



PRIORITISATION AND DECISION MAKING FRAMEWORK

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Linked Documents	All Wales Policy on Making Decisions on Individual Patient Funding Request (IPFR) All Wales Prioritisation Framework		

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Development Groups: All Wales Prioritisation Development Group (see Appendix)
BCUHB Development Group (see Appendix)

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Approved: BCUHB Board of Directors
BCUHB Health Board

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1. Purpose

This Framework is the Betsi Cadwaladr University Health Board (BCUHB) adaptation of the All Wales Prioritisation Framework¹ which was agreed in principal by all Health Board Chief Executives in November 2011. This states that:

“The framework outlines a clear, rational approach and a fair, transparent process to ensure that evidence-based health gain for the local population and value for money is maximised. It shares the values and ethical principles of the All Wales IPFR Policy so that decision making (ranging from individual level to service area level to regional level) is underpinned by a consistent base.”

2. Introducing Prioritisation and Decision Making

Distributing NHS resources is a complex activity. To date, it has been carried out mainly according to:

- historical patterns of activity and spend;
- demand as expressed by patients and healthcare professionals;
- the arrival of new technological and/or service innovations; and
- ad-hoc service pressures arising during the year.

However, allocating NHS resources today requires a different approach; demand for NHS services now exceeds the current available supply and this is not expected to change. This means that not all services can be provided and so prioritisation and decision making has become a pressing consideration for health boards. Continuing advances in technology and medicines, changing demographics, better information and increasing public and professional expectations all mean that NHS Wales has to agree its application of financial and human resources fairly and to best effect. It is vital that decisions to prioritise services are not based on intuitive methods, incomplete information or conflict with a health board’s overall strategic goals. It is important that the impact on health is explicit when decisions are made to provide resource for some areas and not others.

Any prioritisation framework must therefore provide a robust, transparent and fair process to:

- align resources to agreed strategies and policies that improve the overall health and wellbeing of the population and improve the quality of services;
- ensure competing needs are given a fair hearing;
- enable consideration across pathways and discussion of disparate service areas and systems;
- provide better value for money;
- be operationally more efficient;
- increase public and patient confidence;
- add legitimacy to decision making;
- help achieve financial balance;
- meet the requirements of good corporate governance;
- and be underpinned by a sound evidence base wherever possible

¹ All Wales Prioritisation Framework, Dr Sharon Hopkins and Dr Geoffrey Carroll November 2011

<http://www.cardiffandvaleuhb.wales.nhs.uk/sitesplus/documents/864/3%2018.pdf>

The BCUHB can no longer consider investing in any new developments unless they are clearly more effective, improve patient experience and health outcomes, and are at least equal in value for money to existing services or interventions. Choosing one intervention or service means that the BCUHB cannot provide another – that is, there are opportunity costs to everything that BCUHB does. The BCUHB has to make these choices explicit, transparent and fair.

In adopting this prioritisation and decision making approach, the BCUHB will also apply the same principles to develop a transparent process for taking resources from one service to invest in another so as to make the best use of the Health Board's overall resource allocation. Disinvestment is the explicit process of stopping or restricting the use of low value healthcare practices to enable resources to be shifted to higher-value care.

3. Ethical Framework

The report by the Bevan Commission *NHS Wales: Forging a Better Future* identifies that the moral principles underlying planned provision of healthcare need to be renewed and rearticulated, emphasising that the NHS exists to serve the needs of the people and seeks to redress health inequities. The report also acknowledges that these are challenging times for NHS Wales. The UK Government austerity measures will hit Wales hard and additional resources are unavailable to support the increasing demands made on the healthcare system. It is expected that the NHS puts itself in a strong position to support those most in need and at risk during this time.

The Welsh Government published a set of values for NHS Wales that reflect the observations of the Bevan Report and they underpin this framework. They are:

NHS Values

- putting quality and safety above all else: providing high value evidence based care for our patients at all times;
- integrating improvement into everyday working and eliminating harm, variation and waste;
- focusing on prevention, health improvement and inequality as key to sustainable development, wellness and wellbeing for future generations of the people of Wales;
- working in true partnerships with partner organisations and with our staff; and
- investing in our staff through training and development, enabling them to influence decisions and providing them with the tools, systems and environment to work safely and effectively

Health Boards are faced with the ethical challenge of meeting the needs of individuals within the resources available and meeting their responsibility to ensure justice in the allocation of these resources ('distributive justice'). In Welsh Health Circular (2207) 076, the Welsh Government published a set of 6 ethical principles to be observed by NHS organisations when making decisions:

NHS Ethical Principles

- minimising the harm that an illness or health condition could cause;
- treating populations and particular people with respect;
- fairness;
- working together;
- keeping things in proportion; and
- flexibility

The purpose of the Ethical Framework is to support and underpin the decision making processes of the organisation (and decision making bodies) and to support lawful and consistent commissioning policy².

Difficult decisions demand judgement as well as evidence, particularly where evidence is not clear or insufficient. An ethical framework allows these judgements to be made as fairly as possible and to be robust to challenge. The Royal College of General Practitioners recent guidance³ on ethical commissioning suggest that we should

“..aim to use limited resources to:

- *Do as much good as possible*
- *Whilst being fair.*

Doing as much good as possible means maximising health (and any other justifiable) benefit. Sometimes it may be justifiable to do less overall good in order to be fair (e.g. when targeting resources at a deprived group). When considering what is fair, in this guidance we argue that commissioners can apply two fundamental principles of human dignity:

- *every person’s life has intrinsic value and is worthy of equal concern; and*
- *autonomy: each of us has responsibility for the governance of our own life”*

² This framework takes some ideas from “An ethical framework for commissioning in the NHS, South East Essex PCT” and the National Institute for Health and Clinical Excellence (NIHCE) processes for making judgements.

³ Malcolm Oswald and Dennis Cox, on behalf of the RCGP Ethics Committee. *Making Difficult Choices: Ethical Commissioning Guidance to General Practitioners* October 2011.

<http://www.rcgp.org.uk/pdf/RCGP%20ethical%20commissioning%20guidance%20v1.pdf>

There must be fair processes for setting priorities in healthcare resource allocation. The Royal College of General Practitioners suggest using Daniel and Sabin's "accountability for reasonableness" framework⁴, in which four conditions must be met:

- **Publicity:** rationing decisions made, and their rationale, must be made public;
- **Relevance:** the rationale on which decisions are made must be reasonable (i.e. based on evidence and relevant reasons), taking account of how the organisation provides value for money and meets varied health care needs;
- **Revision and appeals:** there must be a mechanism for individuals to challenge and dispute decisions, and for the organisation to learn and revise its policies;
- **Regulation:** there must be either external or self-imposed mechanisms for enforcing the first three conditions above.

4. Application of the Framework

The framework will be used to consider and support resource allocation in the broad areas outlined below:

Scenario 1 – New Resource allocation: CPGs to use to prioritise new proposals for investments such as the introduction of new technologies or interventions suggested by individual clinician/speciality group/ CPG.

Scenario 2 – Pathway redesign: CPGs to prioritise interventions or services within a defined care pathway, either in the context of additional stages or disinvestment

Scenario 3a – Disinvestment: CPGs identify clinical services where 'threshold' discussions are considered to be appropriate in a service pathway

Scenario 3b – Disinvestment: CPG identify/prioritise services which need to be considered for disinvestment e.g. of low value.

Scenario 4 – Reprioritisation of overall budgets: spend across and between full range of services

NB: The Prioritisation and Decision Making Framework will be used alongside the current BCUHB policy for Making Decisions on Individual Patient Funding Requests (IPFR).

http://howis.wales.nhs.uk/sitesplus/documents/861/all_wales_ipfr_policy_e.pdf

Therefore in relation to any decision made in relation to the scenarios above, cases of exceptionalty for individual patient care would need to be made through the BCUHB policy for Individual Patient Funding Requests (IPFR) Policy.

⁴ Setting Limits Fairly - Can we Learn to Share Medical Resources?(Daniels and Sabin, 2007) A short summary was published in the BMJ(Daniels and Sabin, 2008)

This process is about continual adjustment of health services in response to changing needs and evidence, and to best match available resources to meet these needs. In order to invest in more effective services with better outcomes for patients we need to look at where we can move resources around.

This process cannot make all decisions but is designed to help at the *meso* level that is at the service level for a group of patients and not at the high level of overall resource allocation or the individual patient level.

- **Micro level** The recently agreed All Wales Policy on Making Decisions on Individual Patient Funding Requests (IPFR) is the right process for individual patients and for appeals from people who feel they have a need for a service which the Health Board has either discontinued or has changed criteria for access.
- **Meso level.** The Prioritisation Framework gives a process for looking at interventions or services currently provided for a group of patients or being considered as a new development which will affect organisational delivery of a service.
- **Macro level** Resource allocation (of funding, human resources, estate) across major service areas such as Clinical Programs or through Service Reviews which require public consultation on proposed changes. (However, some decisions made during these processes may also benefit from the prioritisation process outlined here)

5. The Prioritisation Process

The process is outlined in the following four steps:

Step 1: Identifying areas to explore

CPG

Inter CPG

Step 2: Compiling the evidence base

CPG

Inter CPG

Step 3: Making recommendations

Evidence presented to CPG Board

Evidence presented to Inter CPG group when necessary

Evidence presented to a Prioritisation Panel

Step 4: Making decisions

Recommendations approved by relevant CPG Board

Recommendations approved by Board of Directors

Major Recommendations presented by the Prioritisation Panel

Chair to Health Board for endorsement

Step 1 Identifying areas to explore

There are multiple ways to do this. Areas for consideration should be generated by CPGs in partnership with clinical and non clinical staff, colleagues in primary care, patients and partners e.g.

- Clinicians with direct experience of service delivery or managerial roles in organising services
- Patients who have experienced services
- Managers who organise services
- Support services with information and knowledge e.g. public health intelligence, financial planning and analysis, planning and performance information, service improvement facilitators.

Initial ideas should be highlighted to the relevant CPG Board. Each CPG Board will require a supporting process through which this can be undertaken and scrutinised.

An item could be considered in the following circumstances⁵:

- The service is one with limited clinical evidence, quality or safety.
- The investment in a service does not maximise the health gain that could be achieved by reinvesting the funding elsewhere.
- Current performance, value for money and the need for service redesign to improve services for patients.
- The original decision was made on assumptions that were not realised.
- There are demonstrable benefits for the decommissioning of a service
- Service does not deliver value for money, as demonstrated through financial review, utilising programme budgeting tools such as the Spend and Outcome Tool
- Service fails to meet the standards of a modern NHS as defined by:
 - Professionally driven change which delivers modern innovative service.
 - Nationally driven change i.e. National policy or guidance requiring change in service delivery.

Step 2 Assessing the evidence

The next step in this system is to complete the prioritisation information tool (see appendix 1) for each service or intervention under consideration so that the evidence base can be assessed later and comparisons made. Completion of this information must not be undertaken by those involved in its later consideration. The tool sets out 4 evidence areas for assessing services and interventions:

- does it work?
- does it add value to society?
- is it a reasonable cost to the public?
- Is it the best way of delivering the service?

⁵ Adapted from *South East Essex Decommissioning and Disinvestment toolkit 2010-11*

Evidence in each of these areas is requested against 9 criteria or ‘factors to consider’; they are defined in the tool and have been the subject of rigorous testing to ensure consistency of understanding.

The completed information for each service/intervention under consideration will be presented by its compilers at Step 3 to enable prioritisation recommendations to be made.

Table 1: factors to consider

Does it work?		
1.	Clinical effectiveness	If not effective, this does not need to go through further process, can make decision to disinvest.
2.	Health gain	Life expectancy, healthy life expectancy, quality of life and risk factors
Does it add value to society?		
3.	Strategic fit	With AQF, NSFs etc
4.	Population and individual impact	Proportionality: a balance between the needs of a group of patients, and that of the wider community
5.	Health Inequities	Reduce or widen?
Is it a reasonable cost to the public?		
6.	affordability	Release resources for alternative uses? What are the opportunity costs for other services or interventions (including those of partners)
7.	Cost effectiveness	
Is it the best way of delivering the service?		
8.	Alternative services	
9.	Impact on services elsewhere	Is there an impact for other UHB service areas or for other interventions? Is there an impact for non-UHB services?
10.	Workforce implications	Will it increase or decrease or change human resources and skills mix?
11.	Geography	Transport, rural isolation

Step 3 making recommendations

The Health Board will establish a formal structured mechanism for making prioritisation recommendations. Where possible the existing CPG, Board of Directors and Committee/Board arrangements will be used.

Individual CPGs, under normal delegation and the principles of the BCUHB Prioritisation Framework approved by the full Board, can receive and make recommendations/ decisions.

Where appropriate, inter CPG discussion should be used to consider and approve recommendations/decisions.

Recommendations involving major rational disinvestment should be submitted to a Prioritisation Panel and then to the Health Board for approval.

It is acknowledged that a range of decision methodologies will be used to reach a set of recommendations: there is no one gold standard method. However, the first component of consideration is very definitely the evidence (does it work?) which will then lead to consideration of the scale of impact and the cost. It is these factors which will be largely subject to comparative judgements. It is accepted that a large measure of informed judgement will be used by the panel and the framework's underpinning values and ethical principles are crucial in support of this. At this stage, it is also expected that the impact of the prioritisation recommendations (health impact, reputational impact and public acceptability) are clearly identified.

BCUHB Prioritisation Panel

The proposed membership of the panel is:

- Medical Director/Deputy Medical Director – chair of panel
- Two Chiefs of Staff (representing CPGs)
- Executive Director of Public Health (or deputy)
- Executive Director of Nursing (or deputy)
- Executive Director of Therapies and Sciences (or deputy)
- Primary Care representative
- Health Professional Forum Representative
- Stakeholder Reference Group Representative

Plus Attendees in an Advisory Capacity:

- Clinical Advisors (Clinical Directors as per topics)
- Service Improvement Advisor
- Health Service Planning Advisor
- Health Economics Advisor
- Finance Advisor
- Equality Advisor
- Ethical Advisor

The panel will be deemed to be quorate if one Executive Director (chair or vice-chair) and 2 other panel members are present (based on the All Wales Policy for '*Making decisions on individual patient funding requests (IPFR)*').

Each meeting of the panel will be recorded to ensure a proper record of the panel discussions and decisions are made. An electronic database of decisions will also be maintained.

Community Health Council (CHC) representation will be invited as lay observers to each meeting of the panel.

Step 4 Making prioritisation decisions

The Health Board will receive the step 3 prioritisation recommendations for decision.

6. Support requirements: administrative, technical & training

The administrative and technical support required for both the corporate level and CPG level systems to function efficiently and effectively cannot be underestimated. It will be necessary for administrative support to co-ordinate and facilitate all arrangements for groups and panels including maintaining a register of members and co-ordinating papers, reports and maintaining a record of decisions made.

The responsibility for the provision of evidence against the criteria will lie with the relevant CPGs, clinical directorates and specialist support may be required. Support will need to include literature searches and critiques of available evidence, economic evaluations, ethical viewpoints, together with benchmarking information from other health bodies and establishments. It will include evidence of impact as well as data on the current position, estimates of numbers of patients to be treated and estimates of numbers who might benefit as well as costings for the proposals.

Training for officers and members involved in this work will be required and specialist training on the Equalities Act, Human Rights Act, ethics and health economics will also be necessary.

APPENDIX 1**List of Participants:****a) All Wales Prioritisation Framework**

- Area for Circulation:** Health Boards in Wales
Welsh Health Specialised Services Committee (WHSSC)
Public Health Wales (PHW)
Public Domain via Internet Sites
- Executive Sponsors:** Dr Sharon Hopkins, Director of Public Health, Cardiff & Vale UHB and
Dr Geoffrey Carroll, Medical Director, WHSSC
- Author:** Claire Donovan, Senior Associate, Public Health Division, Cardiff & Vale UHB
- Development Group:** Representatives from:
- Cardiff and Vale University Health Board
 - WHSSC
 - Powys Health Board
 - Cwm Taf Health Board
 - Hywel Dda Health Board
 - Aneurin Bevan University Health Board
 - Betsi Cadwaladr University Health Board
 - Abertawe Bro Morgannwg University Health Board
- Professor Mike McNamee, Swansea University
Professor David Cohen, University of Glamorgan
Professor Rhiannon Tudor-Edwards, PHW
- Consultation:** All Wales Medical Directors, Public Health Directors
Finance Directors, Planning Directors; All Wales
Development Group (October 2011)
Equality Impact Assessment (tbc)
- Approved:** All Wales Chief Executive (tbc)
- Lead Health Board**
- Contact:** (As per health board)

b) BCUHB Prioritisation Group

- | | | |
|-----------------|---|---|
| Andrew Jones | - | Executive Director of Public Health |
| Bob Evans | - | Assistant Director of Finance/Financial Recovery and Sustainability |
| Viv Vandenblink | - | Financial Strategy & Planning Accountant |
| Martin Duerden | - | Assistant Medical Director – Primary Care Central |
| Kathrin Thomas | - | Consultant in Public Health |

Ian Howard	-	Assistant Director of Planning/Head of Strategic Analysis and Development
John Darlington	-	Director of Development & Performance
Jill Newman	-	Assistant Director Performance Analysis
Matthew Makin	-	Chief of Staff: Cancer CPG/Consultant in Palliative Medicine
Peter Lepping	-	Consultant Psychiatrist
Mark Lord	-	Chief of Staff: Pathology CPG
David Fletcher	-	Associate Chief of Staff (Operations)
Brendan Harrington	-	Consultant Paediatrician
Damian Heron	-	Cancer Network Director/Associate Chief of Staff Operations & PI