Developing a Prioritisation Framework for NHS England Specialised Services Commissioning

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What I’ll cover

• The context and the system in England

• The challenges

• The approach

• Where we are
The context in England

• NHS is funded nationally through general taxation

• Internal market - commissioners and providers
Who’s responsible?

- NHS England leads the English NHS overall
- Majority of hospital services commissioned by groups of family doctors in Clinical Commissioning Groups
- NHS England commissions Specialised Services
- Previously (before 2013) Specialised Services commissioning a responsibility of 10 separate organisations across the country
The context in England – Specialised Services

- High cost
- Low volume
- Limited potential providers
- Financial risk in commissioning
- Specifically defined in Manual
- Examples, renal dialysis, forensic psychiatry, neonatal intensive care
- Includes Highly Specialised

- Circa 15% total NHS spend
- £15.6 BN ($20.3BN)
Challenges

• Initially in 2013 about harmonising clinical policy across England and the legacy of 10 separate commissioners – the easy bit!

• Clinical policy for entirely new services being presented for approval beginning to drive spend and in year growth

ONGOING

• Managing innovation effectively

• Lack of research evidence on effectiveness

• Profile
Approach

• Public Health England review of decision making recommended multi-criteria decision making and use of a scorecard (2014)
• National workshops of stakeholders to refine and evaluate potential criteria for a scorecard
• Risk in scorecard approach and need to strengthen
• Consultation on the Principles for Prioritisation for Specialised Services (2015)
Principles for prioritisation

General
• Transparency of process
• Stakeholder involvement
• Consider relevant guidance

Clinical effectiveness
• Adequate reliable evidence
• Measurable patient benefit
• Equal or greater benefit than current care
• Not give priority simply because the only intervention
Principles for prioritisation

Fairness and equity
• May accept limited evidence on rarity
• Available to all patients in the same group
• Reducing health inequalities
• Benefit the wider health and care system
• Advance parity between mental and physical health

Financial principles
• Value for money
• Affordability or enable release of resources

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Priority order for the use of funds

1. Non-discretionary legal requirements eg NICE TA
2. NHS Constitution requirements eg wait times
3. Supporting pre-existing national strategies and priorities eg improving access to transplant
4. All other developments
Operationalising the principles

• Resilience and strength of process and pathway up to relative prioritisation eg clinical panel

• Clinical Priorities Advisory Group (CPAG) is the body that makes recommendations to NHS England on relative priority of Specialised Services developments must use the principles

• Membership of CPAG clinical, commissioning, finance, patient and public voice, Public Health England
Four groups of principles

- Process principles  eg evidence of stakeholder involvement
- Qualifying principles  eg the intervention better than the comparator
- First two groups are the ‘gateway’ to relative prioritisation and confirmation to be provided to CPAG
- Relative priority principles, evidence, patient benefit, value for money
- Principles supporting wider strategic aims eg parity of mental and physical health
How to apply the relative priority principles?

- No immediately available valid tool suited to assessing the relative value of Specialised Services investments (University of Sheffield 2015)

- How do CPAG members assess relative value?

- Explored use of EQ-5D™ trialling it on previous investments but too subjective

- Pragmatic approach needed
Judging relative benefit

- An overall summary of the strength of the evidence
- In combination with a summary of the clinical benefit
- CPAG se to assign high/medium/low benefit
- Including Highly Specialised
- Equal numbers each category
- Reached by debate and consensus
Judging relative benefit

- Evidence
  - Low
  - Medium
- Measurable Benefit
  - High
Costs are then added
Matrix presentation

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Five levels of priority

Level of Priority
1 (High)        Grid Position
2                A
3                B, C
4                D, E, F
5 (Low)          G, H

Incremental Cost
High

Level of Priority: 5

Medium

Level of Priority: 4

Low

Level of Priority: 3
Fit with the strategic principles

- The fourth and final group of principles for prioritisation
- Should any policy change category?
Where have we got to?

- Pilot in March and public consultation
- Lessons learned
- Not complex to understand
- Clarity of the information presented
- Active engagement in the debate
- Applied at three day meeting June
- Recommendations made to NHS England on five categories of priorities
Thankyou

• You can view on the NHS England website

• https://www.england.nhs.uk/commissioning/spec-services/key-docs/