

3.1 Indicators for whole system decision-making

The *NHS Constitution* outlines the need for PCTs, their SCGs and clinical networks along with Provider Trusts to make local decisions about the funding of medicines and treatments rationally, following a proper consideration of the evidence. The DH has published *guiding principles*, to help improve local decision-making processes and to reassure patients that there will be a common, overarching framework within which such decisions should be made.

Due to local care configurations, PCTs are likely to use a range of different structures to develop policy, and make decisions about medicines and treatments. PCTs, with cooperation from Provider Trusts and other stakeholders, need to develop some indicators against which they can evaluate their **whole**

system decision-making. As a starting point, included below are some examples of high-level indicators, based on key aspects of the *DH guiding principles* for local decision-making (**Section 1.3**) and the key steps in this *Handbook* (**Section 2**).

The indicators need to be refined for local use in order for them to be a meaningful tool to evaluate progress toward whole system decision-making. This will involve an initial baseline assessment of current practice and a clear view of how the system is developing in order to evaluate progress. These indicators can be used in conjunction with the **diagnostic tool** which helps PCTs to evaluate their current performance in some of these areas.

Scope (Supports the SCOPE of the <i>DH guiding principles</i>)	Do you have documentation describing how decision-making processes are linked into the PCT WCC assurance process?
Effectiveness of horizon scanning (Supports the SCOPE of the <i>DH guiding principles</i>)	Did you proactively horizon scan to identify new medicines and treatments? How many unexpected 'in-year' funding requests did you have for new medicines or treatments? Could these have been predicted?
Triage to relevant groups (In support of <i>DH guiding principle 3</i>)	How were decisions separated into those for the whole population of the PCT and those dealing with individual patients?
Collaboration (In support of <i>DH guiding principle 3</i>)	How many commissioning policies were developed/decisions taken on a supra PCT (collaborative) level? Is this in line with expectations?
Speed of decisions (In support of <i>DH guiding principle 5</i>)	How many (what percentage of) commissioning policies took longer to develop than agreed timescales? Where delays occurred, what caused them? How many (what percentage of) IFRs were not decided within agreed timescales? Where delays occurred, what caused them?
Engagement and communication (In support of <i>DH guiding principles 7 and 8</i>)	Have reasonable steps been taken to engage with the public and patients about local decision-making processes and the need for prioritisation? How was feedback solicited? Are all relevant policies and decisions publicly available on the PCT website? Have you got a communication framework? Has the success of the framework for decisions/recommendations been evaluated? Can you demonstrate that commissioners and clinical teams are aware of, and act upon, decisions?
IFR processes (In support of <i>DH guiding principle 3 and 6</i>)	How many requests for IFRs were submitted? What percentage was appropriate for consideration through the IFR route? What percentage of IFR panel decisions was appealed? How many original decisions were overturned?