Making difficult decisions

Commissioning healthcare in changing times

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Foreword

We are delighted to have worked with NHSCC to support the development of some top tips for clinical commissioners when faced with making challenging decisions about prioritisation of resources and service provision. It draws upon some research that my colleagues and I have conducted recently as well as some practical insights from CCGs.

As with all local decision-makers, clinical commissioners are faced with the task of making decisions that balance the interests of a variety of stakeholders, dealing with imperfect evidence, and working through sometimes imperfect implementation channels – and doing all of this in an extremely challenging financial climate.

Against this backdrop, it is useful to pull together the evidence and experience that exists from decision-makers themselves into some general principles, which is the purpose of this publication.

All the tips included reflect what is currently known about the blockages and challenges facing effective priority setting and how these might be overcome. It doesn't replicate existing guidance and requirements around consultation and engagement in the NHS, but focuses on some guiding principles to take into account from the start of the decision-making process. As two decision-making situations are rarely ever the same, it is intended as a helpful guide rather than a blueprint for success.

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We are in a time of change and challenge in the NHS with the development of place-based collaborative sustainability and transformation plans (STPs), and the introduction of new models of care through the creation of potential multi-specialty providers and primary and acute care systems. This is happening alongside moves to fully integrate health and social care, all during a time of pinching budgetary constraint for the whole system.

Clinical commissioners have always had to make tough decisions and with increasing financial pressures, and spiralling demand, this is now more the case than ever. While not about cutting essential services or sacrificing quality, recent news stories and public campaigns have shown that this isn't always what comes across. Patients and the public are understandably concerned about what change and financial pressure in the NHS means for the services they may rely on and have come to expect.

For CCGs, decision-making should always take need, quality and safety, access and cost effectiveness fully into account, but sometimes we may struggle to take all our stakeholders with us from the start and make sure our reasons for seeking to do things differently commands the confidence of others. One of our key messages in this timely NHSCC publication is to engage with all relevant stakeholders from the beginning – patients and communities, local government officials and politicians, national bodies and the media to name just a few.

Difficult decisions around what services to fund within the finite resources available and how they should be organised are an inevitable part of commissioning healthcare, but patient need is changing and the ways we can best respond to that is changing too. While the decisions may be difficult, where they have the potential to take us should be towards services and outcomes that are fit for a transformed and sustainable NHS.

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Introduction

Clinical commissioners have to make difficult decisions on a daily basis that involve balancing needs and wants in healthcare and recognising rights and choices. Out of this comes the requirement to make decisions that prioritise how finite resources are allocated while maintaining a fair and accessible healthcare system. This is a challenge for all healthcare systems, including those facing significant financial issues, and the NHS in England is no exception.

The current challenging financial climate as well as the increasing pursuit of sustainability and transformation – such as through the development of place-based STPs, the redesign of some services across traditional institutional boundaries and the formulation of new patient pathways and different configurations of clinical teams – makes prioritisation in healthcare a very live topic.

Clinical commissioners are arguably at the centre of local priority setting and associated decision-making in the NHS in England. This inevitably takes place within a complex set of values, relationships and systemic levers and drivers. Such complexity may exist within a neighbourhood, within the boundaries of a CCG's footprint or at national level.

To define and implement priorities successfully, and minimise the risk of failure – which could come in the form of last-minute u-turns; unnecessary double-running, whereby new and old priorities are both maintained; delayed decision-making; or unsatisfactory compromise – clinical commissioners are seeking clarity about the factors that can enable good decisions to be made, implemented and maintained, and model them in their decision-making processes.

This publication will contextualise the process of prioritising and potentially decommissioning health services, reflect on relevant research and the experience of clinical commissioners, and set out the factors that can enable challenging decisions to be made and seen through.

Top tips on making difficult decisions

- Identify opportunities for improvement and safe and cost-effective change in service provision.

- Plan the change management process carefully in advance.

- Base decision-making on robust data where available.

- Manage stakeholder perceptions through active engagement, consultation and nurturing trustworthy relationships.

- Recognise that local community, clinician and political support is vital, and engage these interests early.

- Develop an integrated communication and engagement strategy from the start.

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CCG experience of prioritisation and decommissioning

The NHS in England is going through a period of major change to achieve long-term sustainability and transformation. As this gathers pace and some of the drivers of change grow stronger, some potentially hard choices are becoming increasingly unavoidable.

In a series of interviews with CCGs and others about their experiences of prioritising and decommissioning of health services, some clear common themes emerged. In some cases CCGs were yet to feel that processes to re-prioritise, and potentially fully decommission services, were working well, but there was a feeling that lessons learned from recent experiences would inform and improve such decision-making in the future. Many spoke of a 'learning curve', particularly around how to handle external communication and public engagement.

Identifying opportunity for change

Of the CCGs interviewed, most had experienced, or knew of, unanticipated difficulties that had emerged during the decision-making process. This had often caused the implementation of plans to be delayed, reshaped or even reversed.

One interviewee said reconfiguring A&E services, which would involve moving the two current services onto one site, would not only be more cost effective but safer, with all of the consultants based in one location. That project is now on hold as it is thought to be too politically sensitive, particularly after a less obviously contentious plan met with local opposition.

Decommissioning a service is likely to prompt different reactions and opinions from stakeholders. Most commissioners interviewed indicated that they drew a clear distinction between projects that are small in scale or involve services that are believed to be less newsworthy. For example, switching patients with a particular condition from their current medication to a newer, more effective drug or relocating a small clinic that served relatively few patients, was seen as more straightforward and fairly risk free. That said, in some cases even a small change to a patient pathway affecting very few people has been known to result in negative headlines and protests. At the other end of the spectrum, major reconfiguration of some acute services for an entire city or district, or redesigning a traditional service that affected large numbers of people, was thought likely to result in resistance.

Some of the decisions believed to more achievable – 'the low-hanging fruit' – are believed to have already been taken in many cases. According to NHSCC co-chair Dr Amanda Doyle, "many CCGs are already engaging on stopping prescribing of medications for minor ailments which are widely and inexpensively available over the counter, for example."

At Kingston CCG in South West London, some aspects of primary care are currently being redesigned. "We are looking at our key performance indicators and the quality outcome framework, and asking of locally commissioned services 'Do these work?'" says Phil Moore, CCG deputy chair (clinical) of Kingston CCG. "We are beginning to identify some services that we need to change and some that we need to decommission. Those are small fry though." When it comes to the large-scale projects, the situation is rather different, Dr Moore believes. "You have to manage three sets of people and ensure that they are right behind you: the clinicians, the local authority and the local population."

Advance planning

Research and real world practice in setting priorities for healthcare centres around early and robust advance planning. As well as enhancing the quality of the decision-making it can bring transparency, support evidence gathering and data collection, and enable the development of robust cases for change.

Many of the factors involved in successful planning for change were thought by CCGs to be simple and obvious, in retrospect at least. Yet at the time, it can be difficult to stand back and consider the full implications of change. This might be due to competing demands on commissioners' time and the need sometimes to act quickly to respond to unforeseen circumstances in fire-fighting mode.

"Any decisions that need to be made around changing or decommissioning services should be done in a planned, open and transparent way involving patients and people using those services. A knee-jerk reaction to addressing areas of overspend and potentially cutting current services in order to balance the books is immensely risky, and in the long term is not an effective way of managing the process," says Jason Stamp, lay member of Hull CCG.

The chief executive of NHS Clinical Commissioners, Julie Wood, highlights that in the context of developing a sustainable and transformed NHS, particularly in times of financial constraint and pressure, there will be potentially controversial and difficult decisions to be made. She says "the advice to CCGs is to plan early and make sure you have the involvement and support of key arm's-length bodies from the start."

Managing public perceptions

For some CCGs, managing public perceptions of making changes to services is paramount but can be challenging. "We are more in our comfort zone with the technical aspects of decommissioning," says Dr Tim Moorhead, chair of Sheffield CCG. "We are less so in our engagement with the population, the politicians and the press, and we need to think about this much more."

Public reaction and political sensitivities are perceived by some as the greatest barriers to re-prioritising services. Any plan to reconfigure, relocate or withdraw a service can be met with opposition and be perceived by the public, politicians and sometimes clinicians as detrimental to patients and based entirely on the need to cut costs.

Some CCGs were frustrated that, while budget constraints and the austerity agenda were clearly a factor, a sound, rational case for change that would result in a safer and better service for patients sometimes can be drowned out by a local clamour. "There may be a perception among the public and politicians that services are being cut but it may be that a service is obsolete and there are better ways of doing things," says Tim Moorhead.

Cautiousness has also led to instances of so called 'double-running', where CCGs introduce a new service but fail to ever remove the old service that it was intended to fully replace. However, there is a feeling expressed by some CCGs that they need more active national political support when they face community and media opposition to changes.

Julia Simon, former head of commissioning policy at NHS England, says that CCGs should be able to rely on national and political cover on difficult issues like hospital reconfigurations: "If I were a CCG, I would say [to ministers and NHS England], 'You have made a national ask of us and you need to give us political cover'. That must be part of the deal."

At the top of the commissioners' lists of challenging decisions is the closing or relocating of entire services, such as an A&E department, a maternity clinic or a community hospital. "NHS staff sometimes forget that the public have strong emotional ties to hospitals. There is this iconic view of NHS buildings – you've been born there, your relatives have died there and there is always going to be an emotional attachment, regardless of whether the place can actually deliver safe services," says Andy Payne, head of network development at Healthwatch England.

"Often you are taking something away that is not needed or is being used inappropriately, or is not delivering the right outcome, but you have to be able to demonstrate what will be taking its place," says Anthony Hassall, chief accountable officer at Salford CCG. "Making that case really clearly though is often not done or done really poorly."

Stakeholder engagement

Effective stakeholder engagement is seen by CCGs as an important factor to consider. "You need to think about engagement from the very start when you are even remotely considering decommissioning," says Susanne Hasselmann, lay member of South Eastern Hampshire CCG. "You have to think about who your main stakeholders are. They are not hard to identify, it's just that people often fail to do it. You should clearly define the challenge and the issues around any decision and then ask who will be able to help you make it happen? And who will find the proposed changes challenging? Early positive engagement of your main stakeholders will also allow you to ask the right questions and frame your argument."

Clinical commissioners know about the key groups who need to be engaged at an early stage in decision-making, and whose backing is vital. At the top of the list are the local community, clinicians and politicians, along with the media.

According to Andy Payne, "it is important that there is an open conversation about the reasons for any changes or there will be resistance, even with the closing of under-used services, for example. Decision-makers sometimes worry that if they discuss the issues with the public at the beginning and in broad terms, they will open themselves up to challenge. You need to stand back and ask yourself, 'how can I positively involve people?' The public want to be part of this conversation, they want to understand the ideas behind any changes… then they will be more engaged and will understand the reasons for change, even if it is not the outcome they wanted."

"There is a feeling expressed by some CCGs that they need more active national political support when they face community and media opposition to changes"

The commissioners interviewed also recognised that it is essential to engage with clinicians as well as local politicians. Clinicians are deemed important both in the practical sense of making the new plans work and also as powerful advocates for change, trusted by the public in a way that politicians and managers often will not be. "The public will listen to clinicians, which is why you should always front them up at public meetings," says Phil Moore. "Even so, that doesn't always prevent the politicians at the last stage saying, 'No, not in our backyard'."

Political backing

Engaging with politicians is seen by some CCGs as potentially challenging. While they have the power to derail a valid proposal through public opposition, it can sometimes be hard to garner their support in making potentially unpopular choices. Recent research, carried out at the Health Services Management Centre at University of Birmingham by Tom Daniels, identified politicians as a major influence on decision-making in health services. Dr Daniels believes that if politicians are approached early on in the process and the choices explained, they can be supportive: "They have huge influence locally and they also have a responsibility in terms of improving services and getting best value for taxpayers' money, but we don't always harness that properly."

Anthony Hassall says the arguments should be tailor-made for the audience. "You need to map out your case, based on an understanding of the different drivers of the different groups of stakeholders and make a bespoke argument for each," he says.

In one CCG, a plan to move a midwife-led baby unit that was only seeing small numbers of women a year to another site, alongside an obstetric-led unit, was opposed by councillors and some local people. For the GPs involved in making the commissioning decision, the issue was one of cost effectiveness. They were convinced that the money spent on the unit could be better spent on supporting more children to live better lives in the community. For the politicians, it was

a matter of civic pride: they were concerned that children would no longer be registered as having been born in their district. Women, on the other hand, wanted to retain the choice between the midwife-led unit and the obstetric unit. In the latter case, the commissioners had to explain that the unit was not being closed – the choice remained – it was simply that the service would be in a different location.

Sometimes local opposition can be based on a misunderstanding about proposals.

In one CCG area, a maternity unit had 3,000 mothers a year going through, while another other had 50 but, for reasons no one could explain, there was strong resistance to closing the under-used service.

For Susanne Hasselmann, the decision needs to be explained simply and clearly in the context of the whole patient pathway. "It is partly about using digestible information and avoiding NHS jargon," she says. "It's no good using terms like 'acute configuration', for example. What does that mean to the average person?"

One CCG ran a successful campaign to reduce the number of paracetamol prescriptions. They said: "It was led by clinicians rather than managers. But we had a really clear, simple message: 'You can buy paracetamol for 16p in the supermarket. We are currently spending £1 million a year on it. If we stopped doing that, look what else we could buy'."

But when there is an issue of patient safety at stake, the public may be better attuned to the case for change, particularly if the case for change is made by medical professionals.

Engaging the media

If supportive, the news media can be an effective channel through which to explain the rationale of proposals to the public. However, if local people first learn about the plans through headlines about services being 'axed', for example, commissioners can be placed on the back foot and start from a position of public opposition.

Sheffield CCG recently moved to the co-commissioning of general practice and went through the primary medical services review process. As a result, some practices stood to lose substantial amounts of funding. Feelings ran high and the situation became very difficult. "We explained our decision-making and described what discretion we had, which wasn't much," says CCG chair Dr Tim Moorhead. "While some practices were going to lose funding, the money was being redistributed to others. That was the formula." As well as supportive GPs, several local councillors also backed the decision. The CCG had built up strong relationships over time with local authority politicians and that paid off. Dr Moorhead said: "It was a big learning process. The technical part of the decision wasn't that difficult but dealing with the local politics was very time consuming."

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Making difficult commissioning decisions

We have drawn on learning from relevant academic research and from experience on the ground on successful priority setting, to set out the key factors to consider when embarking on making difficult commissioning decisions.

Change management

Some of the clearest recommendations to emerge both from research and the practical experience of commissioners are around the change management process and the role of negotiation, sense-making and leadership. This includes "crafting a narrative, paying attention to the politics and bringing people with you"[1], and linking to health benefits.

Planning
Commissioners make decisions about prioritising and potentially decommissioning services for different reasons in different contexts. Sometimes a decision has to be taken fast in response to circumstances over which commissioners have little direct control. However, where decisions are able to be taken in a planned way, then a clear, explicit and thorough project planning process is essential from the outset.

Strong leadership
Research has found that a strong top team, demonstrating effective and collaborative leadership, heading up any change project is one of the most important factors in making good decisions about what services to fund and in implementing them.

Stakeholder engagement
Effective stakeholder engagement to prompt interest and understanding has been identified as another essential factor, based on thorough stakeholder mapping. The groups of people whose support is vital and who need to be involved at an early stage include patients, clinical leaders, GPs, local councillors and MPs, local communities and the media.

Coordinated approach
Commissioners should adopt a 'whole-system' approach rather than looking at the issue in isolation. It is important to consider how the proposed decision will impact upon other services, other patient groups and the relevant workforce. There should be a clear rationale and a narrative for the change in order to make a robust case to stakeholders.

Transparency
Decision-making processes must be transparent, so that internal and external stakeholders understand who is making the decision, how that decision is being made and why. This should provide a foundation for all stakeholder engagement activity.

Review and appeals processes
Ideally there should be a formal and transparent process for reviewing the decision and administering any appeals.

Providing an appeals process complies with principles of fairness and justice and it also gives decision-makers the opportunity to consider new information, correct errors and address any unintended consequences of plans.

Implementation of decisions
The practical process of implementing decisions can sometimes be given less emphasis than the decision-making itself. It is important to consider how and over what time period any service that is changing, or being fully decommissioned, would be phased out and it should be carried out in a planned and timely way. Without a clear strategy in place, however, there can be a risk of unnecessary and potentially costly 'double-running'.

Evidence

Building a robust evidence base, including around patient outcomes, promotes high-quality decision-making and is integral to effective stakeholder engagement. Commissioners need to be able to explain their rationale for change in an open and transparent way so as to withstand public scrutiny.

Information
Data should be collected and analysed before, during and after the decision is made. This can include:

- health outcomes data
- economic data (such as cost-benefit analysis)
- needs assessment
- equalities impact assessment
- current policies or policy reports
- patient experience
- clinician views.[2]

Examples of good practice
It may be helpful to identify cases where similar decisions have already been made, by the same or other CCGs, and draw upon what has worked well previously.

Tools and frameworks
There are various tools and frameworks available to support commissioners to make decisions about priorities, including the NHS England's Commissioning for Value data packs.

Other tools include: programme budgeting and marginal analysis (PBMA) – a formal process for setting priorities and allocating resources that is increasingly used in the UK and internationally.

Multi-criteria decision analysis (MCDA) is an umbrella term for an approach also increasingly used in healthcare priority setting. The methods range from simple scorecard tools to more sophisticated computer modelling.

Accountability for Reasonableness is an ethics-based approach to priority setting. It poses questions such as 'Can you demonstrate that your decision-making is transparent?' 'Do you have an appeals process in place?'

Relationships

High-quality, targeted communication and public engagement activity are essential to effective decision-making about what health services to fund. Researchers and commissioners identify the following groups as crucial to building and nurturing effective relationships:

- patients
- local community
- politicians – national and local
- local health professionals, including medical practitioners
- news media
- special interest groups, such as condition-specific campaign groups.

Communication and engagement planning

A communication plan should be an integral part of the planning process. It should also be tailored to the decision being sought, rather than generic in nature. Stakeholder engagement should begin at the very start of the decision-making process, where key stakeholders are identified and their perspectives and agendas understood.

Local communities and interest groups

It is crucial to develop engagement strategies with patient groups, community organisations, and relevant charities and healthcare campaigners. They may have strong and legitimate views and concerns, and failure to consider and manage the impact of their interests could delay or prevent decisions being made. Effectively planned engagement with key stakeholders has been identified in research as a key factor in helping to ensure success in making and implementing healthcare decisions. Relevant questions to consider are: What form will engagement take? What is the aim? Who will participate? How will awareness of the opportunity to feed in be raised? How will the results be measured? How will they be used and disseminated?

Clinicians

Support from clinicians is essential for two main reasons. Their cooperation is needed in order to make the new service work efficiently and their opinions carry significant weight with other stakeholders, including in shaping public perceptions.

Politicians

As elected representatives, local councillors and MPs have a legitimate interest in the design, delivery and funding of local health services. They have a public profile, may have established media relationships of their own, and can bring their own influence to bear on the outcomes of priority setting. They should be engaged from the earliest stages of the decision-making process.

News media

Broadcast and printed/digital news media have a powerful role in communicating decisions about local health priorities and service provision. The media can be a positive channel for communicating the case for change. In its many different forms, it offers a platform from which to explain the choices and the decisions to the local population. Mishandled, however, confusing or inaccurate headlines can spark public disagreement. Research shows that where media relationships are nurtured over time they can be more constructive during times of important and potentially controversial decision-making.

Conclusion

Clinical commissioners are at the front line of reshaping the NHS into a modern, sustainable service capable of meeting the changing health needs of the population into the future. While this often means replacing outmoded ways of doing things with better and safer services, difficult decisions are inevitably involved. Strong leadership, early strategic planning and getting stakeholder engagement right are among the key elements to potential success.

Our top tips on making difficult decisions are:

- identify opportunities for improvement and safe and cost-effective change in service provision
- plan the change management process carefully in advance
- base decision-making on robust data where available
- manage stakeholder perceptions through active engagement, consultation and nurturing trustworthy relationships
- recognise that local community, clinician and political support is vital, and engage these interests early
- develop an integrated communication and engagement strategy from the start.

"High-quality, targeted communication and public engagement activity are essential to effective decision-making about what health services to fund"

Recent research into priority setting in healthcare

There are a number of recent academic studies that have investigated how decision-makers set priorities in healthcare and identify factors that can enable effective decision-making to be undertaken collaboratively with stakeholders. Below is a summary of some recent studies.

What is priority setting in healthcare?

One study by Klein in 2010 defined priority setting in healthcare as: "decisions about the allocation of resources between the competing claims of different services, different patient groups or different elements of care".[3] While another in 2014 by Robert et al saw it as a process of 'removing, reducing or replacing healthcare services'[4] that might include doing new things or ceasing existing things. To Dr Iestyn Williams of the University of Birmingham it is about 'fairness' and 'justice', whereby greatest need can be met while maintaining a baseline of universal service.

Sometimes the term decommissioning is used to describe the ceasing of health services and could be argued to be a term that is coterminous with 'cuts'. However, while decommissioning may indicate the ceasing of services, it is also likely to enable the opening up of new services delivered in new ways and following new and arguably better and more cost effective patient care pathways and interventions. This is particularly so where priority setting takes account of current and future projected patient need, new technologies and interventions, and maintaining patient safety and quality. In this light, decommissioning may be an enabler of the new, better and cheaper rather than always a symptom of fiscal challenge.[5]

How does priority setting happen?

Another research team, Shannon Sibbald et al in 2009, recognised the complexity and multi-faceted nature of priority setting in healthcare as well as the lack of guidance for healthcare decision-makers. They called the process of priority setting, taking the Canadian context as a case study, as "a series of unconnected experiments" without top down guidance or sharing of experience between institutions.[6] For them it was a process of "choosing between competing values".[7] Similarly, Iestyn Williams in 2010, in the UK context, saw the health commissioners role being "to ensure that resources are distributed fairly and effectively".[8] Yet, at that time – with PCTs still in place – he believed commissioners had not shown "sufficient authority and resources to implement high-profile decisions".[9] Robert et al in 2014 saw decommissioning as an 'Achilles heel' for healthcare characterised by blunt measures and resultant turmoil.[10]

What factors should influence decision-making?

Robert et al in 2014 identified three considerations that should inform decommissioning decisions: quality and patient safety; clinical effectiveness; and cost effectiveness.[11] Since then, in 2015, Iestyn Williams argued that commissioners should aim to increase the 'receptiveness' of their decision-making by positively managing the external environment. This, he argued, means obtaining the authority – tacit or overt – from four key sources – government, citizens, interest groups, and the media.[12]

The 'authorising environment' concept that Dr Williams describes is not the only framework within which healthcare service prioritisation can be set. Sibbald et al in 2009 identified five process factors and five outcome factors which, they argued, can positively influence priority setting that similarly build to ideally create a positive external reception to decisions – defining success in priority setting is a necessary step towards improving priority setting practices in healthcare organisations.[13] For Sibbald and colleagues stakeholder management, information management, clarifying context and values, and having a revision or appeals process were crucial factors in successfully navigating the priority setting process. Where sufficiently in place, this should result in stakeholder understanding, the ability to reallocate resources, improved decision-making stakeholder acceptance and a positive external environment.[14]

Which relationships are important?

Dr Iestyn Williams argues that priority setters in healthcare (commissioners) must understand their external 'authorising' environment by identifying and mapping those interests who need to engage and enable decisions to be seen through to implementation.[15] He suggests that building and nurturing productive media relations; enabling patient and public engagement; and negotiating with interest groups, can make for a more enabling 'authorising environment' and manage the risk of failure.[16] He goes on to acknowledge that weak evidence and data analysis, weak decision-making criteria, a lack of public engagement and competing objectives and values can bring about challenge and the risk of failure in the process.[17]

Is there a perfect approach?

Despite the range of available conceptual frameworks, research also acknowledges that there may well be a difference between theory and practice. Robert et al state that the "gap between rhetoric and reality of decommissioning is at the heart of the decommissioning challenge".[18] What is consistent is that 'change management; evidence; and relationships and politics'[19] are ever present factors that can positively or negatively impact on the priority setting process and need to be actively managed in order to see decisions through to implementation.

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References

1, 4, 10, 11, 18, 19 from Robert G, Harlock J and Williams I: 'Disentangling rhetoric and reality: an international Dephi study of factors and processes that facilitate the successful implementation of decisions to decommission healthcare services'. *Implementation Science*, 2014, 9: 123.

2, 6, 7, 13, 14 from: Sibbald S L, Singer P, Upshur R and Martin D: 'Priority setting: what constitutes success? A conceptual framework for successful priority setting'. *BMC Health Services Research*, 2009, 9:43.

3, 5, 8, 9, from: Williams I, Dickinson H, Robinson S: 'Joined-up rationing? An analysis of priority setting in health and social care commissioning. *Journal of Integrated Care*, 2010, 19:1.

12, 15, 16, 17 from Williams I: 'Receptive rationing: reflections and suggestions for priority setters in health care', *Journal of Health Organization and Management*, 2015, 29: 6, 701–710.

Further reading

Gainsbury S (2016), *Feeling the crunch: NHS finances to 2020*, Nuffield Trust

Harlock J (2016), *The politics of priority setting and decommissioning in a time of austerity* (presentation of research findings available from the University of Birmingham's Health Services Management Centre at hsmc-enquiries@contacts.bham.ac.uk)

Kieslich K and Littlejohns P (2015), 'Does accountability for reasonableness work? A protocol for a mixed methods study using an audit tool to evaluate the decision-making of clinical commissioning groups in England', *BMJ Open* 2015:5:7

NHS Clinical Commissioners (2015), *A guide for CCGs: Engaging the public in difficult decisions about health service change*

NHS England (2013), Commissioning for Value: Comprehensive data packs to support CCGs and NHS England in the regions

NHS England (2016), *Engaging local people – a guide for local areas developing Sustainability and Transformation Plans*

Robinson S and Williams I (2012), *Priority setting and rationing in healthcare*, University of Birmingham

Williams I, Robinson S and Dickinson H (2011), *Rationing in healthcare: The theory and practice of priority setting*

Notes

NHS Clinical Commissioners is the only independent membership organisation exclusively of clinical commissioning groups.

Our job is to help CCGs get the best healthcare and health outcomes for their communities and patients. We're giving them a strong influencing voice from the front line to the wider NHS, national bodies, government, parliament and the media. We're building new networks where they can share experience and expertise; and providing information, support, tools and resources to help CCGs do their job better.

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