evidence for
better health care

nuffieldtrust

The challenge for clinical commissioning

Setting priorities in health

Research summary

September 2011

A national study into how decisions about NHS resource allocation have been made by primary care trusts (PCTs) has been carried out by the Nuffield Trust, and the Health Services Management Centre at the University of Birmingham. The financial challenge facing the NHS in the coming years will mean difficult decisions will have to be made about how and where NHS resources are used. The proposed new clinical commissioning groups can learn from the experiences of PCTs in relation to priority setting. This research summary presents findings of the study and draws upon these to discuss the implications for primary care commissioning in the light of current NHS reform plans.

Key points

- Most PCTs have priority-setting boards or forums, but these tend to focus on new developments and non-core spending.
- Disinvestment is not being tackled by PCTs in a significant manner, although it is acknowledged to be a key priority for the future, and is changing as PCTs start to address the 'Nicholson Challenge' to save £20 billion over four years.
- Population health data for needs assessment represent the most frequently used tool for decisions about health spending priorities.
- Priority setting in the NHS is considered to have more weaknesses than strengths, with a lack of robust public and local political involvement being of particular concern.
- PCT clusters and emerging clinical commissioning groups (CCGs) should be proactive about learning from the experience that PCTs have amassed in priority setting and commissioning.
- The NHS Commissioning Board (NHSCB) will play a key part in determining the role of national, regional and local decision making, and in supporting local commissioners in making difficult priority-setting decisions.
- The role of individuals, who are increasingly given more choice about their NHS care and, in some cases, hold a personal health budget with which to buy care, needs to be clarified within the wider debate about priority setting. It is not yet clear whether it will be individuals, their local agents (for example, local authorities and CCGs), or national bodies that will shape health spending in the long term.

Introduction

Since 2002, PCTs have been the statutory bodies with responsibility for funding, planning and commissioning NHS services in England. This report presents the findings of a national research study into how PCTs have gone about setting priorities for how money should be spent on health care. The research was funded by the Nuffield Trust and carried out by the Health Services Management Centre at the University of Birmingham and the Nuffield Trust. Their research findings form the basis for the analysis set out here and relate to the challenges facing a new generation of health commissioners, who will have to make difficult choices about funding in a highly constrained economic environment.

Context

The NHS in England has to find up to £20 billion of efficiency savings over the next four years, to cope with the gap between essentially flat funding and rising demand and costs (Charlesworth, 2011).

This scenario, known colloquially as the 'Nicholson Challenge' after the chief executive of the NHS who first articulated the scale of the funding gap, has increased interest in how priorities for 'core' spending might be set and in finding ways to disinvest in expensive hospital and other services. The process of making decisions about resource allocation in a context of scarcity is commonly known as 'priority setting' or sometimes 'rationing'.

£20bn

of efficiency savings required over the next four years in the NHS in England

During the research project reported here, the new Coalition Government unveiled plans to reorganise and reform the NHS in the White Paper, *Equity and Excellence: Liberating the NHS* (Department of Health, 2010). The White Paper proposed to abolish PCTs as part of a bigger shake-up of the resourcing, planning and purchasing of NHS care in England, and to transfer most of their commissioning work to GP-led commissioning consortia – now to be called clinical commissioning groups (CCGs) – and to a new national NHS Commissioning Board (NHSCB).

During the process of writing this report, the Government introduced a Health and Social Care Bill to enact its proposed reforms, and then revised it in response to a 'listening exercise' led by the NHS Future Forum. At a local level, health commissioning is now due to be led by CCGs.

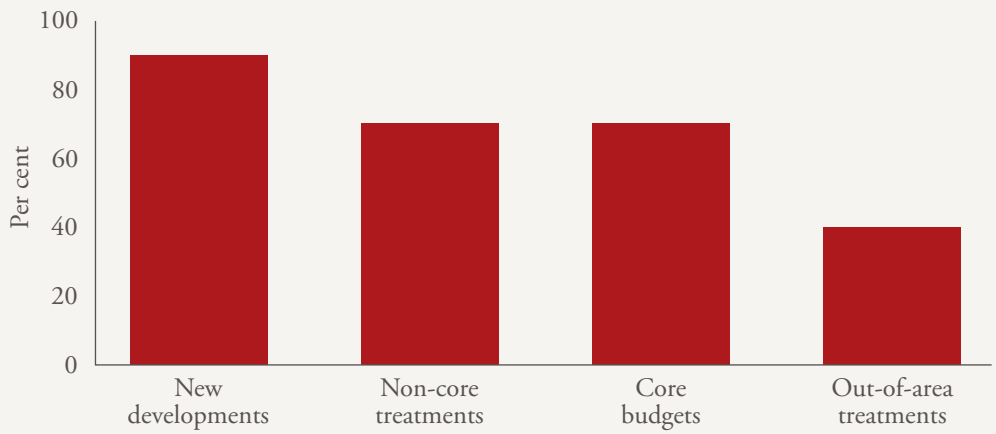
This research sought to identify and describe the types of priority-setting activities being undertaken by PCTs, the extent of such work and the tools being used. It was designed to give some indication of the strengths and weaknesses of priority-setting activities, to derive lessons for future commissioners within the NHS and elsewhere, and to identify areas for further study. Quotes from case study participants are highlighted throughout the text.

PCTs and priority setting – the national picture

Structures

The overriding finding from the research was that most PCTs (86 per cent) have formal arrangements for priority setting, yet their priority-setting boards or forums focus mainly on the funding of new and additional developments (90 per cent), or non-core spending (70 per cent). Review of core budgets was cited as a role of priority-setting boards in 70 per cent of cases, but more in-depth investigation by the researchers revealed that this aspect was not, as yet, very developed. The remit of priority-setting boards is summarised in Figure 1.

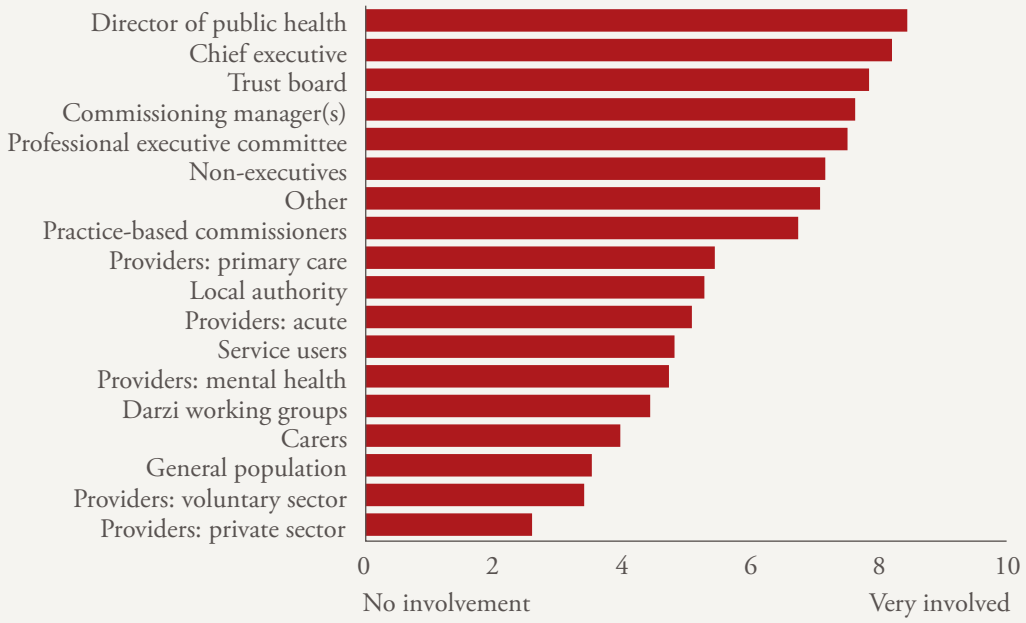
Figure 1: Remit of priority-setting boards



The survey found that most priority-setting boards were operating at the PCT level (81 per cent) and in relative isolation from other funding and decision-making bodies. Of the remaining PCTs, just seven per cent were working at a regional or strategic health authority level, seven per cent with other PCTs, and four per cent with local authorities. This suggests that priority setting was regarded as very much the business of PCTs as local statutory funders and commissioners.

Senior NHS managers and doctors were more involved in priority setting than other stakeholders. Those with the highest level of 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. A summary of stakeholder involvement in priority setting is set out in Figure 2, reflecting the views of PCT respondents as to how far different stakeholder groups were involved in the priority-setting work of the PCT, using a scale of 0 (no involvement) through to 10 (very involved).

Figure 2: Stakeholder group involvement in priority setting



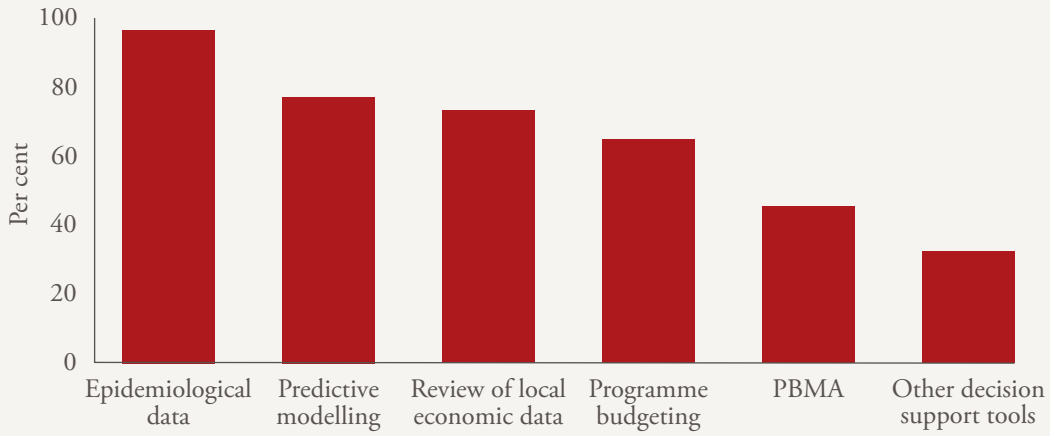
Processes

It was clear that needs assessment using population-level health data was the main approach employed as the basis for decisions about spending priorities; this was used in 96 per cent of cases. Other approaches included: predictive modelling of disease and health care activity (76 per cent); reviewing local economic data (73 per cent); and programme budgeting (64 per cent). Forty-five per cent of respondents said their PCT used programme budgeting and marginal analysis (PBMA) – an economic technique for priority setting designed to accommodate managerial, clinical and public perspectives within a common decision-making framework. Figure 3 sets out the priority-setting tools and techniques being used by PCTs. 'Other decision support tools', used by 32 per cent of respondents, included: Lean prioritisation; multi-criteria score cards; NHS comparators; McKinsey Dashboard analysis; and cost-effectiveness and cost–benefit analysis.

96%

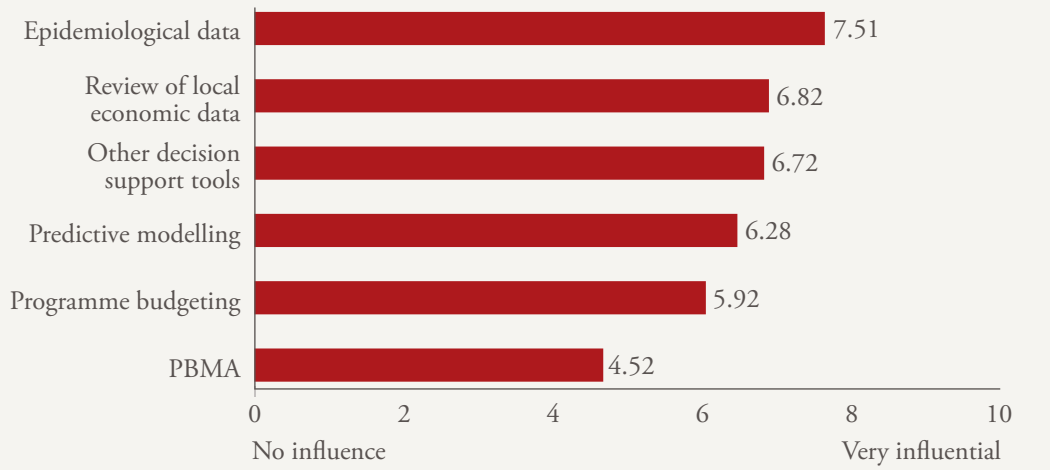
of PCTs are using population-level health data for needs assessment

Figure 3: Different tools used to aid priority-setting processes and investment decisions



In terms of the influence of such tools on decisions about health spending priorities, the use of epidemiological data for needs assessment emerged as most significant, with PBMA being the least influential (see Figure 4).

Figure 4: Respondents' rating of the influence of different tools and processes on investment decisions



More than half of PCTs (51 per cent) had access to a dedicated information resource to support priority-setting work. Public health analysts and PCT information teams were the main information resources used. Only two PCTs suggested they had access to a health economist.

Strengths and weaknesses of priority-setting processes

Respondents identified some strengths on the part of their priority-setting activities, including the use of evidence, and the simplicity and transparency of the process. However, most identified more weaknesses than strengths. Problems included: 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.

A further key concern aired by PCTs was that disinvestment was not being tackled as part of priority setting, although 54 per cent of respondents reported that their PCT had recently made a significant disinvestment decision and 75 per cent had plans to do so in the future. Concerns related to disinvestment included:

- a disproportionate focus on new developments, with processes for identifying areas for disinvestment not well established
- a lack of stakeholder engagement in disinvestment
- even when disinvestment decisions were agreed, they were difficult to implement in practice, especially in relation to secondary care
- a poor evidence base around disinvestment
- a lack of provider support for disinvestment.

Of those (54 per cent) who had made a disinvestment or decommissioning decision, just over half had reinvested the saving in the same disease or service area. PCTs were more likely to have redesigned pathways – or changed the way that patients move through the health system – than to have stopped or withdrawn a service altogether.

54%

of respondents reported that their PCT had recently made a significant disinvestment decision

Three quarters of respondents (75 per cent) said their PCT had specific plans for disinvestment in the future. The majority of these plans included improving the efficiency of pathways and reviewing services which have high costs and poor outcomes. The majority of suggestions pointed to plans for moving care from the acute sector into community settings. What was clear was that priority setting was a 'work in progress' as PCTs developed their capacity and capability in this area, and prepared for harder decisions ahead.

Summary: PCTs and priority setting – the national picture

- Most PCTs have priority-setting boards, but these tend to focus on new developments and non-core spending.
- Most priority setting is at the PCT level, and is not carried out at a wider local authority or regional level.
- Senior NHS managers and clinicians are the main stakeholders engaged in priority setting, with much less input by the general population, carers and patients.
- Population health data for needs assessment are the most frequently used tool for decisions about health spending priorities.
- Priority setting in the NHS is considered to have more weaknesses than strengths, with the lack of robust public and local political involvement being of particular concern.
- Disinvestment is not being tackled by PCTs in a significant manner, although it is acknowledged to be a key priority for the future.

PCTs and priority setting – learning from local experience

In addition to the survey carried out, five case studies were explored as part of the research. This offered a more in-depth insight into the local experience of PCTs when seeking to set funding and service priorities.

It is clear that national programmes and policy have shaped local action by PCTs. The World Class Commissioning (WCC) programme introduced by the Labour Government in 2007 was reported to have been a strong influence, and a driver for making sure that PCTs set up robust processes for setting funding priorities. WCC, with its specific 'competencies' on priority setting and engaging the public, had also encouraged PCTs to draw a wider range of local stakeholders into their decision making about funding and commissioning. However, the PCTs acknowledged that they had more to do in this area, and that it would prove more challenging as the economic context became tougher.

The more recent Quality, Innovation, Productivity and Prevention (QIPP) agenda, initiated by the Labour Government and taken forward by the incoming Coalition Government, was reported to have helped decision making, as it allowed for a common agenda to be shared across the health economy and helped shape priority-setting decisions by providing a clear focus around spending deficits, value for money and accountability.

> 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 driving quality innovation…it was a natural home for the priority-setting work

Concern was however expressed by PCTs about the number and shifting nature of central government policy directives, and the impact this had on attempts to develop and work with robust, engaged and evidence-based approaches to local priority setting.

> There are always changes to policy or something that comes left-wing *[sic]* – we had Darzi groups, then QIPP, and then changes to provider services…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

As was revealed by the national survey, priority setting has to date been focused mainly on new investment, and this was underlined by the work with case study PCTs, where three sites had focused exclusively on new investment. However, there was awareness of the need to extend the work into core services in order to meet the QIPP challenge, and a desire to get the process right before rolling it out more widely. The sense of 'if not now when?' came over clearly from PCTs.

> 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

Priority-setting tools were being used by PCTs to help with resource allocation decisions and to promote evidence-based debate with clinicians, patients and the general public. One PCT had developed an ethical framework for priority setting and this was used mostly to resolve disagreements about the appropriate course of action. Other PCTs tended to use multi-criteria scoring systems that weighted evidence on health outcomes, need, cost, value and cost-effectiveness.

> Using *[scoring systems]* gives us a mechanism for difficult conversations, a framework, and a scoring system is helpful to weight these, especially if there are 100 or more proposals

As in the national survey, the case study PCTs struggled with engaging the public and patients in priority setting, although they realised that this would be essential when addressing disinvestment. One PCT had, however, succeeded in closing a hospital and re-commissioning services in the community. This PCT had set up a stakeholder group that included two GPs and a local councillor who acted as a 'health champion' and was considered helpful in building public confidence in proposals for change.

> 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 meant these groups needed to be involved and their opinion counted with the public

Even where attempts were made to redesign pathways, it was often very difficult to actually implement decisions. Successes tended to relate to modifications of patient pathways, rather than engagement in decisions over the explicit rationing of resources according to agreed criteria. Even where attempts were made to redesign pathways it was sometimes difficult to actually implement decisions.

Furthermore, Payment by Results – a funding mechanism that pays health care providers for the work they carry out, according to a national tariff – was deemed by PCTs to incentivise providers to try and increase activity, rather than engage with commissioners in reprioritising spending to reduce hospital admissions.

However, practice-based commissioning (PBC) – a Labour Government initiative that gave GPs some control over commissioning budgets for their practice population – was seen as a fruitful mechanism for engaging acute trusts. This suggests that Coalition Government proposals for more active commissioning by GPs (latterly with the support of other clinicians) have potential in respect to joint assessment of funding priorities across primary and secondary care.

Other barriers to implementing priority-setting decisions were identified as: a lack of communication with stakeholders; a lack of effective project management; and the need to find additional resources to support change on the ground.

Strong clinical leadership of decision making about funding priorities was identified as important for overcoming some of these problems and, in particular, for making the case for engaging with a particular issue or decision.

> “Getting clinical engagement is important but not just getting clinicians involved – we need them leading on it

The case studies revealed the hard and complex work involved in carrying out robust, transparent and inclusive priority-setting work in the NHS. For PCTs, this entailed: the creation of a range of processes for considering evidence and making decisions; the provision of adequate analytical, public health and project management support; and sophisticated and sustained attention to stakeholder engagement. The challenge now facing the NHS is how such experience can be carried over into the new commissioning arrangements proposed by the government and made robust enough to handle the resource allocation and service change decisions presented by the ‘Nicholson Challenge’.

Summary: PCTs and priority setting – learning from local experience

- Local approaches to priority setting have been very much influenced by national policy, as set out in World Class Commissioning and the Quality, Innovation, Productivity and Prevention agenda.
- Priority setting has been focused on new investment, but this is changing as PCTs start to address the ‘Nicholson Challenge’.
- Priority-setting tools are useful not only for support of the process of decision making, but also as a route for promoting debate about health spending and services at a local level.
- Public engagement in priority setting is difficult to secure but is important, especially at a time when disinvestment is required.
- PCTs have struggled to engage acute trusts in priority setting, making decisions hard to implement.
- Practice-based commissioning has helped with clinical engagement in priority setting, including across primary and secondary care, and this bodes well for clinical commissioning groups.
- Effective priority setting needs significant project management and other support.

Priority setting in the new NHS

It has to be about the whole spend

As recognised by the PCTs in this research, NHS priority setting has to move beyond what appears to have been its comfort zone of new and marginal expenditure. The financial challenge facing the NHS, with an average fall of 2.3 per cent in recurrent real-terms resources available to PCTs for ongoing spending in 2011/12, means that additional funding for investment in new developments is a thing of the past (Smith and Charlesworth, 2011).

PCT clusters, and in due course GP and clinical commissioners, will face the challenge of having to review their total expenditure with a view to making 15 to 20 per cent efficiency savings. This will call for: extensive and sophisticated work to establish a set of local funding and service priorities that take account of both national guidance and strategies (for example, the Operating Framework for the NHS) and local needs and demands. This highlights a need for organisational arrangements with which to conduct priority setting; governance structures that can assure its transparency and legitimacy; adequate clinical leadership; and analytical, public health, and management support (Robinson and others, 2011).

2.3%

average fall in recurrent real-terms resources available to PCTs for ongoing spending in 2011/12

The extent to which commissioners have to ration is heavily dependent upon the level of efficiency at which commissioned providers operate. If providers are more efficient, less rationing needs to occur. Instead of commissioners having to do all the work in setting priorities, there could be a much greater move to commissioners asking providers to work out service priorities within a budgetary envelope. In other words, the work of commissioners needs to be concerned with putting providers at risk for activity, quality and cost. Without this, efforts by commissioners to determine funding priorities could prove futile, and the assessment of NHS commissioning as highly constrained will persist (Smith and others, 2010; Lewis and others, 2010).

Clinical commissioners can learn a lot from PCT experience

The new CCGs do not need to start with a blank sheet of paper when they turn their attention to establishing priorities for funding and commissioning. They can learn from the past five years of experience amassed by PCTs through World Class Commissioning and QIPP. In particular, CCGs can adopt and adapt the policies and frameworks used by PCTs when reviewing expenditure, appraising new developments, and engaging with local patients, clinicians and the public about funding decisions.

Experience of different priority-setting tools can be reviewed within and across PCT clusters and emerging CCGs to avoid reinventing the wheel, and to enable some continuity for local stakeholders with what has gone before. For example, if certain ethical frameworks or scoring criteria have been used for local priority setting, it would make sense for emerging CCGs to review, adapt and consider adopting them, perhaps

within a network where funding decisions are made on a population basis larger than one commissioning group. This highlights a need for PCT clusters to be proactive in capturing, reviewing and sharing local experience of priority setting, and helping embryonic CCGs to establish robust approaches to this important and politically-sensitive part of their commissioning work. There is also scope for local commissioners (old and new) to come together to redraft processes that have been perceived locally as failing, or lacking in legitimacy. Likewise, there is potential to review the previous use of tools for priority setting and to determine what would make sense for the future.

This latter point highlights a need for consideration of how far individual CCGs will be allowed to have different approaches to priority setting. The extent of this variation will depend on the approach taken by the NHSCB to strategic planning and priority setting at a national level. How far the NHSCB sees its role as writing the 'menu' of services to be commissioned at different levels, including nationally, regionally and locally, or whether it gives broad guidance and leaves detailed planning and commissioning to be shaped by local commissioning groups, remains to be seen.

Clinical commissioners are likely to be vulnerable in this area

Priority setting has proved difficult for PCTs, particularly in respect of being able to scrutinise or challenge their core spend, and this has been at a time of increasing resource for the NHS and with 45 per cent more management infrastructure than will be the case for the reformed NHS. This suggests that clinical commissioners will be particularly vulnerable in this area; having to make critical decisions about how local NHS resource is used at a time of flat (and in effect reducing) funding and with rather fragile levels of management support (Robinson and others, 2011).

A further degree of vulnerability for clinical commissioners as setters of priorities flows from their dual role as carers for individual patients, and custodians of resource for a local population. As originally constructed, the proposed reforms would have placed GPs on the frontline of resource allocation and priority setting at a local level, having to account for what is funded (or not) for their population. The changes adopted following the work of the Future Forum will draw in other clinicians, nurses and lay members to CCGs, which may help to legitimise difficult decisions. However, GPs will still be expected to take a key and public-facing role. How far GPs will be comfortable with this role remains to be worked out. In practice, it is likely to be a subset of the local GP community who will sit on a CCG board (or a board drawing together representatives from a number of CCGs) and make the final decisions about commissioning priorities. The extent to which this impacts on individual GPs' relationship with patients will depend on how a CCG structures its internal governance arrangements, the methods it adopts for setting priorities, and the wider governance put in place for local commissioning.

Robust governance of local commissioning is critical

The research reported here reveals the struggle many PCTs have had in engaging patients and the public in their decision making about funding priorities. This experience took place in a context of expanding resource for the NHS, and when PCTs had clear and formal arrangements for public accountability and governance, based on the corporate board model of executives and non-executives, and operating within the Nolan principles of standards in public life.

Governance of clinical commissioning within the reformed NHS will be a critical issue, and one that is subject to considerable debate as the Health and Social Care Bill makes its way through Parliament. The area of priority setting is where this governance will be most visible to the public and is most likely to be tested. The ways in which clinical commissioners make, communicate and account for decisions about the funding of local services will be subject to the scrutiny of the local health and well-being board (LHWB) based in the local authority, the local Healthwatch patient and public involvement body, and the NHSCB through its annual performance assessment of a group's progress in relation to its declared commissioning plan.

Governance of clinical commissioning will need to be robust enough to withstand challenge from these bodies, and also potential judicial review of its decisions, assuming that CCGs as statutory organisations are regarded by the courts as public authorities. For GPs to be board members of public authorities and subject to this range of public and potentially legal scrutiny will be a new and challenging experience, unless individual GP commissioners have previously been part of the senior management team and board of a PCT.

The NHS Commissioning Board can provide vital support and guidance

The NHSCB will play a key role in determining the framework within which NHS priority setting will be enacted in future, for as seen in the research with PCTs, national guidance and templates play an important role in supporting the work of local commissioners. The extent to which the NHSCB sees itself as setting national templates for what should be commissioned (or not) for a particular client group, condition or service at a local level will in turn determine the degree of latitude falling to clinical commissioners, and hence the extent to which CCG decisions are likely to be subject to scrutiny and challenge (as opposed to the decisions of the NHSCB).

As part of determining its role, the NHSCB will need to clarify how it intends to work with the National Institute for Health and Clinical Excellence (NICE) and how it will use NICE guidance and appraisals to help inform a national framework of priorities for health commissioning. This goes to the heart of how far the proposed reforms will be about localism and a more devolved approach to commissioning. The Health and Social Care Bill sets out a number of significant reserve powers for the NHSCB, so it is possible that the Board will take a more national approach on some issues and specify what is and is not to be commissioned by CCGs.

Such a centralised approach has to be more possible in a context of financial constraint, when it may be considered more appropriate to shield local GPs from unpalatable decisions about funding of services, and to avoid allegations of 'postcode rationing' by CCGs. On the other hand, in the spirit of a liberated and devolved NHS, it may fall to CCGs to make the majority of priority-setting decisions based on what local clinicians deem to be the needs of their population. In this scenario, robust governance, management and analytical support, and strong clinical leadership will be critical, and stormy waters will have to be navigated by GPs and their commissioning teams.

Local authorities will be key stakeholders in local health priority setting

Priority setting in the NHS has long been considered to be largely the business of health authorities and PCTs and, to a lesser extent, primary care-based commissioners such as GP fundholders and practice-based commissioners. In the reformed NHS, however, the local authority will become a much more significant player. This is due to two factors: the role of new LHWBs in scrutinising and advising on local commissioning and health improvement plans; and the move of the public health function from PCTs into local government.

The role of LHWBs will need to be clarified in conjunction with the governance arrangements and functions of CCGs, for it will be important that their respective roles, responsibilities and accountability are complementary, and easily understood by patients, staff and the public. Assuming that a degree of local latitude is accorded to commissioning groups by the NHSCB, the LHWB is likely, under current policy proposals, to represent the main local scrutiny of NHS spending and service development (or decommissioning) priorities. The presence of local councillors on LHWBs would bring a new degree of direct democratic challenge to local NHS commissioning, something that has been argued for in academic analysis of the deficits in accountability of current commissioning arrangements in the NHS (Glasby and others, 2010). The members of LHWBs will, however, need support and development for their new role, most specifically in relation to the tools and techniques of health priority setting, and drawing on local and national experience of such activity in the past.

The proposed move of public health to local government in 2013 could provide the opportunity for joined-up or integrated priority setting across health and social care; the joint commissioning agenda has emerged as an important function in the provision of high-quality care (Dickinson and Nicholds, 2011). However, given the different trajectories of health and social care, a number of barriers to integrated priority setting (including funding, accessibility, evidence and politics) could limit the success of integrated priority setting (Dickinson and others, 2011). The research reported here highlights the central role of public health specialists in advising on, and providing the evidence for, priority-setting work at a local level. Health needs assessment informed by epidemiological data has been the primary tool for priority setting, and this requires careful and robust public health analysis, together with skills in presenting such data in a way that is meaningful to GPs and other commissioners. Commentary on the move of public health to local government (for example Nuffield Trust, 2011) points to the risks of the health commissioning/services element of public health being watered down within local government, in favour of a focus on health protection and improvement. The role of public health in commissioning will be vital as a route for advice, evidence and support for GP commissioners, and to reassure and advise LHWBs, especially given the complex evidence requirements for reviewing new and exceptional treatments. Where this support will come from is yet to be determined by emerging CCGs and local authorities.

£60bn

of NHS funding may be allocated to CCGs

Priority setting applies across the continuum of commissioning

Clinical commissioning will not be the only 'game in town' within proposed new commissioning arrangements for the NHS. Whilst some £60 billion of NHS funding may be allocated to CCGs, some £50 billion will be commissioned through other arrangements. This highlights the need for careful consideration of how priority setting at a local level, by PCTs in the first instance, and then increasingly by CCGs, will interact with commissioning and priority setting at other levels. The importance of a 'continuum of commissioning' has been explored in previous analysis (Smith and others, 2004), and a version of the continuum that reflects commissioning arrangements at the end of the New Labour years (when this research was carried out), is set out in Figure 5.

Figure 5: Scope of commissioning responsibilities

Adapted from Smith and others, 2004

The continuum of commissioning raises a question as to who in future will determine the overall shape for a local health community. In other words, which body will set funding priorities in relation to deciding which body commissions certain services? This 'design of continuum' role has been described in the past as the 'conscience of the commissioning system' (Smith and Mays, 2005), given its important role in determining the allocation of public resources to those charged with commissioning.

Whilst GP commissioning will operate at the practice and multi-practice or locality level, it needs to be borne in mind that priority-setting activity will also take place at national and regional level as resources are allocated for specialised services. This element of commissioning will be carried out by the NHSCB, but the determination of what falls to the NHSCB and what is devolved to CCGs, will impact on the extent of priority setting that takes place locally and on the size of clinical commissioning budgets. The more that is retained by the NHSCB, or mandated to be commissioned by regional networks, the less the room for manoeuvre and choice of funding priorities that will be available to local clinical commissioners.

Likewise, the extent to which personal budgets are used as a means for individuals to commission their own health and social care will impact on priority setting by CCGs. Personal budgets arguably remove the need for formal priority setting by public bodies, representing as they do a move to a form of individual purchasing, akin to the use of vouchers or stakeholder funds in other health systems.

Competition and choice influence the setting of priorities

The choice represented by personal budgets raises a more general point about how policy on choice and competition will interact with the setting of priorities for funding and services. In other words, will the decisions of individuals drive the funding of health services, or will it be their agents (GP commissioners), or a higher body such as the NHSCB? The term 'priority setting' as applied within health policy assumes implicitly that there is a body that will take decisions about what is funded or not, and that this will lead to some form of 'menu' of services that people receive or can access. Indeed, priority setting is often referred to as 'rationing' with a clear sense of the state giving to people only what is considered essential and appropriate.

The desire for increased competition and choice within the NHS is a core theme of the White Paper *Equity and Excellence: Liberating the NHS* (Department of Health, 2010), and its spirit runs counter to the 'rationing' approach. If individuals through personal budgets, and multiple and relatively small CCGs with commissioning responsibility, use their power to purchase care from a range of NHS, private and third sector providers, this presents a significant challenge to priority setting as construed within the research reported here, and within health policy more widely. This goes to the heart of the debate about proposed changes to the NHS – the extent to which choice and competition will be predominant – which implies more providers and choice, the failure of some providers, and an acceptance of variation in access to services across localities. On the other hand, some will argue for or a primary concern for equity of provision and access, and the use of national priority-setting frameworks to steer the work of local commissioners.

What the research reported here suggests is that whatever the degree of competition in a publicly-funded health system, commissioners need access to robust evidence on which to base their resource allocation decisions. Likewise, they need sophisticated support for working with a range of stakeholders (for example, clinicians, patients, local politicians and public health specialists) to secure some form of consensus about the overall 'menu' of care to be put in place for a local population. How far individuals are then able to exercise choice within that 'menu' is a decision for both local commissioners and national policy makers, and will to some extent depend on the local provider market (that is the extent to which alternative providers are available).

Summary: Priority setting in the new NHS

- The NHS has to move beyond new and marginal expenditure when setting priorities: PCT clusters and emerging CCGs will need to review their total expenditure if they are to make 15 to 20 per cent efficiency savings.
- PCT clusters and emerging CCGs do not need to start from a blank sheet of paper: they can learn from the five years of work amassed by PCTs through World Class Commissioning and the work to develop the QIPP agenda. PCTs and CCGs should be proactive about disseminating and learning from this experience.
- GPs will need to be comfortable with their new priority-setting role, and CCGs are going to need robust governance arrangements to withstand challenges to difficult decisions.
- The NHSCB will have a key role in determining the role of national, regional and local decision making, and in supporting local commissioners in making difficult priority-setting decisions.
- Local authorities will become more important in priority setting, as local health and well being boards scrutinise local commissioning and health improvement plans.
- Proposals to move public health specialists into local authorities could affect the information and expertise available to CCGs to carry out priority-setting activities.
- Individuals will also play an increasing role through the expansion of choice, personal health budgets and competition. It is not yet clear whether it will be individuals, their local agents, or national bodies that will shape health funding in the long term.

Conclusion

With some five to seven years of work, and a focused national programme of support for the development of commissioning (WCC), most PCTs have developed organisational and governance arrangements for priority setting that appear to operate in an effective manner for the allocation of new resources, and for making decisions about exceptional or marginal treatments. These arrangements were not, however, generally tested in respect of overall PCT spend, nor in the area of making significant disinvestment decisions.

In the new economic context of the NHS, with flat funding for the coming four years at least, priority setting is moving centre-stage, and will be the business of national and local commissioners. These commissioners (CCGs) will need sophisticated and robust evidence on which to base decisions, but, even more than this, they will need to find new and convincing ways of working with local clinicians, provider organisations, patients and the public. And, in the longer term, they will need to find an accommodation with the government's determination to introduce more personal choice and competition to the health service.

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This research summary was written by Judith Smith, Head of Policy, Nuffield Trust, based on original research conducted by Suzanne Robinson, Helen Dickinson, Iestyn Williams, Tim Freeman, Benedict Rumbold and Katie Spence of the Health Services Management Centre, University of Birmingham, and Nuffield Trust.

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59 New Cavendish Street
London W1G 7LP
Telephone: 020 7631 8450
Facsimile: 020 7631 8451
Email: info@nuffieldtrust.org.uk

www.nuffieldtrust.org.uk

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