NHS commissioners admit to more weaknesses than strengths when it comes to setting priorities

Posted on Friday 16th September 2011

One of the most extensive reviews into how primary care trusts (PCTs) made decisions about funding priorities confirms that while most commissioners have established robust systems in relation to funding new services and exceptional treatments, they generally struggle to apply the same rigour to 'core' spending.

Eighty PCTs contributed to the study by researchers at the University of Birmingham's **Health Services Management Centre and the Nuffield Trust. The (http://www.birmingham.ac.uk/schools/social-policy/departments/health-services-management-centre/index.aspx) full findings (http://www.nuffieldtrust.org.uk/sites/files/nuffield/setting-priorities-in-health-research-report-sep11.pdf)** are published today alongside a **policy commentary (http://www.nuffieldtrust.org.uk/sites/files/nuffield/publication/setting-priorities-in-health-research-summary-sep11.pdf)** by the Nuffield Trust. (University of Birmingham) and the Nuffield Trust.

Several of the PCTs that took part reported good progress in respect of their priority-setting activities. However, the majority identified more weaknesses than strengths. Obstacles to effective priority setting included:

- Finding sufficient evidence on which to base decisions;
- The tendency for priority setting to take place at just one point in the financial year;
- A typically narrow focus that fails to reach across health economies;
- A lack of involvement from local authorities, patient groups and the public;
- The seeming reluctance to tackle significant disinvestment decisions, despite this being acknowledged as a key priority.

PCT commissioners also expressed concern about the number of shifting central government policy directives and the impact this had on their ability to develop a robust, evidence-led decision making framework. The impact of developing greater patient choice, as represented by personal budgets and competition among providers, poses particularly complicated questions for those seeking to ensure equal access to services through a conventional 'rationing' approach.

However it was also evident that national programmes and policy had made a positive impact locally. For instance, the World Class Commissioning (WCC) programme introduced by the previous Government in 2007 was thought to have been instrumental in making sure that PCTs set up robust processes for setting funding priorities. There are signs too that the new approach of clinical commissioning could potentially strengthen cooperation between primary and secondary care when it comes to assessing priorities, historically a weak point for PCTs.

The report's authors conclude that priority setting has proved difficult for PCTs, and that to succeed in future GP commissioners in clinical commissioning groups will need to move this activity beyond the comfort zone of new and marginal expenditure, and tackle the core spend for which they are responsible. A critical question that remains is how they will be guided and supported by the centre, for example the NHS Commissioning Board (NHSCB) and NICE, in doing so.

The Health and Social Care Bill sets out a number of significant reserve powers for the NHSCB. It is therefore possible that the Board will take a more national approach on some issues and specify what is and is not to be commissioned by clinical commissioning groups (CCGs). On the other hand, if it does fall to CCGs to make the majority of priority-setting decisions, then robust governance, management and analytical support, and strong clinical leadership will be critical. (http://www.dh.gov.uk/en/Publicationsandstatistics/Legislation/Actsandbills/HealthandSocialCareBill2011/index.htm) sets out a number of significant reserve powers for the NHSCB. It is therefore possible that the Board will take a more national approach on some issues and specify what is and is not to be commissioned by clinical commissioning groups (CCGs). On the other hand, if it does fall to CCGs to make the majority of priority-setting decisions, then robust governance, management and analytical support, and strong clinical leadership will be critical.

Dr Suzanne Robinson, Lecturer in Health Economics and Health Care Policy at HSMC and lead author comments:

'Priority setting is moving centre-stage. However changes brought about as a result of the Health and Social Care Bill mean there is a risk that knowledge around priority-setting tools and processes will be lost as organisations disband and staff scatter into new posts.'

'The issue here is to make sure that the learning 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 fifteen years is crucial to meeting the efficiency challenge.'

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