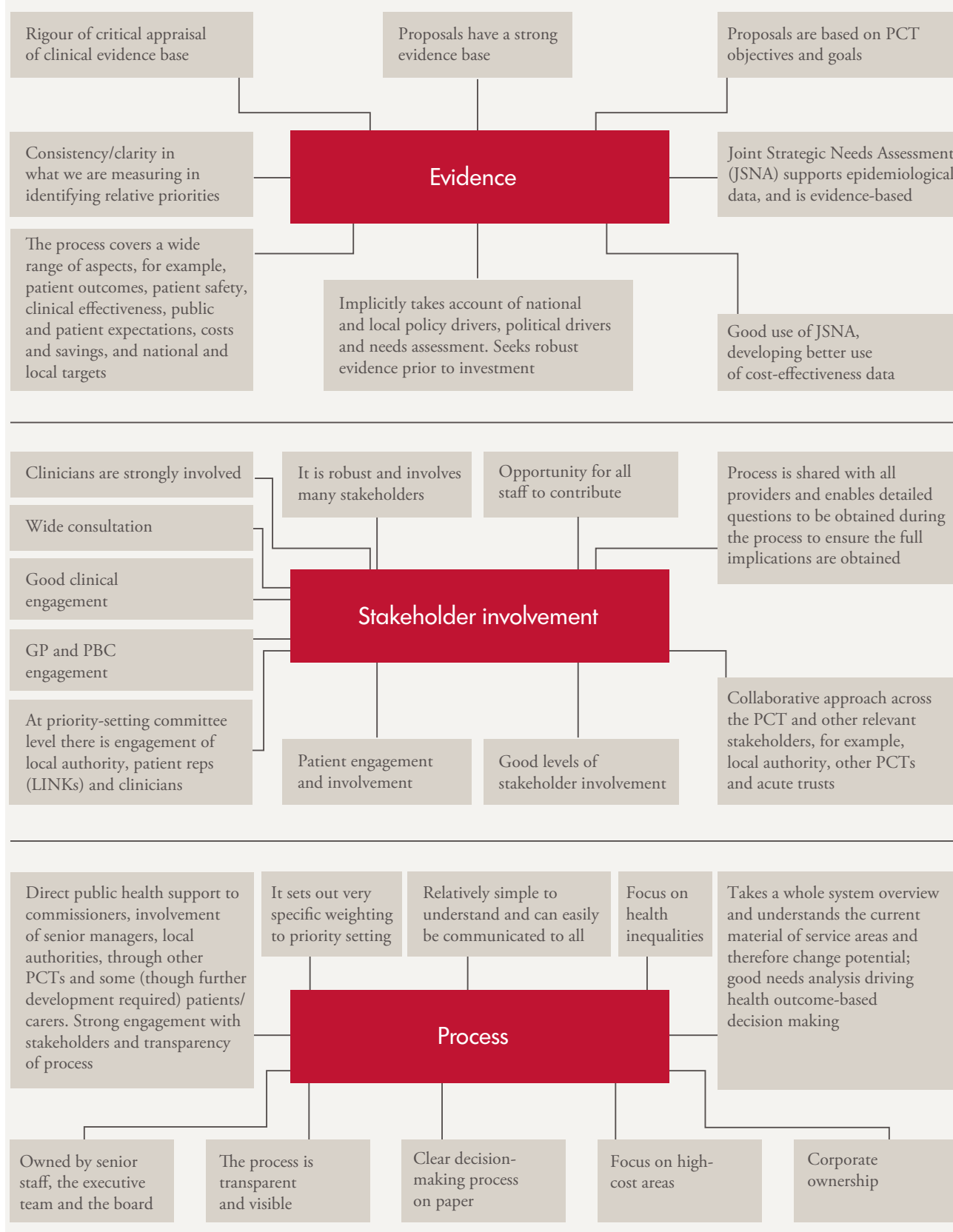
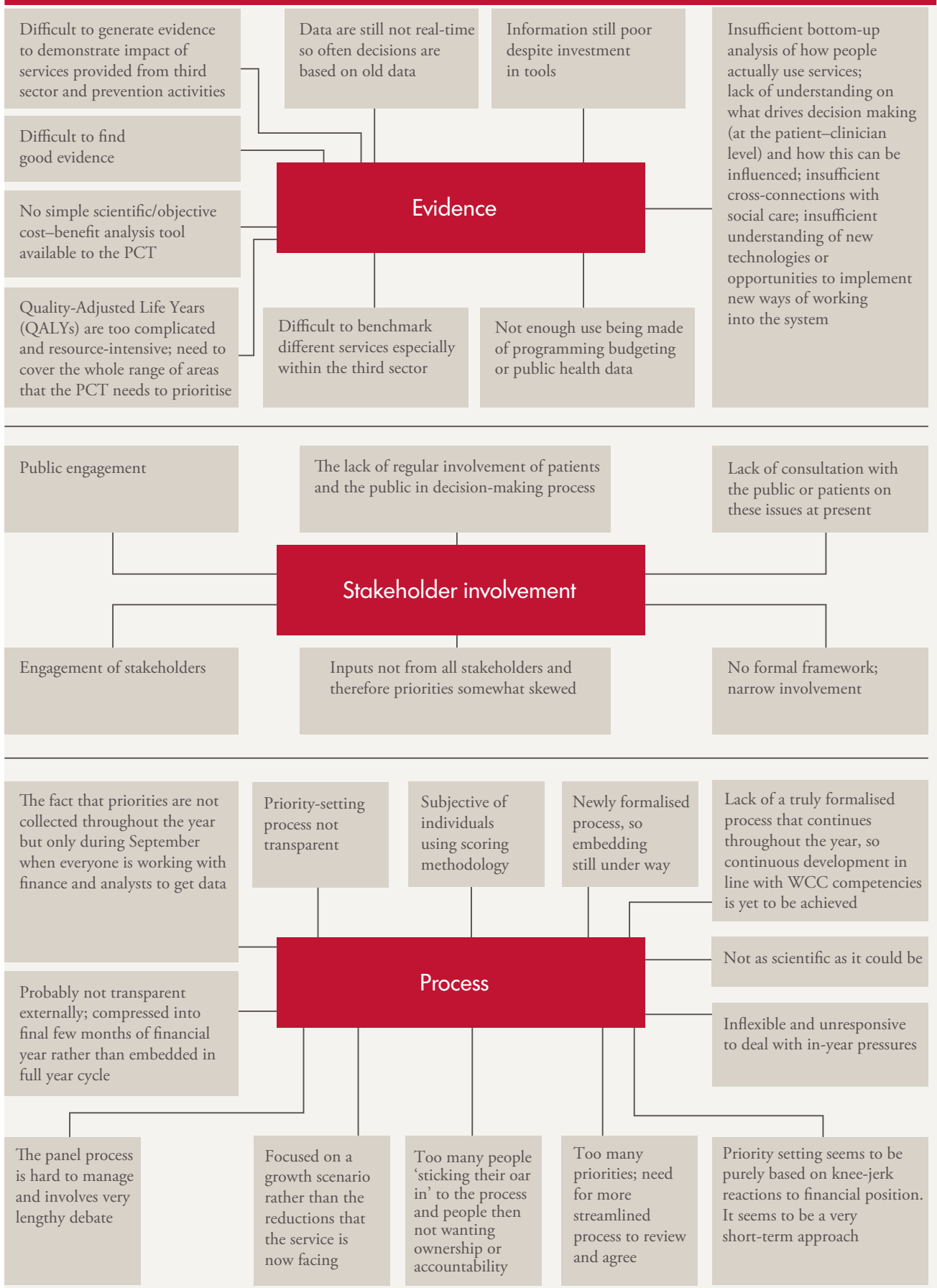


Figure 3.9: Perceived weaknesses of priority setting



The respondents identified a lack of attention to disinvestment decisions within priority-setting activities. Concerns in relation to disinvestment included the following:

- a disproportionate focus on new developments, with processes for identifying areas for disinvestment not well established
- a lack of stakeholder engagement in disinvestment
- even though there might be agreement over the aims of an initiative, it often proved harder to disinvest funds from acute care in practice and therefore this faltered
- even when disinvestment decisions were agreed, they were difficult to implement in practice
- a poor evidence base around disinvestment
- a lack of provider support for disinvestment.

Disinvestment decisions

As suggested in the previous section, one of the weaknesses frequently identified was that of dealing with disinvestment decisions. A section of the survey was included that dealt specifically with the issue of disinvestment decisions and respondents' perceptions of the tools used to aid disinvestment within their PCT.

The respondents were asked if their PCT had made any significant disinvestment or decommissioning decisions in the last three years. The authors had responses from 79 per cent (63) of PCTs who took part in the questionnaire, with just over half of these respondents (54 per cent, 43) suggesting that their PCT had recently made a significant disinvestment decision. A further 20 per cent said that they had not, and eight per cent were unsure. Of those PCTs that had made a disinvestment decision, 53 per cent stated that the PCT had reinvested all or part of the released resources back into the same disease or service area, while 16 per cent had reinvested across service areas and 30 per cent suggested that all or part of the resource had been used to fund other activity (such as service of debts). The examples given by the respondents in the free-text space suggest that some had made a decision to disinvest (that is, to stop spending on certain service areas), but there were limited responses of this type. More respondents suggested that rather than just withdrawing or stopping a service, they had redesigned pathways and services, disinvesting to reinvest. A number of respondents mentioned the move from hospital-based to community-based services as an example of disinvestment. The move to design more community-based services is very much in line with government policy around transforming community services (DH, 2010f). Table 3.2 gives some examples of the types of responses made by the respondents.



Of those PCTs that had made a disinvestment decision, 53 per cent stated that the PCT had reinvested all or part of the released resources back into the same disease or service area

Table 3.2: Disinvestment activity

Disinvestment and decommissioning services	Disinvest to reinvest
<ul style="list-style-type: none"> • Decommissioning of Accident and Emergency (A&E) and centralisation of non-elective acute hospital services on fewer sites • Disinvestment in the following series: homeopathy or complementary medicine, and currently considering <i>in vitro</i> fertilisation (IVF) • Closure of an ineffective community hospital • Policy to disinvest low-benefit procedures 	<ul style="list-style-type: none"> • Personal medical services contracts and enhanced services have been recommissioned and the savings reinvested in other targeted areas within primary care • Shift from bed-based service models to community-based models, and to investing in earlier intervention • Reinvesting in prevention and health inequalities • Redesign of stroke and end-of-life services to be more effective • Early discharge of people from hospital to assessment units to reduce premature placement in nursing homes

In terms of the types of data used in disinvestment decisions, 70 per cent of the PCTs which responded to this survey suggested that they used epidemiological data (for example, needs assessment) to inform disinvestment decisions, with 56 per cent suggesting that they undertook predictive modelling, and 49 per cent programme budgeting techniques to inform their decisions. Only 25 per cent suggested that they used PBMA to inform disinvestment decisions (see Table 3.3 for a full breakdown of results).

Table 3.3: Breakdown of responses to the types of tools used in disinvestment decisions

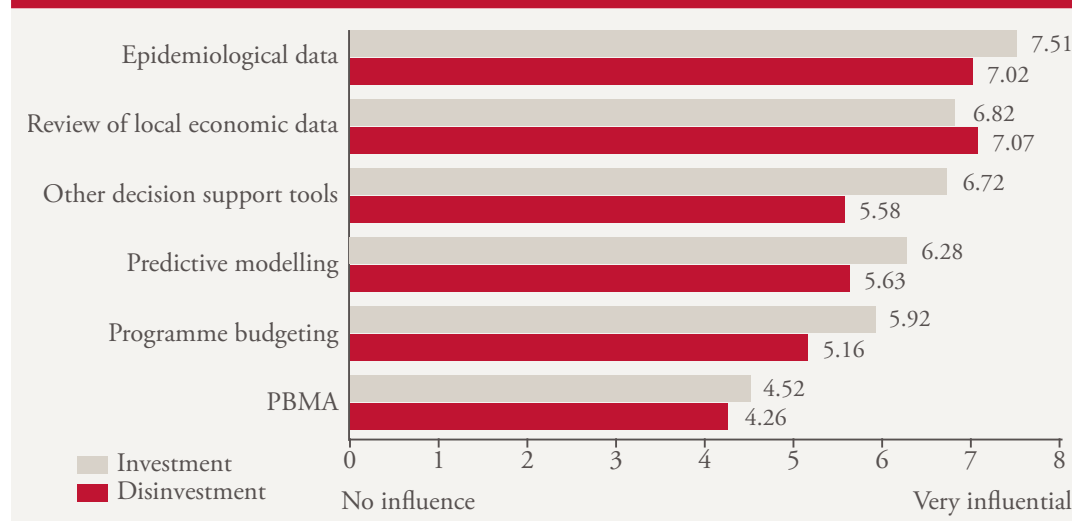
Tool/process	Yes (%)	Number
Epidemiological data (for example, needs assessment)	70%	44
Review of local economic data	67%	42
Predictive modelling	56%	35
Programme budgeting	49%	31
PBMA	25%	16
Other decision support tools (for example, the Portsmouth Tool or the paired tool)	25%	16

Other decision support tools used by PCTs included the following:

- Lean prioritisation tool
- quality and performance frameworks – evidence-based research and analysis to review appropriateness of activities (for example, low-benefit procedures)
- the PCT developing their own prioritisation tool
- locally-designed Service, Workforce and Financial Framework (SWAFF) tool
- hospital statistics, historical data and trends, Joint Strategic Needs Assessment
- prioritisation tool adapted from other regions
- Multi-criteria decision analysis (MCDA) to assess disinvestment decisions – this involves assessing a number of criteria, including: quality-adjusted life years (QALYs), life years gained, value for money, and public complaints.

Again, the respondents were asked to rate the influence that different types of tools had on disinvestment decisions. The rank order of responses was slightly different to that for investment decisions, with the review of economic data being higher than that of epidemiological data. With the exception of local economic data, all scores for tools were lower for the tools used in disinvestment decisions than those for investment decisions (suggesting that they had less influence). Figure 3.10 outlines the different responses in relation to the influence of tools used to inform both investment and disinvestment decisions.

Figure 3.10: Respondents' perceptions of the influence of tools on investment and disinvestment decisions



The survey also asked respondents about their PCT's future disinvestment plans, and 79 per cent of PCTs responded to this question. Of these, 75 per cent indicated that they did have specific plans for disinvestment in the future. Just five per cent indicated that they did not have any future plans to disinvest, while 20 per cent suggested that they were unsure of future plans around disinvestment. The majority of future disinvestment included improving the efficiency of pathways and improving efficiency in relation to services which have high costs and poor outcomes. The majority of suggestions on disinvestment pointed to plans to move care from the acute sector into community or primary care services nearer patients' homes.

Summary

The response rate to the survey compares well to comparable, unsolicited surveys of this type, with more than half of all PCTs providing detailed information about their priority-setting activities. While the survey highlights some interesting and important information around priority setting across England, we need to be mindful of the fact that these are the views and perceptions of commissioning leads and do not represent the views of other stakeholder groups, which may perceive and judge activity in a different manner. Further, the method of data collection means that there was no opportunity for clarification or exploration of responses. Against this background, the findings of the case studies are helpful in exploring these general patterns in more detail. The main headlines and lessons from the national survey are outlined in Box 3.2.

Box 3.2: Key headlines and lessons from the national survey

- The picture of priority setting across PCTs is of a complex patchwork of different approaches and tools being adopted.
- Most PCTs have some form of formal process in place, but these have been predominantly geared towards introducing new developments or how to spend additional money, rather than on core budgets and disinvestment.
- PCTs employ tools and processes devised to deal with the economic, ethical and management aspects of priority setting.
- Frustrations were expressed that decisions tend to be ‘made at the margins’, rather than in relation to the ‘core spend’ and ‘across the whole commissioning strategic plan’.
- Much of the focus of PCTs seems to have been in creating ‘rigorous’, ‘transparent’ and ‘accountable’ processes at the level of the PCT, but less emphasis has been placed on deliberative, widespread, inclusive and meaningful stakeholder involvement across the health economy.
- Concerns were raised about the ‘join-up’ across health economies, with priority-setting processes being described as insufficiently comprehensive across providers, and pathways with different priority assessments being used across commissioning streams.
- A substantial number of PCTs did not have information support readily available to underpin their priority-setting processes.
- Stakeholder engagement tends to be in terms of clinicians, GPs and PBC groups rather than local authorities, the general public and service users.
- Relationships with the local population seem to be more related to information sharing than meaningful engagement, although many respondents noted that the new statutory responsibility to engage with the public would mean that this would become an important focus going forward.

4. In-depth exploration of priority setting

This section of the report presents the findings from the case studies of local priority setting in practice. Two of the case study sites were identified as being beacons of best priority-setting practice, and the remaining three were identified from the survey as undertaking innovative activities in relation to particular parts of their priority-setting activities. The W1 sites, Morebeck and Donative, involved a ‘deep dive’ into priority-setting processes in situ. The remaining three case study sites in W2, Chatterton, Chetwynd and Nethersole, involved a more light-touch approach, as the interest was in particular aspects of their priority-setting activities. The focus for Chetwynd and Nethersole was on the application of relatively new tools and priority processes for decisions around new resource allocation, with plans to use these to inform decisions around disinvestment in the future. Chatterton involved an investigation of the closure of a community hospital: that is, decommissioning services and recommissioning new services in the local community.

This part of the research was designed to gain a greater understanding of the different tools and processes used in priority setting and to explore how decision-makers make complex decisions across different priority-setting activities (core spend, disinvestment and so on). The study also focused on the involvement and acceptability of priority-setting activities to the vast range of stakeholder groups from across the health economy; the outcomes and impact of decisions on service delivery; and the practical lessons relating to particular types or features of priority-setting processes and activities that are transferable within and across PCTs. This chapter is structured so as to provide a high-level picture of the make-up and characteristics of the case study priority-setting functions.



This part of the research was designed to gain a greater understanding of the different tools and processes used in priority setting and to explore how decision-makers make complex decisions across different priority-setting activities

Tables 4.1 and 4.2 provide a brief overview of each of the five case study sites.

Table 4.1: Wave 1 case study sites

	Morebeck	Donative
History and demographics	<p>Created in October 2006 from the merger of three former county PCTs, Morebeck serves a population of approximately 700,000 (making it one of the largest in the country), with 85 per cent of the population living in towns and urban areas. Although 97 per cent of the rural population and 50 per cent of urban dwellers belong to the least deprived or second least deprived areas in the country, these figures hide pockets of deprivation and relatively low life expectancy.</p>	<p>Created in October 2006 from the merger of five PCTs, Donative serves a population of approximately 600,000 and controls a budget of approximately £900 million. Its boundaries are broadly co-terminus with the County Council. While the population served largely enjoys excellent health, there are significant geographical pockets of inequality reflected in poor health care outcomes compared to national averages, with significant difficulties in obtaining access to services.</p>
Priority-setting process under study	<p>Our study concentrated on priority-setting work around: the Quality, Innovation, Productivity and Prevention (QIPP) programme (concerned with core spend, pathway redesign and reallocation of funds across disease areas); and the business case development work based on the Darzi workstreams (concerned with new service developments).</p> <p>QIPP – based on a previous county-wide partnership board, the PCT instigated a set of new arrangements to sharpen the focus of priority setting. The PCT commissioned McKinsey & Co to undertake an evaluation of a number of disease pathways. Programme budgets were mapped onto a cost and effect two-by-two, which allowed the trust to map out and respond to priority areas. McKinsey's approach drew on data (including QALYs) within these disease pathway areas, facilitating clinician engagement.</p> <p>Business case – this is an inductive approach that gives the PCT flexibility to respond to local pressures that are not accommodated within the more top-down approach of the QIPP initiative. PBCs are involved in working with commissioners to develop the business case. In addition to the referral centre, a rapid response team is envisaged.</p>	<p>Our study concentrated on two areas of priority-setting work: the Operational Plan, concerned with core services; and the priority-setting forum, concerned with new investments and disinvestment in specific treatment regimens.</p> <p>Development of the Operational Plan conceives priority setting as a continuous process of refinement, rather than discrete annual cycles. Organisational priorities were identified from existing data and strategy documents, debated at manager workshops, then subsequently by executive directors, the clinical executive and the board. Once priority areas were agreed, detailed proposals were developed by commissioning leads, scored by PCT staff, and formed the basis for the first Operational Plan, with subsequent refreshes.</p> <p>Priority-setting forum – this considers the adoption of, or disinvestment in, treatment regimens. It is supported by specialist advice on available cost-effectiveness data to inform decision making, is explicitly informed by an ethical code, and draws wide representation from local acute, primary (GP) and community organisations, as well as finance and clinical governance leads. It has operated for many years and enjoys a good reputation within the county. It is currently merging with adjacent counties within the region in order to make its support more widely available.</p>

Table 4.2: Wave 2 case study sites

	Nethersole	Chetwynd	Chatterton
History and demographics	<p>Created in 2006, Nethersole has a combined population of 327,600 people across a mixture of urban and rural communities. The PCT has a budget of £373 million a year. While the majority of health indicators are the same or slightly better than the England average, there are pockets of high deprivation. Within six wards in the locality, the life expectancy of men and women is seven to eight years less than it is in the more affluent wards. The total population is forecast to increase by nine per cent to around 359,000 by 2027.</p>	<p>Created in 2006, Chetwynd has an estimated population of 205,500, living mainly in the coastal towns. It also has a small market town and nearly one in three people live in rural villages and settlements. The PCT oversees the largest region in England, and has a budget of around £325 million a year. The PCT has the biggest social inequalities gap in the region, and the 11th biggest inequalities gap in the country, with some areas that it serves being in the two per cent most deprived areas in England.</p>	<p>Created in 2006 by the merger of three PCTs, Chatterton has a population of 530,000 people across a mainly rural county, with concentrations of urban areas. Five local authority districts and boroughs make up the county. The PCT has an annual budget of £791 million. The population is projected to reach a total of 634,900 by 2033. By 2033, those aged 65 years and over are expected to account for more than one-quarter of the population.</p>
Priority-setting process under study	<p>Our study concentrated on priority-setting work around new service redesign.</p> <p>The PCT is developing a tool for use in prioritisation of investment and disinvestment. The principles of the tool have been developed by the PCT. The aim of the model is to assist in the options appraisal process around current and future spending proposals.</p> <p>The PCT has a business delivery process for the prioritisation of new investment. After an initial viability assessment, a case outline is submitted to the Executive Directors Performance Committee. If this is approved, a full case for change is submitted to the PCT Clinical Commissioning and Strategy Committee. Final scrutiny and decision of a proposal is undertaken by the PCT board.</p>	<p>Our study concentrated on priority-setting work around new service redesign.</p> <p>The PCT has developed an MCDA tool for use in relation to prioritisation of investment – with the potential to review areas for disinvestment. The tool is used to prioritise expressions of interest received as part of the Operational Plan process, and to support decision making on proposals to be taken forward for business case assessment. The tool has been used to score proposals in 2009/10 and is being developed for use in 2010/11.</p>	<p>Our study focused on work around disinvestment and decommissioning of services.</p> <p>The PCT recently closed a community hospital, decommissioning its services, and recommissioned new services in the community. The future of the hospital had been debated for the previous 20 years.</p> <p>Discussions had never materialised into action due to changes in policy and leadership, and NHS reorganisations. At one time the hospital was to be rebuilt.</p> <p>A PCT-led team was tasked with undertaking the work. It developed strong links with the local authority and developed a process for engaging with stakeholders from across the health economy. While the work was successful in achieving its aim, there are lessons to be learned for the future decommissioning of services locally, and in particular the process of involving stakeholders.</p>

Rationale for forming priority-setting processes

The case study sites were selected as examples of attempts to put in place formal mechanisms for the prioritisation of resources. Although the formation and function of these priority-setting processes showed some variation (see ‘Key features of the case study priority-setting processes’), there were a number of common factors cited as being important in driving these developments, which included the need to address the financial challenge, and central government policy. PCTs were concerned about avoiding spending deficits and saw priority setting as a means of keeping within their allocated budgets. It was clear that within these sites, the economic downturn had sharpened focus on issues of efficiency and further driven the need to provide savings. In addition, aspects of national policy were seen as drivers, as local organisations recognised the requirement for effective priority setting in recent government policy. Most notably this was in relation to WCC and the QIPP agenda.



PCTs were concerned about avoiding spending deficits and saw priority setting as a means of keeping within their allocated budgets

World Class Commissioning

With the exception of the disinvestment work at Nethersole (W2), the PCTs involved in the research had been given a strong motivation to look at their priority-setting processes by the WCC agenda and the associated assessment criteria which applied to all PCTs. The WCC assessment process ostensibly aimed to increase the transparency, efficiency and quality of services. Commissioners indicated that WCC had acted as a lever, enabling them to engage with stakeholder groups around priority setting. Thus, the commissioning assessment criteria were used as a lever to initiate engagement with stakeholders in conversations about priority setting. As such, the need to perform well against WCC criteria was a significant driver of developments in local priority setting.

Quality, Innovation, Productivity and Prevention

Within three of the five sites, the QIPP agenda was used to focus attention on priority setting. As with WCC policies, QIPP acted as a lever with which to engage stakeholders from across the health economy. The language around the QIPP agenda was perceived to be in line with the need to set priorities explicitly. By drawing attention to efficiency and quality, QIPP was seen as compatible with a health economy-wide approach to priority setting.

However, as well as facilitating priority setting, the national context was seen by some as a potential impediment to the development of local arrangements, with particular reference to the amount and shifting nature of central government policy directives. For example, some respondents were concerned about the impact that the reforms set out in the White Paper *Equity and Excellence: Liberating the NHS* (DH, 2010a) could have on priority setting and commissioning more generally, particularly in relation to the achievements that had been already made, and future developments around investment and disinvestment decisions. All sites mentioned the difficulties and tensions in managing the competing imperatives to deliver on nationally derived expectations, respond to the local political climate and adopt an evidence-based approach:

People want to be world class, so having the competencies helps us to identify what we can improve – and being more efficient and improving on Competency 6, then having the assessment and scores, help us to focus on areas for improvement.

The QIPP agenda has been helpful in getting everyone signed up. It's really given us a focus in terms of having that shared understanding and driv[ing] the criteria quality innovation... it was a natural home for the priority-setting work.

There is [sic] always changes to policy or something that comes left-wing [sic] – we had Darzi groups then QIPP, and then changes to provider services – [it] all slows change, [it's] difficult to set priorities and make changes when you have a workforce who are worrying about their jobs... The NHS is really unstable. There is constant pressure to do things quickly, meet targets, save money, and on the other hand we don't take time to look at what is stable. We don't really know where we are going, just a constant reaction – no planning.

We do the national 'must dos' and then do the local ones. For example, bowel screening is a must-do, as [it] will be the only one failing if we don't. The cost-effectiveness work is done for us, and it is the third biggest killer in Morebeck. This is easy when the evidence is strong, but when it is only a political priority, it is harder to do.

Key features of the case study priority-setting processes

The stated aims of priority-setting work were similar across all the sites, and tended to relate to local PCT strategies, focusing on areas such as efficiency, service quality and adherence to national and/or local priorities. There was often dissonance between the PCT strategic plans and those of other stakeholder (member) organisations. There was some variation in the formal membership of organisations and individuals involved in priority-setting work: some of this variation related to the different types of priority-setting activity under study, but it also related to the strategy of engagement, and seemed to be affected by the relationships between commissioners and stakeholder groups (see 'Stakeholder involvement in priority setting' for further discussion).

Three out of the five sites had developed priority-setting processes which focused exclusively on new (that is, additional) resource allocation. Commissioners suggested that the reason for such a focus was due to the fact that developing processes around new investment was less complex to undertake than the prioritisation of core spend or disinvestment. In addition, there was often a desire to get the process right for new resource before rolling this out more widely:

It is much more manageable. Looking at overall budget spend is really complex.

There is a desire to get the process right with new resource before we use it to disinvest in services.

Formal decision criteria

The stated criteria of priority-setting decisions should reflect the scope and aims of the exercise. The most longstanding priority-setting function (at Donative) had formally adopted an ethical framework as a guide to decision making and was the only site to have done so. This framework included considerations of utility maximisation and social justice. However, while this had informed the priority-setting forum's practice for many years, it had not been explicitly incorporated into the Operational Plan processes used to review core spend. In practice, the ethical framework was usually referred to when there were disagreements between forum members on the appropriate course of action:

The chair would bring us back to [the framework] if we could not make a decision. IVF was a good example: do you apply the same rules for pre-implantation genetic testing to patients requiring IVF – that is, given that there are limited cycles for IVF, if a patient has high risk of a child with a genetic deformity, do you implant following IVF or test first? Cost data was considered, but late terminations are also costly. [The] chair referred discussants to the framework to guide the decision.

Chetwynd had developed a tool that was underpinned by the PCT's ethical framework, as described in its commissioning strategy. Other case study sites had modified or adopted multi-criteria scoring systems based on work undertaken in other localities, and had weighted considerations of ethical frameworks such as evidence on health outcomes, need, cost, value and cost-effectiveness (more detail on the application of these models is provided in 'Technocratic approaches to aid priority setting: the evidence-based approach'). Further, when asked about what ethical frameworks are employed, a number of respondents suggested that doctors "are behaving ethically as under Hippocratic Oath".

While some of the decision-making tools may incorporate criteria that consider ethical frameworks, the difference with these compared to those who have adopted an ethical framework such as that used by Donative, is that they do not explicitly start from an agreed ethical standpoint. In the absence of an explicit (agreed) ethical framework, many of the ethical dimensions of priority setting (and trade-offs between them) remained largely implicit in decision making. For example, through processes such as PBMA, the utilitarian concern with maximising health gain was invoked, but rarely acknowledged or explored.

The existence of deliberative elements in the process may allow other considerations to affect the outcome, including those informed by distributional justice and equity (reduction of health inequalities):

We do talk about patient and population benefits. I'm not sure about ethical systems. We do talk about benefits and risks at personal, population and organisational levels. It is more than just money, not just savings. Not sure that I can articulate it or describe it, but we do look at personal, organisational and population benefits in our funding decisions. It does feel fair, and the projects fit well with the strategic direction of the PCT, so I think the mix is right.

Decision processes

The sites which had more developed priority-setting processes tended to have a collaborative health economy-wide approach to priority setting and service planning. The experience of those involved suggested that this collective model was important for success. There was also evidence that when case study sites seemed less developed in their priority-setting work, there was an apparent lack of engagement with the wider health economy and relevant stakeholders. However, there was some apparent lack of fit between the PCT operational planning cycle and system-wide plans. Further, the system-wide approach raises a number of issues around power, politics, culture and governance (see below).

Pathway redesign

Given the scale of savings required by the case study sites, the focus seemed to be shifting from simply having priority-setting processes for new developments to looking at areas for disinvestment as well. Reallocation of resources and disinvestment through whole pathway redesign are important if the NHS is to make efficiency savings and give high-quality service provision (Smith and others, 2010). Pathway redesign at the two sites in W1 involved forms of delegated autonomy, and provided the opportunity to organise services around care pathways rather than along organisational boundaries. There was also the view that the “low-hanging fruit had already been plucked”, and that pathway redesign was an important vehicle which could help transform and streamline services, potentially leading to greater efficiency savings.



Reallocation of resources and disinvestment through whole pathway redesign are important if the NHS is to make efficiency savings and give high-quality service provision

Legitimacy and fairness of processes: Accountability for Reasonableness

Many of the decision processes encapsulated in this study can be explored with reference to Daniels and Sabin's (1997) Accountability for Reasonableness framework. According to this model, priority setting may be considered legitimate and fair if it meets the four criteria of 'publicity', 'relevance', 'appeals' and 'enforcement'. Table 4.3 maps the site-specific decision processes against these criteria. An emergent pattern is that most sites included relevant evidence to inform the priority-setting process; however, in some instances the evidence provided was superseded by clinical expertise. Equally, there were instances when evidence was lacking within processes; the reason for this included the 'bluntness' of the criteria used in priority-setting tools, an actual lack of evidence around a service or intervention, or the fact that the relevant evidence had not been accessed. All sites involved stakeholders from across the health economy, but only one, Chatterton, demonstrated strong engagement with the public; Donative had moderate engagement and Morebeck had limited engagement. Sites had limited mechanisms for both appeals and enforcement (Daniels and Sabin, 1997).

Table 4.3: Site-specific decision processes against the Accountability for Reasonableness criteria

	Morebeck W1	Donative W1	Cherwynd W2	Nethersole W2	Chatterton W2
Publicity The extent to which decisions taken over the allocation of health care resources are made accessible to the public	Limited engagement with the public	Moderate engagement with the public	No engagement with the public	No engagement with the public	Strong engagement with the public
Relevance The extent to which decisions are influenced by evidence that fair-minded people would consider relevant	Draws on relevant evidence to help inform decisions	Draws on relevant evidence to help inform decisions	Draws on relevant evidence, although the criteria used may lend themselves to more clinical-type interventions	Draws on relevant evidence, although the criteria used may lend themselves to more clinical-type interventions	Difficult to ascertain
Appeals The existence of mechanisms for challenge and review of decisions and for resolving disputes	No evidence of appeals mechanisms	Some evidence of appeals mechanisms	No evidence of appeals mechanisms	No evidence of appeals mechanisms	No evidence of appeals mechanisms, although there is a forum for discussion of decisions and ability to voice objections
Enforcement The existence of effective mechanisms for ensuring that the other three conditions are implemented	No evidence	No evidence	No evidence	No evidence	No evidence

Role of discussion and deliberation

Discussion and deliberation can be important in increasing decision transparency and the creation of a shared understanding in relation to the priority-setting decision. This can help legitimacy and develop relationships within and across stakeholder groups (Daniels, 2000). All sites engaged in some level of discussion with both clinical and managerial professionals in their locality. Wider inter-organisational discussions tended to occur at Morebeck (W1) and Donative (W1), especially around core spend activity and pathway redesign, and at Chatterton (W2) in its disinvestment work. All sites seemed to place an emphasis on the importance of discussion and deliberation, and there was a sense that this provided greater transparency and legitimacy for the decisions reached.

Sites that had developed multi-criteria scoring systems and business case proposals tended to have a more structured decision-making process, which involved either the individual or collective scoring of proposals: for example, a ‘Dragon’s Den’ or panel-based process, which assesses proposals for new service developments or reallocation of funds, had been developed by some sites. This type of process was seen as providing an arena for tackling difficult discussions. Multi-criteria scoring systems were often used to facilitate these discussions. This is important, as scoring proposals often operated not as a summative mechanism, but as a formative means of fostering debate. Therefore, the scoring was a means to an end rather than an end in itself, which is what the developers of MCDA would suggest such technocratic approaches are intended to achieve (Belton and Stewart, 2002). However, this may be in contrast to the views or wishes of those who use these tools in practice, with some individuals suggesting that tools such as MCDA and PBMA could provide a solution to the difficult task of priority setting and decisions around resource allocation.

Technocratic approaches to aid priority setting: the evidence-based approach

The respondents at all the sites suggested that both clinical and cost-effectiveness evidence played an integral part in priority setting. Priority-setters at Morebeck (W2) suggested that the use of evidence in the PBMA approach acted as both a ‘carrot’ and a ‘stick’. That is, on the one hand, it provided a common language that spoke well to clinicians and to policy directives around QIPP, while on the other hand, it gave commissioners the opportunity to question poor performance and to engage clinicians in improvement initiatives. Processes which involved the use of priority-setting tools (such as multi-criteria tools and business proposal templates) were supported more explicitly by evidence. The types and levels of evidence requested varied between sites, but tended to focus on clinical effectiveness, patient eligibility, numbers intended to treat, cost-effectiveness and value for money.

A number of sites placed a high premium on the deliberation of evidence, even when the tool produced different results to the actual decision reached. This also enhanced perceived transparency, as those involved felt that they were able to articulate the processes undertaken to stakeholders. Further, commissioners suggested that this type of deliberative process enhanced clinical engagement and, as such, gave the priority-setting process more ‘clout’.

There was a suggestion that where processes managed to capture clinical enthusiasm, while testing the ability to deliver innovative practices, they were more effective. The importance of linking process to strategic priorities was also noted:

The latitude in the tool allows for that discussion, so who is involved is important, and how it is done. Using these approaches gives us a mechanism for the difficult conversations, a framework for it, and a scoring system is helpful to weight these, especially if there are 100 or more proposals.

The benefit of the explicit linking of commissioning to priority-setting approaches is that it acts as a balance against clinical enthusiasm. So scrutiny is really important here – far too often PCTs act like a dog without a head waiting for a tail to wag it, sitting without strategic vision across the whole strategy. Harnessing the ‘Dragon’s Den’ to strategic priorities may be the way to link the wishes of clinicians to the bigger picture.

While most people involved in the research generally welcomed a more transparent and deliberative approach to priority setting, there were some concerns raised over the subjectivity of scoring systems. Given that a different emphasis might be placed on different criteria, this was seen as a way in which bias could be introduced to the process.

The Nethersole case demonstrated some dissonance between the overall scoring and the final decision reached. It was felt that this was largely due to the ‘bluntness’ of the tool rather than the merits of the proposed intervention or service, and the organisation was looking at how the criteria might be modified to be more in tune with both clinical and public health interventions.

While the evidence-based approach was seen as important to priority setting, there were other dimensions which might be seen to dilute the degree of rationality. These included:

- the exigencies of the NHS financial planning context
- political processes
- difficulties in accurately estimating savings from disinvestment and/or service redesign
- having the expertise and sophistication to produce and understand evidence.

There was also some suggestion that gathering accurate evidence could be difficult, and that often national evidence around cost-effectiveness had been poorly translated at the local level. A common theme was the tendency for proposals to be over-ambitious, especially in terms of the actual savings that would be realised. Moreover, there was some frustration in relation to the lack of clinical and cost-effectiveness evidence for some older existing technologies, which many perceived should or could be decommissioned.

The issue here is that, without the evidence, it is difficult to persuade others that practice needs to change (Elshaug and others, 2007), and there is often little evidence about established technologies and procedures, even where there is a shared feeling that these are ineffective.


Presentations seemed hugely ambitious, and with limited outcomes and deliverables against them, I don't think they will realise the savings they suggest – which is problematic for the process and our financial position.

Some projects were difficult to show financial savings: for example, screening should lead to earlier intervention, but cost reduction does not necessarily follow. If you find patients, they then cost money to treat – if you don't pick them up earlier, they may cost more down the line... One of the things rejected was for Hep[atitis] C testing. The assumption was that £200,000 would find and test high-risk populations in Donative. However, no modelling had been done on the treatment costs. All agreed that we should find and treat, but the case for cost-effectiveness treatment was not made, so it was rejected. It wasn't that it was a bad idea, just that the business case was not complete.

There was a general feeling that multi-criteria tools and business case models are more aligned with clinical than public health and other interventions which have ‘softer’

outcomes and a less ‘scientific’ (in a formal sense) evidence base. Thus, it is more difficult to make the case for efficiency savings and outputs in the format demanded for public health services; often easier to make an evidence-based case for downstream interventions; and more challenging to provide good evidence for more upstream interventions. This is problematic, as often it focuses activities on more reactive types of services and neglects preventative and therefore potentially cost-saving options.

It was apparent that in some cases, decision-making tools and processes (such as PBMA) were valuable not only in generating evidence and analysis, but also in making the case for priority setting to potentially sceptical clinical stakeholders. Explicit priority-setting tools helped to provide a structured setting for deliberation and coalition-building; facilitating the decision-making process rather than algorithmically deriving the ‘answer’. The relationship between decision rules and deliberation was a common theme of interviews, and this is returned to in the ensuing sections.

 It was apparent that in some cases, decision-making tools and processes were valuable not only in generating evidence and analysis, but also in making the case for priority-setting to potentially sceptical clinical stakeholders

Stakeholder involvement in priority setting

A plethora of stakeholders were involved in priority-setting activities in each of the case study sites, including:

- citizens
- patients
- local authority professionals and representatives
- local councillors
- health organisations such as primary care providers, acute providers, voluntary sector and mental health providers
- PBC groups
- GPs.

Table 4.4 outlines the different stakeholders involved across the sites. Again, the process and level of stakeholder involvement varied between sites, but broadly involved citizen forums, public and patient involvement in priority-setting events, and representatives from health and social care organisations sitting on priority-setting boards. As Table 4.4 identifies, all sites involved primary care, hospital providers, GPs and PBCs.

Table 4.4: Stakeholder involvement in case study priority-setting processes

	Citizens	Patients	Local authorities	Local councillors	Primary care providers	Hospital providers	Voluntary sector	Mental health providers	PBC/GP
W1:									
Morebeck			✓		✓	✓	✓	✓	✓
Donative	✓	✓	(indirect)		(indirect)	✓	✓	✓	✓
W2:									
Chetwynd					✓	✓ (limited)			✓
Nethersole					✓	✓ (limited)			✓
Chatterton	✓	✓	✓	✓	✓	✓			✓

The authors have used an adaptation of Arnstein's (1969) ladder of engagement to explore the level of involvement of various stakeholder groups from across the different health economies (where 0 = 'no involvement' and 8 = 'total control of the process') (see Figure 4.1). Table 4.5 outlines the level of engagement for each site by each decision activity.

Figure 4.1: Adaptation of Arnstein's ladder of engagement

8	Control	} Degrees of power
7	Delegated power	
6	Partnership	
5	Placation	} Degrees of tokenism
4	Consultation	
3	Informing	
2	Therapy	} Non-participation
1	Manipulation	
0	No involvement	} No involvement

Table 4.5 illustrates that no site engaged fully with all stakeholders. Even where involvement was routinely incorporated into decision processes, this tended to be around the middle to lower end of Arnstein's continuum.

Table 4.5: The level of engagement for each site mapped against Arnstein's ladder									
	Stakeholder groups								
	Citizens	Patients	Local authorities	Local councillors	Primary care provider	Hospital providers	Voluntary sector	PBC/GP	Mental health providers
Morebeck									
Overall budget allocation	0	0	0	0	3	3	0	4	NS*
New resource allocation	0	0	0	0	6	5/6	5	6/7	NS*
Disease pathway redesign	0	0	0	0	6	6	4	6	NS*
Donative									
Overall budget allocation	4/5	4/5	4/5	0	5/6	5/6	5/6	5/6	0
New resource allocation	6	6	4/5	0	6	6	5	6	6
Disease pathway redesign	0	0	0	0	7	7	0	6	7
Reprioritise across budget areas	4/5	4/5	4/5	0	5/6	5/6	5/6	5/6	0
Chetwynd									
New resource allocation	0	0	4	0	4	4	0	4	0
Nethersole									
New resource allocation	0	0	4	0	4	4	0	4	0
Disinvestment	0	0	0	0	4	0	1	3	1
Chatterton									
Disinvestment	4/5	4/5	6/7	6/7	3/4	0	0	6	0

*NS - Not stated: we are unable to report on mental health involvement here as this was not referred to by the respondents.

Engagement and involvement of health and social care organisations

In all of the sites there was a recurring theme relating to the difficulties in engaging the acute sector in priority setting. Even in sites where there was some engagement and signs of effective partnership working, the power of the acute sector and differences in culture, focus and strategy made priority setting a challenge. Where successes were reported, this tended to relate to modifications to patient pathways rather than engagement in decisions over the explicit rationing of resources according to agreed criteria. However, even where attempts were made to redesign pathways, sometimes it was difficult to actually implement decisions. One site in particular had struggled historically to challenge the acute trusts that were seen as having a very strong power base. Further, the incentives of policies such as Payment by Results, which encourages productivity, meant that acute hospitals had little incentive to engage with commissioners, especially when the discussion was around designing services and potentially reducing hospital admissions.

Morebeck reported involvement from all chief executives from both primary and secondary care and had moved towards a more 'joined-up' approach to priority setting in health care at least. This meant that all organisations were represented on the priority-setting board, although in practice the extent of engagement from commissioners and acute providers varied. One observation during our research was that the emerging relationship between PCT commissioners and practice-based commissioning was considered fruitful as a mechanism for shaping discussions with acute trusts. The involvement of clinical commissioners was seen as a helpful way to engage acute partners in discussions about priority setting across the local health economy. Furthermore, in the context of disinvestment, implementation was considered to require clinical acceptance.

Engagement and involvement of the public and patients

The case study sites demonstrated little by way of meaningful citizen engagement in decision making. Although the respondents were generally receptive to the idea of greater public involvement and engagement, they were less clear about when and how this ought to be instigated. Indeed, some sites had taken a conscious decision *not* to involve the public in their priority-setting activities. For example, Morebeck (W1) felt that it was not appropriate to involve the public in most of its priority-setting work, arguing that there was a need to get the process established in-house and that organisations from across the health economy needed to agree on decisions before involving patients or the public.

Clearly, this concept of how and when the public should be involved runs counter to notions of meaningful citizen engagement in decision making, and is more consistent with a traditional, 'closed-shop' model of resource allocation. By contrast, Donative (W1) felt that engaging with the public was important and should take place at an early stage of decision processes. This site involved the public in the planning phase and in setting priorities as part of its five-year strategy. However, commissioners felt that they struggled to gain engagement on large-scale, population-based priority setting with those members of the public in attendance. They did have rather more success in engaging the public in debates around more specific issues, such as service provision in particular locations. Other sites also discussed the issue of public engagement and

the fact that individuals who often turn up to public engagement events represent one issue or disease area, which was perceived to narrow the engagement process and the views represented. This issue of representativeness was considered to present difficulties for commissioners who were broadly unaware of existing methodologies for overcoming some of these challenges.

Chatterton (W2) highlighted the importance of public engagement, in this case in relation to the closure of a hospital and the subsequent decommissioning of services from a hospital setting into the community. This tended to be done through a stakeholder group which consisted of representatives from across the health economy, including a well-respected local councillor and two GPs. A high-profile local politician was referred to as a 'health champion', and GPs were seen as important in helping to gain public confidence. This site tended to use public engagement as an information-sharing exercise: that is, it was used to impart information relating to decisions already made rather than actually empowering citizens to influence disinvestment decisions. As such, forums often acted as a space for the public to vent their anger and frustrations around, for example, hospital closure.

While the public generally had little influence over the decision to close the hospital, the forum did allow them the opportunity to influence the planning of future community-based services. Issues around current levels of services were highlighted at the forums and subsequent action taken to resolve these issues when recommissioning new services following the hospital closure:

Having respected individuals from the local council and GPs was very important in gaining support and trust – I think this would have been the case anyway, but the fact that the mistrust was more with the management team at the PCT, rather than the clinicians and the local council, meant these groups needed to be involved and their opinion counted with the public.

Although limited as a means of involvement in specific decisions, these forums were seen as beneficial in helping to address the broader issue of resource constraints and the need for priority setting. Interviewees from all sites identified the need for a collective acceptance of the need for rationing as a crucial step in the process – albeit one which had not as yet been fully taken. There was also a general feeling that rationing discussions with the public needed to take place at both local and national levels, and that the government needed to endorse and support discussions around resource scarcity and rationing:

We want to make decisions on clinical cost-effectiveness of services, but patient wants are not always in agreement. For example, we invested £1.5 million to sustain services at [X Hospital], which was not a cost-effective decision or one based on clinical effectiveness – it was hugely influenced by public expectations and policy.

Overall, it was clear that legitimacy is an important factor in priority setting, especially when this led to the removal of high-profile services. The respondents identified political and clinical support, and public engagement, as key factors in the struggle to establish legitimate decision making. In addition, there was a general suggestion that having such dialogues during the current economic crisis was both crucial and possible – the respondents felt that the time was right to have such national and local discussions around investment and disinvestment in NHS services. That is, the financial crisis had allowed commissioners to frame the issue of rationing in a more acceptable way to the general public:

If we can't have discussions with the public and staff about the need to disinvest and redirect resources now, when there is no money, then we can never do it. We can't provide everything, and we need to say that.

Despite the relative absence of substantive public engagement, there was a clear realisation within case study sites of the need for wider support if the tough choices involved in priority setting were to be considered legitimate. This led to the apparently contradictory standpoint of shielding priority-setting processes from a potentially sceptical public, while acknowledging the necessity of wide-scale public trust in these processes.

What was apparent from the study was the importance of agreement on the basis for reaching decisions and the active engagement of stakeholders in managing the fallout from disinvestment decisions. Across the case study sites, there was general agreement that the public had only rarely been engaged sufficiently for there to be a degree of confidence in the perceived legitimacy of the decisions. In the absence of national debate over what the public might reasonably expect from NHS services, such decisions will continue to be difficult to implement.

Implementation

The need to disinvest in services raised challenges associated with implementing decisions. It was not clear in all circumstances precisely which mechanisms and levers were in place to ensure that the determinations reached by prioritisation processes would be fully implemented in local delivery systems. The explicit inclusion and 'buy-in' of organisations from across the health economy was seen as important to the priority-setting process. However, this type of inclusivity was also suggested as a factor that could slow down the decision-making process and get in the way of developing and implementing priority-setting policies. For example, at one site there was frustration that the decision-making board was too big and therefore limiting the opportunity to discuss, deliberate and make "actual decisions". There was a suggestion that the meeting was more of a "talking shop", and this had an impact on engagement. This was actually discussed at a priority-setting board and it was agreed that changes to the process needed to happen in response to this perception. It was decided that the chief executives would hold additional meetings to discuss and monitor implementation.

A further aspect that emerged from this study was that involvement within organisations was often limited. While senior leaders or managers from across the health economy acted as decision-makers in the priority-setting processes, they did not always involve or engage individuals from within their own organisations. This lack of transparency and communication to all internal and external stakeholders can serve to limit the priority-setting process, especially during the implementation phase. Another perceived blockage to full implementation of decisions related to organisational reluctance to 'take the losses' implicated in disinvestment decisions.

The existence of powerful Payment by Results incentives for increasing activity was identified as a potential difficulty for cross-system planning. Quasi-market incentives reward activity, and thus acute provider units are directly incentivised to increase activity at a time when health economies are attempting to optimise patient pathways and shift care from acute to primary and tertiary providers. While such incentives clearly act as a barrier to system-wide care pathway planning, acute providers are aware

of the need to avoid unnecessary over-performance in relation to commissioners' agreed levels of activity, as there is a danger that commissioners may not be able to pay for such over-performance. The respondents gave clear indications that despite the existence of goodwill and a harsh financial climate, often commissioners and non-acute providers are unable to reduce acute admissions.

Economic pressures notwithstanding, disinvestment remains distinctly counter-cultural for many. In a quasi-market context it is understandable that allegiance may be primarily focused organisationally, rather than on any wider concept of economy-wide benefits. In such a context, disinvestment involving pathway redesign may be experienced as profoundly unsettling. Culturally, 'stopping doing things' is not what NHS providers are used to, and there is the practical difficulty that changes can mean having to invest additional resource in the short term:

We have developed some community alternatives to secondary care but cannot decommission hospital beds – we audit our clinical schemes, it shows that because of intervention it prevented an acute admission. Community services say that they reduce admissions, but the number of admissions continues to rise! So we are not yet brave enough to make the first step to challenge and reduce acute services. But the last ten years were well resourced, and necessity may be the mother of invention here to deliver QIPP and savings – forcing the realisation that we need to work across the economy.

Disinvestment? Not easy. That could be a big chunk of our income being removed. If we are going to have proper transformation then we need to make sure we can deliver on that. It's a balancing act, but we need to look at things as a health economy rather than having organisational boundaries. Egos get in the way, and the focus is on my organisation and what we are set out to do, rather than a shared approach. If you were an alien landing from Mars, you would never understand that the NHS was one organisation.

On a more positive note, corporate performance management of clinical and financial outcomes was considered useful in providing assurance and troubleshooting designed to improve performance, supported by data systems. Typically, the respondents indicated a positive experience of such assurance systems, as they responded flexibly to difficulties and were able to support development when things were not progressing as anticipated:

My experience of the assurance groups was largely positive. Before them, money and targets were kept separate, which was not helpful. For example, on one workstream we were not meeting the target but were saving money, and the assurance group enabled us to have a discussion in the round – 'Should I spend more to meet the target?' – which was very helpful. Similarly, if we meet the milestones but there are no savings, how might we best revisit the plan of action on results? So, this was positive.

The monitoring system does work: the monthly nature means we are concentrating on it, and we know where we are at any time. However, the indicators do need to be the right ones, and it is difficult to set indicators for outcomes when you are setting up. For example, we thought we would have 150 pharmacy heart-checks per month, but have only 50: the performance threshold was too high, which means we will not meet our financial savings target. We need to make sure that where services are not being taken up as expected, we need to ensure sensitivity analysis, and this takes time.

Chatterton found that once the decision had been implemented it was met with greater positivity, suggesting that for many, the fear of losing the hospital and all the potential problems highlighted (quality of care for patients, and so on) seemed to be more around anxieties and fears rather than the reality of lived experience. There was some suggestion that these anxieties and fears can be further exacerbated if the implementation phase and the timelines set are not undertaken effectively. There was a sense that once a decision is made, then sticking to agreed timelines is important.

Leadership

The respondents frequently cited leadership as being an important factor in both reaching and implementing priority-setting decisions. The leader's role was seen as extending to a range of different activities including project management support, stakeholder engagement strategies built on negotiation and dialogue, and ensuring that incentives systems are in place to influence behavioural change. What is clear from this is that although some of these tasks (for example, project management support) are relatively straightforward types of managerial behaviours, the majority of leadership tasks pertains to more complex, relationship-based issues (influencing others, engaging stakeholders, and so on).

At less successful sites, there was some criticism of leaders' communication of information and a sense that poor implementation resulted from executive leaders' inability to reach lower tiers in the organisational hierarchy. Again, this suggests that an important role of leaders is not simply in the application of hard power over followers, but instead in appealing to others on an emotional level and encouraging them to engage with particular agendas. This also suggests that the middle tier of management may need to be stronger, or have more support in the form of a project manager for priority-setting policy. Thus, there are distinct roles for leaders around engagement, and for managers in terms of project management and overseeing a range of process-related issues.

What also rang true across the sites was the importance of clinical leadership or clinical champions in appealing to other clinicians, patients and the public with a form of legitimacy that general managers are not able to possess. Without clinical leadership, sites felt that inevitably, attempts to change processes or disinvest in services would be unsuccessful. Moreover, without getting clinicians 'on side', any plans might be disrupted by clinicians who were either not engaged, or failed to engage, with these decisions:

CEO group have a strong presence, but information [is] not passed down [through the] organisation... frustration that it is not led enough in terms of having [a] clear idea of where we need to get to – also, we have lots of activity at the strategic level and not at the 'doing level': when do we get to the 'just do it' people?

On the ground we have lack of support – [the] balance [is] not good. We need project managers holding people to account: it's not good that we have been milling around in this pond forever. When are people going to give information and unblock that...? [I'm] not sure we have [the] correct governance structures in place.

Getting clinical engagement is important but not just getting clinicians involved – we need them leading on this – I am hoping the new GP commissioning role will help here.

With acute care, the whole model has to be clinically led. We have a joint primary and secondary care clinical council, and the next phase of priority setting might be to use the clinical council's clinical criteria, which are focused on reducing health inequalities and providing integrated care.

Overall coherence and 'success' of priority-setting processes

Having explored some of the different aspects of priority setting and how these are operationalised in practice, this section will give consideration to the extent to which the case study sites delivered on their aims. Sibbald and others (2009) provide a conceptual framework that outlines ten areas for successful priority setting; these are divided into process concepts and outcome concepts. Process concepts include: stakeholder engagement; use of explicit process; information management; consideration of values and context; and revision or appeal mechanism. Outcome concepts include: improved stakeholder understanding; shifted priorities and/or reallocated resources; improved decision-making quality; stakeholder acceptance and satisfaction; and positive externalities.

Table 4.6 outlines how well each of the sites did against the framework. There is some positive activity in relation to Sibbald and others' (2009) criteria, with evidence of stakeholder improvement, and moderately transparent and explicit processes. Three sites showed some positive changes in relation to shifted priorities and/or reallocation of resources. For Morebeck this involved the release of funds generated by the business case development model; the pathway redesign work had not yet been fully implemented and thus it was too early to see any tangible outcomes. Although outcomes are limited, the health economy-wide approach to priority setting was welcomed by the majority of respondents. A similar pattern was suggested for Donative (W2), which was also relatively early in the development of its priority-setting work around core spend. Again, sites did less well in terms of systems for the revision or appeal of decisions.

Table 4.6: Application of Sibbald and others' (2009) framework to the priority-setting activity at case study sites

	Morebeck (W1)	Donative (W1)	Chetwynd (W2)	Nethersole (W2)	Chatterton (W2)
Process concepts					
Stakeholder engagement	Yes to some extent, but not with the public – this was a strategic decision	Yes to some extent, but struggled with public engagement	Limited engagement at this stage, but recognised the need to involve in future	Not much engagement with wider stakeholder group	Evidence of engagement with stakeholders, although often information-sharing for public and some provider groups
Use of explicit process	Transparent and explicit in terms of decision-makers – could have been more explicit for other wider stakeholder groups: that is, cascaded throughout organisations, although communication was attempted through QIPP agenda	Transparent and explicit in terms of decision-makers and attempts to communicate to wider stakeholder groups, but more could be done to increase use of this process	Transparent and explicit in terms of decision-makers – could have been more explicit for other wider stakeholder groups	Limited	Decision to close hospital was made by a small number of decision-makers. The decommissioning and recommissioning of services was more explicit in terms of process, but more could have been done with some groups
Information management	Needs to be developed – more communication around what information decision-makers require and in what format	Relevant information accessed and a good information team supplemented by clinical knowledge, but less on patient views	Criteria of tool not always relevant to non-clinical interventions, leading to lack of relevant information to populate the tool	Criteria of tool not always relevant to non-clinical interventions, leading to lack of relevant information to populate the tool	Difficult to ascertain what information was provided – some providers criticised the lack of information
Consideration of values and context	More explicit in organisational strategies and more implicit in priority-setting processes	Explicit in priority-setting forum but less explicit in other priority-setting activity	More explicit in organisational strategies and more implicit in priority-setting processes	More explicit in organisational strategies and more implicit in priority-setting processes	More explicit in organisational strategies and more implicit in priority-setting processes
Revision or appeal mechanism	None developed	Appeals on individual decisions according to interviews	None developed	None developed	None developed

Table 4.6: Application of Sibbald and others' (2009) framework to the priority-setting activity at case study sites (continued)

	Morebeck (W1)	Donative (W1)	Chetwynd (W2)	Nethersole (W2)	Chatterton (W2)
Outcome concepts					
Improved stakeholder knowledge	Yes, for those involved in the process	Yes, for those involved in the process	Yes for some, but not all	Limited	Yes, very much for some stakeholders
Shifted priorities and/or reallocation of resources	Yes, for business case development; limited for QIPP. Slow in implementation but potential in coming months	Yes for some areas, but early stages for others	No	No	Yes
Improved decision-making quality	Yes	Yes	Limited	No	Difficult to ascertain
Stakeholder acceptance and satisfaction	To some degree, although issues of power, cultural differences and fear of associated risk are barriers	To some degree, although issues of power, cultural differences and fear of associated risk are barriers	Limited to certain groups – this could be due to the stage that the process is at	No	Yes for most, although only since decommissioning happened and new service is in place
Positive externalities	Mixed – this is apparent to some degree	Mixed – this is apparent to some degree	Limited	No	Yes, but again since decommissioning and new services are in place

Response to the White Paper: the impact of government reforms on priority setting

As outlined in Chapter 2, significant reforms to health care commissioning were announced as the authors were collecting data. Given the wide-ranging implications that these have for priority setting, the authors incorporated some questions about these changes into the research.

Policy instability

As noted above, there was a general concern raised about the direction of government policy. Concerns related to organisational unrest in the period leading up to the demise of PCTs, and the extent to which the new policy directive could shift focus away from a health economy-based approach to priority setting, with the latter being seen as an important element to previous successes. Some respondents felt that the proposed reforms would lead to a short-term weakening of PCT authority in commissioning relationships, and that this would make it difficult to implement change. Concerns were raised also at the timing of the policy and the impact that this would have on priority setting. There was a sense that major policy reform at a difficult financial time would limit the amount of disinvestment and service redesign that could be achieved.

It was further noted that any new CCGs would need to address the issues of legitimacy and engagement within their commissioning systems. Although clinically-led, commissioning is seen as important, but this in itself will not win automatic support for difficult decisions:

It is unfortunate that we face changes in how this is going to work due to government policy – reorganised structures will take time to be functional. We have the data, links, provider involvement and are on the cusp of progress, so this does feel [like] a lost opportunity. It will take GP commissioners a while to work out what we are going to do, or if there is a national lead. Priority setting has to sit with commissioners.

Losing the knowledge and history of commissioning

Some respondents discussed the need to maintain the work already done to develop commissioning. Rather than ‘reinventing the wheel’, they felt they needed to make sure that good practice is taken forward and that learning is not lost in the transition period. In addition, there was a fear from some that CCGs may resist recruiting existing employees from within the PCT and look to gain new ideas from the private sector. This could lead to the development of a new industry around commissioning which could be more costly than the old system.

Readiness of GPs to take on the commissioning role

There was a general view that some GPs would embrace this opportunity and work well in the commissioning role, especially where consortia and strong PBC activity already existed. However, there was a concern that this was not the case for a high number of GPs, and that there are many who will struggle to take up the commissioning role – especially in terms of population-based decision making.

The majority of respondents were concerned about the changes. However, there were some positive opportunities presented in relation to community providers being in a position to become foundation trusts. There was also a suggestion that the tension in relationships between acute hospital providers and GPs would be less than in previous structures, and that this could impact positively on priority setting:

There are pockets within Morebeck where it could work really well and the GPs are ready. One developed consortium in the south has been working well. I don't know if they feel ready to take on a big commissioning role, but they seem to be the most ready. In the north and Linden it's been more difficult. We haven't had such a synergy of people working together yet. It doesn't feel as smooth, so I think they will not be as ready.

Yes, [it's a] time and resource issue. In Linden I think it's also not having the basic knowledge of what each other's services are offering. In the south I think GPs are on board in terms of knowing what community services are offering, but I have my doubts in the north and Linden. I doubt they are fully aware of the wide portfolio of care and service on offer. They may lack knowledge on what exactly it is that they are commissioning. They are pretty much clear on acute commissioning, I think, but community is more vague for them. That is the skill that may be missing.

Population health

Overall, there was some concern over the demise of PCTs, which tend to have a good focus and grasp of population health need. Diluting this function to a number of CCGs within regions potentially could reduce the focus on population need and inequalities in health, thus leading to greater inequalities within and across localities. Of course, many of those themselves whom the authors interviewed would come under threat with the winding down of PCTs, but this view was often shared across the health care economy more widely:

[The] main concern is around strategic thinking. In neighbourhood or town hall-type teams, there is a lot of diversity in terms of need and population. The PCT has a good focus on inequalities in the area and the services needed to provide for these inequalities. When we move from the PCT to... many GP consortia, how do we retain that focus on equality provision and translate that into strategic direction? Practically on short-term stuff I'm sure we will muddle through, but when we take an overarching view of what we end up with, I'm sure there will be increased inequality.

We have been here before with PCGs [primary care groups], and it was difficult for smaller organisations to really get a handle on local health needs and inequalities. I think getting the financial balance right while making sure you are being equitable is difficult for PCTs, so it could be even harder for smaller commissioning groups.

5. Discussion

This chapter sets the research findings within the context of the wider literature and considers the implications of this work for priority setting in health care. The response rate to the survey gained good coverage across the country, and seems to indicate that although many PCTs were at a relatively early stage in terms of the development of their priority-setting processes, there are significant levels of activity under way. However, the majority of this attention has tended to focus on an organisational level of activity and making processes transparent, evidence-based and visible, focusing predominantly on the engagement of clinicians and managers, and less on the wider engagement of the general population and service users.

The survey data demonstrate that priority-setting processes have tended to focus on the allocation of additional funds to new service developments rather than decisions around core spend and disinvestment in or withdrawal of services, with very limited focus on allocative efficiency. This reflects findings from previous studies, where priority setting in the NHS has focused on allocating new resources (McIver and Ham, 2000; Mitton and others, 2003). The case study data suggest that often, priority setting has involved ‘tinkering’ around the edges rather than planning the majority of spending activity. This was partly practical – putting in place a contained process around new additional resource was seen as more achievable. In addition, it may reflect the issue of incentives for involvement, as it may be easier to engage stakeholders in an exercise that could lead to extra resource for service areas than in making decisions around efficiency savings, reallocation of resources and disinvestment.

These observations are not new. Historically, the NHS has found it difficult to decommission or disinvest in services, and the drive for World Class Commissioning (WCC) introduced by the previous government has not brought about significant change in this respect (Crump, 2008; Klein, 2010; Robinson and others, 2011). The case studies suggested that while the first wave of assessment using the WCC assurance framework ensured that PCTs were developing their priority-setting activities, it may well have incentivised a focus on new resources and turned attention away from core budget and disinvestment. However, the revised WCC competencies placed stronger emphasis on allocative and technical efficiency (through the inclusion of Competency 11) and disinvestment. This shift in focus, allied to the economic downturn, appeared to have refocused priority setting onto core spend and disinvestment and this was supported by the survey findings. However, with the discontinuation of the WCC assurance framework and the proposed new government reforms (DH, 2010a), the sites suggested that the gains achieved via WCC might be in doubt. Indeed, a common theme of the case study sites related to the turbulence that was caused by changes in the external financial, structural and political environment, and the impediments that this presented to those implementing and leading local priority setting.

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The remainder of this chapter draws out the key themes emerging from the research.

Decision tools

In priority setting there has been a recent shift towards more explicit, open and transparent approaches, and a growing interest in evidence-based approaches (Williams and Bryan, 2007). Technical approaches that rely on quantifiable epidemiologic, clinical, financial and other data are increasingly argued for in the wider literature (Coast and others, 1996; Neumann and others, 2005). The research suggests that this theme is reflected in the activities of PCT priority-setters, albeit to different degrees across the country and across individual respondents.

Within the case study sites, needs assessment was considered to be an important element of priority setting. However, needs assessments were not necessarily recognised by other stakeholder groups outside PCT management. Despite this, moving needs assessment more firmly centre-stage was advocated as a mechanism in which priority-setting processes might speak to different stakeholder groups and engage them in driving such work and this has been reflected in other research (Glasby and Ellins, 2008).

Aside from needs assessment, one of the case study sites placed a strong emphasis on the use and influence of PBMA in priority setting. As mentioned previously, this site suggested that PBMA acted as both a ‘carrot’ and a ‘stick’ in terms of engagement with the wider stakeholder groups. Other commentators have advocated the use of PBMA as a priority-setting engagement tool, which facilitates engagement with a variety of stakeholders and can reduce tensions between clinicians and managers (Ruta and others, 2005; Peacock and others, 2009). However, the present survey data suggest that only 45 per cent of respondents were using the PBMA approach. What became apparent in the case study sites was that PBMA was often used at an early part of the priority-setting process. Therefore, where PCTs were already some way into these processes, they may have lost sight of the results of earlier PBMA exercises.

Multi-criteria scorecards and business case templates were used by a number of PCTs nationally and within the case study sites, although their design and approaches varied, as did perceptions of their influence. The main issues cited in relation to these types of approaches included excessive data demands, the limited availability of data and expertise to generate and interpret data. When these types of management approaches were applied in practice, they tended to be developed for clinical areas and then modified and applied to all priority-setting work, including non-clinical services which often have ‘softer’ outcomes and a less scientifically robust evidence base. This led to difficulties in populating the tools and made it more difficult for some of the ‘softer services’ to make the case for efficiency savings and outputs in the format demanded.

Other studies have found similar issues with data demands and the ability to generalise and apply such tools to wider priority-setting work (Robinson and others, 2009). Multi-criteria scorecards and business case templates have tended to be applied to new resource decisions in practice, and less work has been done around their use to inform decisions on new disease pathway redesign and disinvestment.

Economic and management tools and frameworks were cited as being useful in engaging stakeholder groups and providing a focus for discussion and deliberation. However, there was evidence to suggest that clinical expertise and preferences often overrode the published evidence base when assessing proposals. Other studies have found that when making health care decisions, clinicians rely less on evidence-based guidance and more on their own and colleagues' experiences (Gabbay and le May, 2004).

Outcomes of priority-setting work

Although the case study organisations demonstrated developments in priority-setting criteria and processes, it is difficult to tell if the development and implementation of these types of technocratic process will increase the efficiency and quality of services over time. Despite the work undertaken, there was a general concern that impact on actual service configuration and health outcomes had yet to be demonstrated.

One of the key reasons for the apparently modest impact of priority setting was the tendency to confine scope to allocation of additional resources. However, one of the case study sites (Chatterton, W2) did have some success in moving beyond this peripheral approach. The success in Chatterton was due to strong leadership and direction, the support of a health champion who was well respected in the local community, and the work done to engage with wider stakeholder groups to support these types of activities. While other sites have made some marginal achievements, there is still a long way to go to achieve outcomes relating to disinvestment and the redesign of services. There was general frustration across case study sites around the limited return in relation to their priority-setting work. That said, it was early days for many organisations – PCTs had existed in their current form for only three to four years, and research evidence shows that the impact of organisational restructuring might be felt for around 18 months (Peck and others, 2006). At Morebeck and Donative the authors did not necessarily observe changes to outcomes, but did see systems being implemented that could start to impact over the coming months. However, the recent policy moves from the White Paper *Equity and Excellence: Liberating the NHS* (DH, 2010a) could well stifle these developments.

Non-technical dimensions of priority setting

While national guidance, a strong evidence base and focus on pathway redesign are important to priority setting, and in meeting some of the major financial challenges facing the NHS, non-technical aspects such as governance, engagement, organisational power, politics and culture are some of the most difficult aspects of priority setting. Precisely because these are such complex issues, and there are no easy or technical answers, means that people often find them the most challenging aspects of priority setting. The case study sites that focused on both technical and non-technical aspects made the most headway in terms of service redesign disinvestment and potential efficiency savings. Thus, the strong message here is: 'Ignore the "softer side" at your

peril' – these aspects are as important as the more technical and process aspects of priority setting. These are now considered in more detail.

Engaging stakeholders and the public


The main lessons from the case study work in this research (Chetwynd and Nethersole in particular) are the importance of engaging with wider stakeholder groups in both the developmental and implementation stages. The evidence from the research suggests that trying to get engagement 'downstream' once the tool or process is developed can lead to difficulties in terms of the process and implementing decisions. Managing and negotiating with a variety of stakeholder groups from across the health economy and beyond is integral to priority setting.

Dealing with stakeholders involves thinking about factors such as clinical and public engagement, media and social marketing, and creating a coalition of support for investment and/or disinvestment decisions (Moore, 1995). Daniels and Sabin (2008) argue that neither philosophical nor empirical foundations are sufficient to provide legitimacy for rationing decisions, which can only be achieved through a process of engagement with stakeholders and the public. This research supports this claim, and those sites that involved stakeholders tended to have achieved more in terms of their priority-setting work than others that little or had no formal stakeholder engagement.

There is strong evidence from the authors' work, and that of others (e.g. Dickinson and Ham, 2008; Ham and Dickinson, 2008), that engagement with wider health care organisations – especially with clinicians – is vital to successful priority setting. The inclusion of a deliberative element to the decision-making process allows for discussion and consideration of evidence and analysis, and a shared understanding of the process and policy decision, all of which were seen as enhancing transparency and openness. However, sometimes the discussions and outcomes of priority-setting boards are not cascaded throughout organisations, and often those who need to implement change are not well informed as to the reasons for it. In some instances this can act as a barrier to implementation. What was also evident at the Morebeck case study site was that when the deliberative process was not codified, those involved became unclear over roles and processes. For example, it was suggested that individual respondents' expectations were not always clear. One of the frustrations for this site was the lack of implementation or visible outcomes in relation to priority setting; this meant that the priority-setting forum was often described as more of a 'talking shop' than a decision-making body. While the deliberative element was identified as a helpful process in priority-setting work, and goes some way to helping to improve transparency and legitimacy, attention needs to be paid to the specific functions of decision-making bodies and how these connect to wider processes of decision implementation.

Public engagement at the case study sites was generally understood as information dissemination rather than shared decision making and/or partnership working. Therefore, engagement with the public was used to try to educate local people and thereby to legitimate the decision process. The difficulties of engaging with the public are well documented in the literature (Chisholm and others, 2007). Commissioners need to ascertain what aspects of the decision-making process the public should be involved in, and which involvement mechanisms to employ. Within the present research there was evidence to suggest that public involvement worked best when

debates were related to specific issues of service provision, rather than attempting to engage the public on broader questions. This was most evident at Donative, which found that the public struggled with the complexity of large-scale priority-setting activities. More research is needed to explore current activities around public engagement in priority setting. The focus of this work needs to be on who should be involved, *when* to involve the public and how best to engage the public (this may vary for different groups and activities).

 **there was evidence to suggest that public involvement worked best when debates were related to specific issues of service provision, rather than attempting to engage the public on broader questions**

Political dimensions of priority setting

This study supports the view that those involved in resource allocation decisions need to negotiate the difficult political and cultural aspects of health care. The broader political climate was seen as a powerful influence on the success or otherwise of local priority setting. For example, many PCTs felt that the failure of government to engage in debate about what health services might reasonably offer the public had led to unrealistic expectations being placed on local services. Therefore, a nationally led debate was seen as important to help strengthen and legitimise local decision making.

The results suggest that government policy can act as a catalyst to drive priority setting, while also being one of the main barriers to ‘joined-up’ working and implementation of resource allocation decisions. For example, the incentives of Payment by Results – that is, to reward productivity and provide the incentive to increase demand through payment by activity – can hinder cross-system planning and disease pathway redesign. Getting the right incentives to shape and change behaviour is important. The work at Morebeck (W1) demonstrated the positive use of incentives to engage stakeholders in service redesign. Giving part of the resource realised back to the service or disease area following service redesign meant that individuals and groups were more willing to engage in both planning and implementing more efficient service provision. What central and local decision-makers need to develop are positive incentives that will help to shape behaviour and increase engagement in priority-setting and rationing decisions.

While national guidance and a well-developed evidence base, along with a focus on pathway redesign, are important aspects of priority setting and indeed may go a long way to help with the financial climate facing public services, broader considerations of governance are also key ingredients for successful priority setting. By governance, we do not simply mean performance management relating to the actions associated with the decision, although as mentioned above, this is important. Governance in this context also refers to the practical politics associated with coalition-building, stakeholder engagement and securing the acceptance and legitimisation of decisions. As demonstrated in this study, the lure of technocratic approaches to decision making is even greater when facing tough rationing decisions where the legitimacy deficits are greatest (Robinson and others, 2011). The findings from this study demonstrate

the importance of giving attention to the perceived legitimacy of decisions. If commissioners are to secure active engagement and cooperation from the diverse stakeholders involved in health and social care, then for any possible benefits to be achieved (that is, efficiency savings and improved, safe, quality care), commissioners need to consider efficacy in the performances of decision making (McKenzie, 2002).

Leadership

The respondents at all of our case study sites indicated the importance of leadership to successful priority-setting and decision-making processes. While the need for strong leadership was often stated, the respondents were less clear about what this would look like in practice. This is not unusual, as leadership has often been seen as a catch-all notion that will cure any number of difficulties (Peck and Dickinson, 2009). However, the nature of the leadership challenge is clear – to introduce new systems and processes of priority setting, while simultaneously gaining acceptance of their legitimacy from a wide range of different stakeholders with potentially conflicting interests.

The context in which priority setting operates is important to the leadership responses required. For example, Grint (2005) suggests that problems which may be addressed in a linear manner ('tame') require management of a process; in contrast, more complex (or 'wicked') problems that face high resistance and conflict require a more specific brand of leadership. Dickinson and others (forthcoming) provide scenarios that map resource allocation processes against Grint's conceptual frame of 'tame' and 'wicked' problems (Table 5.1).

Table 5.1: Examples of priority-setting scenarios and management/leadership responses

Predominantly 'tame'	Combined 'tame and wicked'	Predominantly 'wicked'
When a statutory (government) mandate or guideline requires that a service should be provided (for example, measles, mumps and rubella vaccinations in children in the UK). The role of local actors is predominantly to ensure implementation of this directive.	When new or additional resources become available to budget-holders and decisions need to be made in relation to which service or technology should receive this additional resource. Currently tabled bids (that is, demand) exceed the available resource, and therefore decisions between competing claims must be made.	When budgets are substantially reduced, requiring the discontinuation of some existing services despite continued demand. Local leadership will be required in order to tackle difficult decisions and a potentially hostile political environment, and achieve changes to complex delivery systems.

Source: Dickinson and others (forthcoming)

While the technical challenges associated with collating evidence and establishing robust processes are important, successful leadership within complex systems requires actively constructing a degree of consensus between potentially conflicting stakeholders. This involves an expanded set of leadership skills or behaviours such as creating alignment between stakeholders, fostering vision ('sense-making') and mobilising support for change.

The importance of alignment was clearly recognised within the case study sites. Most were attempting to appeal to a range of different constituencies, and the respondents often indicated the importance of leaders engaging ‘followers’, while recognising the limitations of simple exhortation or compulsion. The problem of engagement is compounded when priority setting takes place within a complex system of interdependencies across multiple organisations in which those notionally ‘leading’ local processes may not be able to call on sufficient formal authority to mandate their decisions. Under these conditions, leaders are required to draw upon persuasion, facilitation and/or mediation to secure compliance and without recourse to position (Peck and Dickinson, 2008). Additionally, the complex adaptive nature of the priority-setting environment may be such that no single individual will be able to lead the process. In fact, what was evident from our research was that priority setting was dependent upon multiple leaders (‘champions’) seeking common ground around which to mobilise.



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The requirement for priority-setters to engage with a wide range of stakeholders and institutions – all with potentially conflicting cultures, values and beliefs – draws attention to the political dimensions of leadership. While considered vital to managerial success, it is suggested that NHS managers often struggle with the political dimensions of their work (Alimo-Metcalfe and Alban-Metcalfe, 2005). This difficulty has been ascribed to an assumption that politics is somehow inappropriate, contrary to evidence-based practice and inconsistent with public service. Yet, an alternative framing of the political dimension is that politics may act as an important site for negotiation over the allocation of resources, reconciliation of contrasting interests and mobilisation of support for programmes of action (Hartley and Branicki, 2006). If priority setting is cast as a ‘wicked’ problem, then it follows that local leaders will need to develop their political acumen to attend to legitimacy *internally* within the organisation, and *externally* with partners. In this regard, Hartley and others (2007) identify the importance of a range of skills, including shaping key priorities within the organisation, building external partnerships, promoting the reputation of the organisation and managing organisational risk.

In the case studies, a number of people spoke of the importance of setting the scene and framing the issue of priority setting appropriately in order to gain engagement. Indeed, for some, the recent economic downturn had been an effective means through which to start engaging stakeholders that they had not previously managed to engage. The national focus on the need to save money and the pressure on budgets meant that leaders could facilitate difficult conversations around priority setting and the need to disinvest in some services. Thinking about the way in which the messages of priority setting are framed is crucial in mobilising support and securing a mandate to make decisions which then will be implemented in practice.

As part of this process, chief executives and directors of commissioning may find that they cannot do this framing alone. Clinical leadership was seen as a crucial component of priority setting at the case study sites. Clinician engagement requires that clinicians both *understand* the macro processes of priority setting in terms of population-level decision making, and *accept the legitimacy* of the approach and intended programme of work. The case studies provide examples of the difficulties that may arise if such acceptance is not secured.

The final point made here about leadership is that although models of transformational leadership and leaders as sense-making currently are seen as crucial roles in terms of leadership, this does not mean that we can forget the value of management. One of the most frequently cited difficulties in priority-setting processes in the case study sites was a lack of good project management: an undue focus on the transformational vision had led to a neglect of the transactional management of day-to-day processes. Again, this is not an unusual experience in the NHS, and has been noted in other large-scale organisational changes (for example, Peck and others, 2006). One of the most important lessons that comes from this research is not to presume that individuals can do all that is required of them in their day job and do these changes in addition. Effective priority-setting processes require dedicated project management.

Information resources and expertise

Clearly, information plays an important role in effective priority-setting processes. What was evident from the research was the need to have in-house resources including individuals who can understand the financial and clinical aspects of decision making. There was evidence of very effective financial and information specialists within the case study sites. One of the criticisms often made by NHS staff is the amount of bureaucracy and information that they need to provide (Glasby and Ellins, 2008). What was evident from the research was that where difficulties occurred, it was often because there was limited clarity in terms of what information was required, and what constitutes robust evidence. There were also some instances of too much information and a lack of skill to translate data to the practice interface. Lord Darzi's review (DH, 2008b) noted the lack of analytical and planning skills within PCTs. Sophistication in terms of requesting, managing and interpreting data is important to the delivery and success of priority setting (Sibbald and others, 2009).

Furthermore, the skill of requesting and understanding information lies not only with information specialists, but is also integral to all those involved in resource allocation decisions (House of Commons Health Committee, 2010). The case study sites demonstrated a lack of knowledge and/or use of the Department of Health planning and programme budgeting software, which is available free from the Department. Two of the sites had used private companies to undertake programme budgeting work. The reasons for this included a lack of in-house skill and expertise, along with the view that information generated by an independent body would be seen as more credible to other stakeholders.



What was evident from the research was the need to have in-house resources including individuals who can understand the financial and clinical aspects of decision making

Impact of government reforms on priority setting

The respondents broadly agreed that introducing new NHS reforms in the current financial climate would most likely have a negative impact on any potential efficiency savings brought about by priority-setting processes. The results from this study support the claim that organisational stability is important to the implementation and delivery of commissioning (and in this case, priority setting) (Smith and others, 2005).

An important factor that emerged from this study was the positive impact of a system-wide approach to priority setting, as well as concern that this might be threatened by the emergence of multiple commissioning bodies within a region. Furthermore, commissioning for population health was contrasted with meeting individual health needs. It was suggested that many GPs currently lack the skills needed to take on this wider commissioning role. The possible use of private sector organisations to fill this skills gap was seen as a potentially costly exercise at a very challenging financial time (British Medical Association, 2010; House of Commons Health Committee, 2010).

Summary

The research produced rich and interesting findings about local priority-setting activity across England. As the NHS continues to deliver health care in a changing political environment and difficult financial climate, this work raises important messages of relevance to current and future priority setting and commissioning activity.



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6. Conclusions and recommendations

The findings from this research confirm a number of challenges facing priority setting in health care and the commissioning of services more generally.

Key policy drivers

The recent key policy drivers of priority setting have been World Class Commissioning (WCC), the QIPP agenda, service reconfiguration and the economic climate. While these have acted as drivers or levers to instigate and develop priority setting, in some instances they have been seen as potential barriers to success. For example, the focus on WCC competencies may well have led PCTs to develop priority-setting processes around new resources, rather than looking at priority setting within core spend and disinvestment. The current economic crisis may, however, change this focus. Furthermore, PCTs have not had sufficient levers to instigate change, and the relative power imbalance within local health economies – especially between PCTs and acute providers – has been problematic. Policies that focus on competition and activity-based funding have been seen by PCTs to incentivise providers to increase activity in certain areas and act as a disincentive to some providers participating in cross-system planning.

Governance

When we talk of governance in respect to priority setting, it is often conflated with organisational structure. This was evident in initial policy announcements about current NHS reforms (Department of Health, 2010a), where the emphasis was on the size and structure of the governance of commissioning, with less focus on legitimacy and engagement. This has, however, been addressed to some extent by the government's response to the NHS Future Forum (Department of Health, 2011), which has led to requirements for lay and wider clinical engagement in CCGs. Our research highlights the importance of coalition-building by commissioners, and going beyond formal structures of governance and performance management. In this way, commissioners stand a greater chance of securing acceptance and legitimacy of their deliberations and decisions.

Technical challenges

Research demonstrates that technical processes can play an active role in the governance of priority setting. These are the managerial, ethical and economic tools based on rational evidence-based approaches that can appeal to stakeholders and provide a way to engage with certain groups. For example, clinicians can be more willing to engage with these types of tools, and so they might be effectively used as part of a wider process. In the deliberative aspects of decision making, these types of processes help to increase the transparency and legitimacy of decisions reached. The tools will not provide the answer, but they can help to inform the process. Therefore, the tools can provide a means to an outcome – not an outcome in

themselves. As such, it was not surprising that a strong feature from the study was a focus on technical process, and trying to find or develop a tool and process that would provide the 'right decisions' for their particular sorts of resource allocation. For some sites this focus on process was frustrating, a barrier to decision making and, in particular, implementation – with implementation of decisions often slow to take effect.

Processes and approaches had a varying degree of explicitness, openness and effectiveness, and structured decision making that involved well-developed evidence-based practices and tools provided a forum for difficult decision making. Of course, process is important in meeting the challenges associated with priority setting, but process in its wider sense (that is, inclusion of the non-technical aspects) is also important to the success of priority setting. While technical processes can be robust and reliable, without attention to processes around engagement, support and legitimisation from within and outside the organisation, the priority-setting function may lack validity (that is, it will not do what it is intended to do). Sometimes referred to as the 'softer side' of decision making, the non-technical aspects can present the biggest challenge for commissioners and others involved in priority setting.

System-wide approach to priority setting

The biggest impact has tended to be when commissioners have taken a system-wide approach to priority setting, which involves shared decision making and engagement with a number of different stakeholders from across the health economy. However, the research demonstrates that the stakeholder groups involved often have differences in organisational strategies, culture, power and politics, which can impede priority setting. Having an awareness of these factors and being able to negotiate and manage these differences was seen as crucial to the commissioning function. Strong leadership and political acumen are needed across stakeholder groups and at various levels within health and social care organisations.

Political realities

The national political arena does not specifically support prioritisation around core budget spending and/or decommissioning services. An honest national debate around priority setting and resource allocation across health and social care is required to support and legitimise local decision making. This present research suggests that the relatively low starting base of PCTs in terms of commissioning practices, linked to their limited autonomy, has been a crucial factor in the focus on new investments in the shorter term. The case study sites demonstrate that even when commissioners are focusing on core spend, they are restricted in relation to the 'must dos' (government policy around certain disease and treatment areas which PCTs must commission locally). These sometimes conflict with local priorities and make decisions around allocative efficiency difficult to undertake. The focus on new developments means that often only marginal efficiencies are achieved, and in many instances it does seem that PCTs have only 'tinkered around the edges' in terms of priority setting and rationing decisions. The current financial crisis has further fuelled the need to have a stronger focus on efficiency savings, and a number of PCTs reported their intentions to develop priority-setting processes around disinvestment and service redesign.

The research has a number of specific implications for priority setting in a newly reformed NHS. As yet, the extent to which the priority-setting responsibilities placed on PCTs (not least via the WCC competency framework) are expected to transfer to CCGs is unclear. One possibility is that explicit priority setting at the population level is expected to play a reduced role in future commissioning as increased competition, choice and micro-level purchasing become the major drivers of resource allocation. However, it seems unlikely that the need for population health planning and decision making will be removed entirely. Therefore, responsibility for priority setting is likely to be allocated to (or distributed across) CCGs, the NHSCB or local government.

If primary responsibility for priority setting is to reside with CCGs, the present research suggests that the following issues will need to be addressed:

- **Skills** – it has taken some time for PCTs to build capacity in relation to needs assessment, decision analysis, economic evaluation and stakeholder engagement. Indeed, the research suggests that deficits still exist in each of these areas. However, these are likely to be greater for CCGs, implying the need for significant levels of additional support.
- **Resources** – evidence generation, public engagement and the development of robust decision-making bodies are extremely resource-intensive activities. Clinical commissioning groups may lack the economies of scale required to generate sufficient resources to carry out these aspects which, the present research suggests, are essential to effective priority setting.
- **Implementation** – the PCTs included in the study found it difficult to ensure that priority-setting decisions were fully implemented within their organisations and across wider health economies. To be effective, priority-setting CCGs will need to attend to issues of decision implementation in a context of complex delivery systems.
- **Legitimacy** – the PCTs in the study struggled to establish the legitimacy required to make difficult and unpopular decisions. Priority setting led by clinicians may have advantages in this regard. However, trust in the authority of the clinical commissioner is unlikely to deliver all of the legitimacy required for unpopular decisions to be made and implemented, and therefore the other strategies described in relation to PCTs will still need to be considered.

If a significant level of responsibility for priority setting is to reside with the NHSCB, this also raises a number of issues. For example, some resolution of roles and responsibilities between the board and other national decision-supporting bodies such as NICE and the National Screening Committee will be required. Allocating responsibility for evidence generation, decision making and supervision of implementation will need to be clarified if arrangements are to work effectively. Horizontal coordination will need to be accompanied by considerations of vertical integration. While the involvement of national decision-making bodies in priority setting has its strengths – for example, in enabling economies of scale in evidence generation, public engagement and institution-building – it also threatens to undermine local accountability and responsiveness. Managing the tensions between local and national imperatives will be a key challenge for priority setting under the new arrangements.

Finally, the role played by a newly integrated local government partner in priority setting raises separate concerns. For example, the frameworks and measures associated with population resource allocation in health – such as health technology evaluation, QALYs, and so forth – are less common in other public sector settings. Similarly, the cultural and professional codes associated with the health sector diverge significantly from those of many other local authority departments. Finally, systems and processes of accountability and resource allocation in a health setting are somewhat atypical. It would appear necessary to tackle some of these obstacles if a joined-up approach to priority setting is to be adopted (Williams and others, 2011).

Recommendations

Based on this research, there are a number of key messages in relation to priority setting and resource allocation decisions in health care:

- A national debate around priority setting and what the NHS can afford and should provide will help in identifying and advancing the intended goals of the NHS, and will play a role in educating and raising awareness of the difficulties of rationing.
- Priority setting needs to take a central role in commissioning, rather than being an exercise around processes for new service development, with more focus on priority setting in relation to core spend, pathway redesign and disinvestment.
- Priority setting and rationing of scarce resources is contentious – commissioners need to be realistic with stakeholders, including the public.
- Restructuring is taking place at a crucial time of financial constraint when focused active priority setting needs to take place. Furthermore, turbulence during the transition from PCT to GP-led commissioning may already be impacting on current priority-setting work that has the potential to restructure services and provide allocative and technical efficiency savings.
- GPs, local authorities and public health specialists need clear directives on their roles and governance structures – if health savings are to be realised, a more nuanced local health system-wide approach to priority setting is required.

Specific recommendations emerging from the research include the following:

Evidence and information

- There is a need to provide a strong evidence base for decisions. Having a shared agreement on what evidence is appropriate for decision making within localities is important, as is a recognition that, often, evidence for many services is not going to be found in randomised controlled trials or economic evaluations.
- There is a need to draw on existing data sources which are often under-utilised. These include Department of Health resources, which draw on data provided by PCTs, to examine performance around and across programme budget areas (DH, 2010b, 2010c, 2010d).

- NICE's role around evidence generation in relation to the clinical and cost-effectiveness of technologies needs to continue in relation to new technologies. This role could be further expanded to include more on the evidence on existing technologies and services, in order to aid decisions on decommissioning and disinvestment of services.
- There is a need for good information analysts (whether in-house or externally) who can understand and generate the required information.
- Evidence and information is not just the job of specialists. Others involved in priority setting need to understand what information is important to the question of priority-setting activity. This requires a degree of knowledge and sophistication so that the right criteria for data collection can be set. Decision-makers need to be asking the right questions, while being able to interpret the information generated (that is, will the estimated cost savings be realised, and so on).

Engagement and involvement

- There is a need for improved involvement and engagement of a wide range of stakeholders.
- Commissioners need to provide the right incentives to engage stakeholders in priority setting. Examples of this from the study included allowing providers to maintain a percentage of the resource that they have realised by changing service delivery practices.
- Engaging with stakeholders, and building trust and respect in relationships take time; therefore so do priority-setting processes and tough resource allocation decisions.
- Ethical frameworks such as Accountability for Reasonableness provide a structure that can enhance the engagement, transparency and legitimisation of priority setting.

Leadership skills

- Strong and effective leadership skills are important to priority setting.
- Leaders need to understand and negotiate the political and cultural differences and barriers that impact on priority setting and rationing decisions.
- Leaders need to ensure sufficient and transformational leadership to drive the priority-setting process and implementation of decisions.
- Leaders need to gain engagement and motivation from those in middle management and front-line positions.

Governance

- Sound organisational and performance management structures are required to make sure that due process is followed and implementation of decisions is achieved.
- There is a need for clear timelines around implementation of priority-setting policies and to make sure that people are held accountable for the implementation and delivery of outcomes.

- There is a need to look at governance in its broadest sense, and to focus on the engagement and legitimisation of priority setting and decision making with wider groups.

Sharing best practice

- Sharing best practice in relation to the tools and techniques used in priority setting is to be encouraged. These include:
 - managerial, economic and ethical tools
 - public engagement exercises
 - data resources, both local and national – PCTs have tended to do this through local and national networks such as the Public Health Commissioning Network
 - public health observatories
 - the NHS Institute for Innovation and Improvement.

Recent policy changes mean that there is a risk of dilution and disbanding of organisations and groups that hold knowledge around priority-setting tools and processes. The issue here is to make sure that the learning is not lost, and that it is transferred to the new world of clinical commissioning. While politicians may want to move away from past government policy, the expertise and learning from the evolution of commissioning over the last ten to 15 years are crucial to future work on priority setting.

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Appendix: Different types of priority-setting activity to be considered

Overall budget allocation (core budget spend)

Often, the allocation of current resources is based on historical allocation, with additional resources being allocated according to local need. However, there may be times when the large sections of spend may need to be reviewed and relative spend re-prioritised across and between different areas of service.

New resource allocation

When new investment is available, then a review of all new proposals for funding is appropriate. This review (like other commissioning activity) should be set against an agreed framework.

Reprioritising across programme budget areas

Programme budgeting allows PCTs to review the overall budget allocation to disease groups in the context of need and outcomes. As budgets usually reflect historic allocations, using prioritisation with programme budgeting enables the PCT to shift resources strategically over time.

Disease/care pathway redesign

Pathway redesign or development may be initiated by local or regional/national considerations. Prioritisation can be used to select interventions within a defined budget, or to prioritise interventions in the context of disinvestment.

Review/recommissioning/decommissioning of existing service provision

Many services have developed over a period of time, often with ad hoc increases in funding. However, the historical development may not match current need or the highest priority needs. Bids or business plans for retaining services or decommissioning them could be considered within this framework.

This framework is adapted from Southwark PCT prioritisation policy, 2009/10.

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ISBN: 978-1-905030-47-7