

Prioritisation Process

Overview

PCT's are under a statutory duty to promote the health care of the local communities. They are also under a duty not to exceed their annual financial allocation. This inevitably means that, particularly in the challenging financial climate with limited resources in which we operate, difficult choices have to be made. These decisions need to be made in a rational way that is transparent, consistent and provides accountability. They must also address inequalities. This prioritisation and review process is intended to reflect the reality of those difficult choices that must be prioritised, whilst seeking to maximise our ability to focus time and resources on programmes that effectively deliver positive and lasting health care benefits for our populations.

Methodology

With 125 initiatives across the sub cluster, we must focus interventions on service areas which have a significant impact within a limited timescale. There are 2 levels of prioritisation:

- Level 1: A high level identification of the services in which we want to make or refine interventions
- Level 2: Once we have identified those areas, a further prioritisation framework must be used to compare and prioritise the different interventions so we focus our resources to those with the most positive impact

Level 1: Identification

Prioritisation must be considered and the following 5 dimensions have been identified:

1. National priorities, statutory/legal requirements
2. Public, partner or stakeholder priority
3. Need
4. Quality issues
5. Value for Money

Level 2: Process

Each of the above dimensions is important in identifying our priorities but if used in isolation, we run the risk of identifying different sets of priorities across different dimensions. The following 5 steps must be taken to refine our list of service areas and identify our priorities:

1. Group our initiatives
2. Identify dimensions of importance for each area
3. Identify areas which are identified in more than one dimension
4. Sense Check
5. Importance and Do-ability rating

Step 1 – Group our initiatives

All our initiatives can be categorised into the following groups

Groups	Definition	Action
Must do's	These are initiatives that are statutory or legislative requirements, national or regional requirement and that the sub cluster is collectively already committed to with no potential for control or influence, and commitments legitimately prioritised for the benefit of our residents, a wider partnership, or collaborative commissioning arrangement.	Agreed priority
Core Business	These are initiatives which will contribute to the QIPP plan across any of the QIPP categories. These may include: invest to save proposals; admission avoidance or early discharge schemes; moving activity to a lower cost setting; productivity improvements; demand management or cost containment schemes and other technical efficiencies; national targets; disinvestments; where the return on investment is substantial and rapid enough and sufficiently evidence based to justify the initial investment of time and/or money.	Proceed to steps 2 and beyond and identify relative priority
Contributes to longer-term sustainability and/or vision	This may include initiatives that contribute to our wider aspirations for health and wellbeing; longer-term invest-to-save initiatives; the shift from specialised care and treatment to prevention and early intervention; the delivery of specific local priorities and goals set out in the Integrated Business Plan.	Subject to capacity/funding, proceed to steps 2 & 3 to identify relative priority
Doesn't fit any of groups 1-4		Not a priority. Hold in reserve

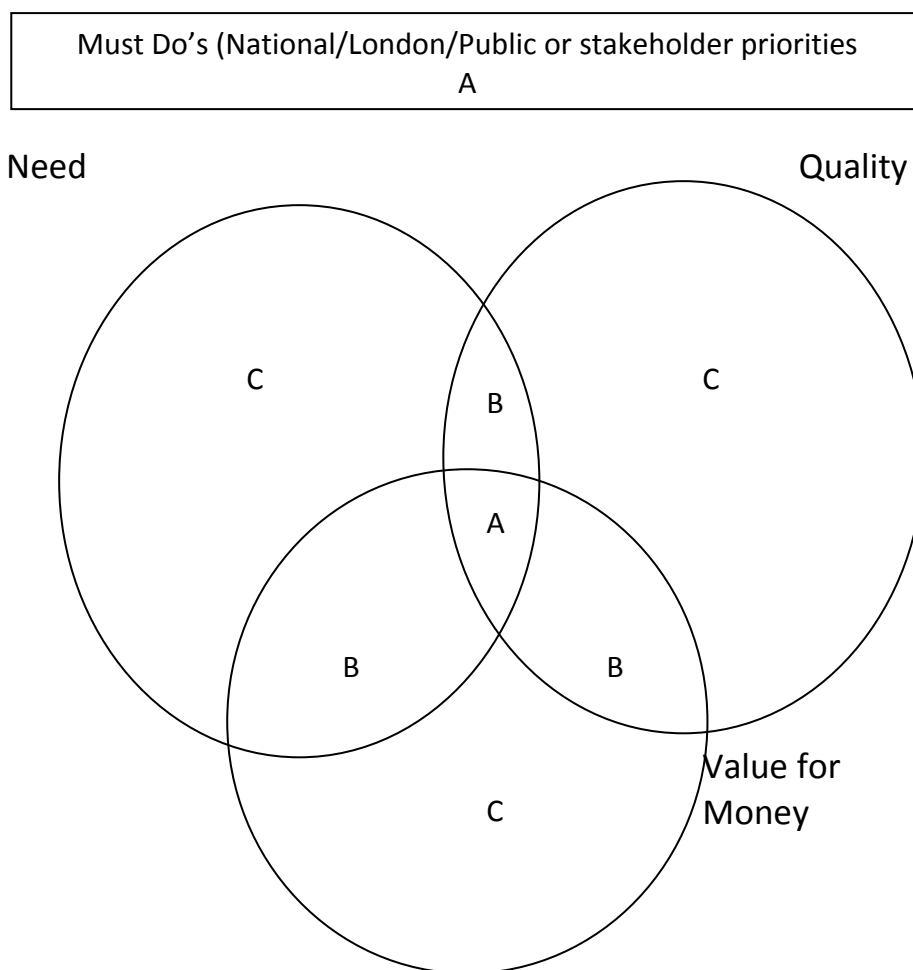
Step 2 – Identify service areas of importance in each dimension

Step 3 – Identify service areas which are identified in more than one dimension

It is important to note that service areas in dimensions 1 and 2, the ‘must do’s’, will be an agreed priority and may not need to be prioritised using the process below

This requires a collective understanding as set out in the strategic components, with information and data collected from a range of sources, e.g. public health, benchmarking, programme budgeting, KPI’s etc. Each initiative/service area is attributed to a sub section within the Prioritisation Venn

Prioritisation Venn



Using the Venn diagram above, we can begin to see the relative priority areas set against Priorities A, B and C. A is an area where all three dimensions are of concern: B, 2 dimensions are of concern and C, one.

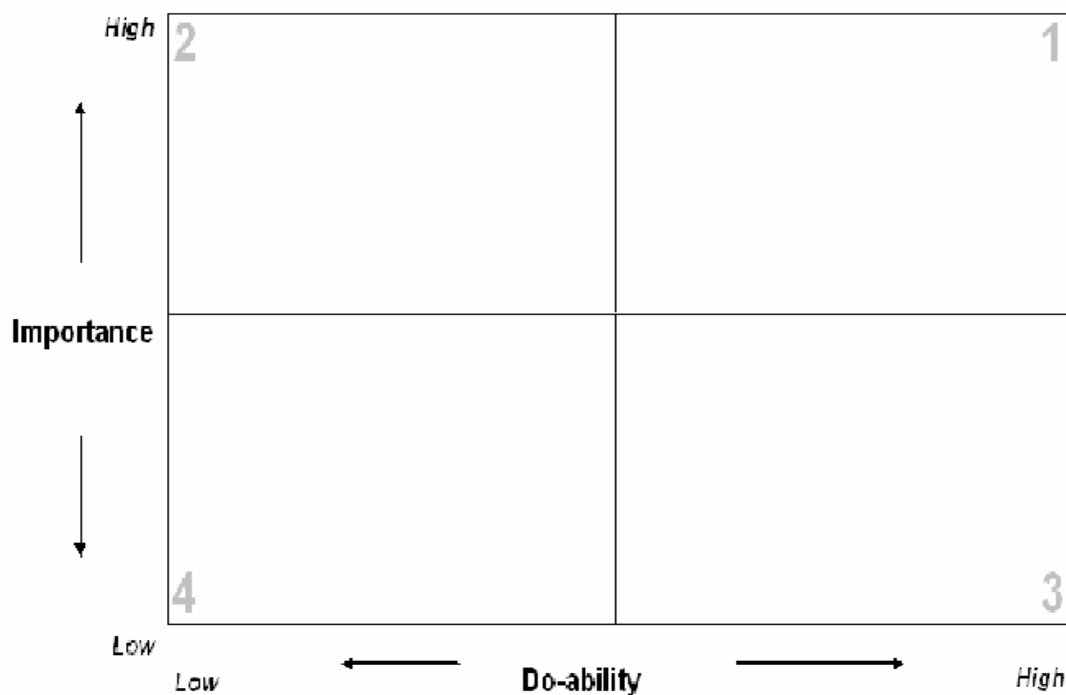
Step 4 – Sense Check

It is important to note that although a service area may only be identified in one area, the severity of the issue may raise its priority status legitimately and so therefore it is necessary to apply a sense check mechanism to the final prioritisation. Another note of caution is that in using classifications of services and budgeting information, we must ensure that we are working with an agreed understanding of the scope and definition of the area we are prioritising, e.g. prevention services. Appendix 1 provides us with a sample range of sense check questions which should/can be applied

Step 5: Do ability and Impact

A final step for relative prioritisation within any given priority groups is also required to ensure that our resources are targeted at the highest impact and achievable areas of change, given both capacity and time limitations on us: assess and score potentially competing priorities against criteria. After completing this stage outcomes can be plotted on a Prioritisation Map which will identify relative order of priority. A range of sample questions is provided in Appendix 2 in order to compare and plot competing priorities within the map. Prioritisation is then identified in the quadrants

Prioritisation Map



Appendix 1

Sense check questions

A set of questions intended to check that the proposed prioritisation or initiative is the most appropriate one available, or refine it if necessary, before considering it further. The following is not an exhaustive list:

- a. What justifies/evidences the allocation of the service area to this priority group and categorisation– is it really a key priority?
- b. Is the programme/initiative/spend the best or most appropriate approach to deliver the desired outcome, based on evidence of good practice/effectiveness/cost-effectiveness, or informed innovation?
- c. Is the proposal being considered the minimum we need to do, or the maximum we might aspire to? Where does the appropriate balance lie in the current circumstances? If the appropriate balance has changed, is it in the right group, or does it require re-grouping?
- d. Are there opportunities to shape the proposed approach to fit better with the sub cluster and/or deliver enhanced value in taking forward the vision?
- e. Are there opportunities for the proposed approach to generate savings in another area (either as it stands or with some amendments) and if so how will we ensure these opportunities are realised?
- f. Have timing and sustainability issues been considered in looking at potential alternative approaches (example speed of generating savings/outcomes versus longer term benefits/issues)?
- g. Have we fully considered the implications (financial, political or otherwise) of revisiting an existing commitment or stopping a current service/programme? Are we clear of the implications of committing to a new initiative (example de-commissioning costs, should that prove necessary)?
- h. Is the level of spend/investment justified? How could current services/pathways /programmes be adapted to incorporate this proposal?
- i. How does this spend/programme/initiative/service contribute to reducing Health Inequalities?
- j. How will/does this improve access to services and outcomes?
- k. Does this support Cluster/London/National priorities?
- l. What, and when, is the return on investment/spend?
- m. How many residents benefit from the investment/service/spend? Cost per patient?
- n. How will/does this initiative/spend/programme support a shift of activity to a lower cost setting?

Appendix 2:

The example questions below set out the criteria against which the spend/initiative/programme/service should be assessed, both in terms of 'importance' and 'do-ability'.

1. Relative Prioritisation Criteria

(a) Importance - How important is the spend/initiative/programme/service in comparison to all the other initiatives under consideration? *(NB Unavoidable commitments and statutory requirements are not weighed in these criteria as they are deemed unavoidable. Enabling strategies should be assessed against the criteria below in the same way as specific initiatives)*

Patient and service user benefit

- How many people would benefit as a result of the initiative? How strong is the evidence for this? And how much would they benefit? When would they benefit?(Timescales)
- To what extent would the initiative contribute to reducing health inequalities?
- Are there wider community benefits (example community safety, environmental) that rely on us delivering this?

Quality benefit

- To what extent would the initiative demonstrate continuous quality improvement and desired outcomes?
- To what extent would the initiative deliver safe and effective care making the experience positive for the patient?

National priority

- To what extent would the initiative address the key national priorities such as National Indicators, Vital Signs or Core Standards?

Local priority

- To what extent would the initiative take forward the overall Strategic Goals/Initiatives and Health Outcomes?
- To what extent would the initiative address specific local priorities and objectives (as informed by the JSNA, LAA corporate priorities)?
- To what extent is there pressure for change in the area of the initiative from other people or organisations (e.g. the public, stakeholders or local politicians)?
- To what extent would the initiative address other issues (e.g. workforce, safety standards compliance, changes in regulations, reputation, market management or improving commissioning leverage)?

Financial - Performance benefit

- To what extent would the initiative result in financial savings?
- How long would it take to realise the savings?
- To what extent can we identify the value of other benefits? Example social capital, etc
- How does this address current benchmarked levels of expenditure/value for money/equity?
- To what extent is this helping to deliver benefits from previous investments?
- To what extent will the initiative result in, or demonstrate impact in performance?
- How will this improve the performance of the trust?
- What is the Return on Investment?

(b) Do-Ability – How easy is it to deliver this initiative in comparison to all the other spend/initiatives/programmes/services under consideration?

Stakeholders

- To what extent are stakeholders within the local health & well-being community supportive of this spend/initiative/programme/services?

- What is the likely reaction of local people/ groups and politicians to the initiative (e.g. Health and Wellbeing Boards, Overview and Scrutiny Committees, LINK's, local politicians)?
- Has funding commitment been agreed with the relevant stakeholders?

Buildings & equipment

- To what extent would this initiative require change to buildings and equipment?
- Are Premises required for this proposal?
- Have premises been secured, or are they required?
- Has the cost of new premises been built into the proposal?

Workforce

- To what extent would the initiative require the current provider workforce to be redeployed?
- To what extent would the initiative require a cultural change?
- To what extent are any new or additional skills that are required for the initiative scarce or reliant on long-term training once staff have been appointed?

Service delivery

- To what extent does this initiative represent a complex service change (e.g. extent and number of changes, interdependencies with other projects)?
- Would this initiative affect the viability of other services?
- Is there a provider capable of delivering the service required through this initiative?
- Has this initiative been undertaken successfully elsewhere?
- Has the initiative been planned appropriately?

Resources required

- Would this initiative require additional financial investment?
- What is the level of management capacity required to implement the initiative?

Consequences

- What additional risks/consequences are introduced by proceeding (either initiating a new project/service or by prioritising the next phase of an existing initiative) – i.e. if we subsequently fail to complete it or decide to stop it?
- What is the level of risk of failure to complete/deliver the initiative?
- What is the shift of activity expected as a result of this initiative? (Amount/Setting)
- What is the potential impact on equality of access and outcomes?

The above criteria can be scored to calculate a percentage (%) score on each axis. These can then be plotted on the Prioritisation map (below) in order to inform judgements about relative prioritisation.

Vision:

- A modern, efficient system of care delivery that aligns patient need in terms of speed, convenience and equality of access with the availability of professional skills, knowledge and expertise; within the financial constraints of the NHS.
- A system that actively engages patients, GPs, secondary healthcare providers, Social Care, the Third Sector and others in its development implementation.
- An efficiency and quality driven solution that takes account of the reality on the ground of the Westminster community.
- Well managed community based resources through the implementation of effective IT and communications infrastructure.
- A collaborative management and governance structure that ensures full participation and engagement for stakeholder groups: patients, GPs, local care service providers.

Benefits:

For Individual Patients

- Faster, more convenient access to higher quality, better integrated care provision.
- Maintenance and development of the close and trusting relationship with existing GP.

For the Westminster community


- Healthier more active population
- Higher quality health provision
by:-
 - i) Reducing health inequalities
 - ii) Adding years to life
 - iii) Building a choice of quality healthcare
 - iv) Adding life to years (increasing the time people live disability free)
 - v) Promoting healthy lifestyles in Westminster
- More efficient use of public money

For Health and Social Care professionals

- Maintenance and development of the relationship with patients
- Ability to provide patients with the treatment / advice they need quickly and conveniently.
- Enhanced professional development
- Development of a collegiate / collaborative approach to working with colleagues locally.
- More rewarding roles leads to fewer problems with recruitment and retention of high quality staff.

For Local Hospitals

- Relieving the pressure surrounding waiting times
- Taking away more "routine" case load from scarce and valuable resources
- Allowing time and space for the development of skills and expertise in specialist areas



WCN Networking event

Keeping Going in Difficult times

Health and Well Being – Future service models and collaborative working

30th June 2011


Mary Dalton
Head of Learning Disabilities, Transition and Carers

Key themes for today




- Tri Borough Commissioning
- Risks and opportunities
- Case example learning disabilities

Tri Borough Commissioning RBKC, H&F and Westminster



- In current commissioning portfolio (contracts) 3 sets of budgets and 3 sets of accounts
- Can we achieve better value by sharing best practice and systems
- For any service redesign, commissioning new services or re-commission we ask if we can do this on a 3 borough basis
- Not all or nothing and can work at different levels from sharing ideas to full tri borough commissioning of services using one procurement process
- We can commission all aspects of a service jointly or some elements or none
- Doesn't prevent wider partnerships eg Brent or commissioning on smaller locality scale eg targeting parts of Borough
- There will be a single commissioning and procurement team across all 3



- Tri borough provider (operational) working more closely together eg 3 learning disability teams to have one service manager. Already sharing ideas for small populations eg Aspergers.
- Current Partnership Boards for care groups bring together service users, carers and provider reps to lead on implementation of strategies
- Do we have tri borough Partnership Boards and how do we still retain local ownership and involvement
- Less management of providers, more market engagement

Risks



- Providers used to grants may need to tender to deliver clear outcomes
- Smaller providers – capacity to compete across 3 boroughs
- How to keep voluntary sector informed eg links to CompeteFor
- Readiness for personal budgets
- Funding (less core funding)

Opportunities



- For smaller services providers can come together for "critical mass"
- Collaborate on all elements of contract or parts – depending on how specification is designed. Consortia and collaborative bids will still need identified lead
- Strength of consortia bids considered in same way as single bids ie on ability to meet specification and VFM
- It is in our interests to make things as attractive to the market as possible
- Funding (fundraising, use of volunteers)

Examples



- LD short breaks
- Joint Procurement with RBKC (H&F not ready to join)
- Already sharing services, did joint consultation, carers wanted more flexibility & we have more demand and pressure on resources
- Small numbers, so by combining to re-commission services makes it more attractive to potential bidders and spreads risk
- Following RBKC procurement process – had to make sure their systems linked to ours eg Compete For



- Doing user and carer involvement and selection jointly
- Increasingly using "market warming" if not sure of market gives a chance to hear from potential providers and help us design the service specification eg carers services, day and employment for LD
- Key features of commissioning remain the same whether single or tri Borough ie based on needs assessments and gaps, design of services, market development, contracting of services, review of outcomes and plans
- We want to continue to work with providers as partners in developing services

Questions

