

# Shifting the gravity of spending?

Exploring methods for supporting public health commissioners in priority-setting to improve population health and address health inequalities

Second phase interviews: report of qualitative findings

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# 1 Introduction

## 1.1 Background

The study, funded by the National Institute for Health Research (NIHR) School for Public Health Research (SPHR), is concerned with decision-making for investment in prevention at a time when local authorities in England are now responsible for public health. The research has taken the form of applied research and is based on the premise that if decision support methods are to be employed and have an impact, they should be developed in conjunction with those charged with commissioning services, reflecting local priorities and political contexts. The main study began in December 2012 and was completed in August 2015. A one year follow on study was funded which ended in August 2016. This report presents an analysis of the findings from the second phase interviews conducted for the main study and a prelude to the follow on study.

## 1.2 Aims and objectives

The study aims are twofold: (a) to understand the issues surrounding the decision-making process, and (b) develop support for local authority-based public health commissioners and other stakeholders in prioritising investment in health and addressing health inequalities, and in deciding on disinvestment. The specific research questions addressed in the overall study are:

1. Which prioritisation tools do commissioners find useful for prioritising public health investment and why?
2. What are the enablers and barriers for decision-making related to prioritising investment in public health?
3. What difference does the use of specific decision-making support exert on spending within and across programmes with reference to improving health and addressing health inequalities?

As noted above, the study included a second phase of interviews which are reported here. These were carried out to shed further light on interviewees' thinking around the issues surrounding priority-setting, considering also priority-setting tools and their practical adoption in public health prioritisation processes<sup>1</sup>.

## 1.3 Report content

Following a brief description of the methods, this report presents the findings from the second-phase qualitative interviews in terms of the three original research questions in turn.

Supplementary findings are presented on interviewees' views on the economic prioritisation workshops (see Chapter 6). Lastly, the report raises some points of discussion that helped to guide the team in carrying out the follow-on study, for which funding was secured from September 2015 to August 2016.

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<sup>1</sup> See also Hunter DJ, Marks L, Brown J, Scalabrini S, Salway S, Vale L, Gray J & Payne N. (2016). The potential value of priority-setting methods in public health investment decisions: qualitative findings from three English local authorities. Critical Public Health DOI:10.1080/09581596.2016.1164299

## 2 Methods

### 2.1 Participants

The site-based second-phase interviews took place at three sites with Directors of Public Health or Consultants, locally elected politicians, other senior LA officers, senior representatives from the NHS Clinical Commissioning Groups and representatives from local Healthwatch (the local independent consumer watchdog for health and social care). These categories are not mutually exclusive, as some interviewees had jobs that included, for example, both health and social care. To allow for some distinction between the public health professionals and the other local authority officers and council members, while also ensuring confidentiality and anonymity, respondents have been categorised as follows: 'public health representatives'; 'CCG representatives'; 'Healthwatch representatives'; 'elected members' (local authority elected councillors); 'cabinet members' (elected members form the cabinet in each local authority; 'LA representative' (non-elected council officer).

Overall, six people were interviewed from Site 1, eight in Site 2 and eight in Site 3 between September 2014 and March 2015. Most had been involved in either first-phase interviews or targeted workshops but it was decided to interview three additional participants in Site 2 who had not been so involved: because of their roles and responsibilities within the LA, it was felt that their contribution could be relevant to the further exploration of prioritisation and decision-making processes. Ten of the interviewees had participated in one or more health economics targeted workshops delivered by the research team in Phase 1 of the study and were invited to comment on the support received, the extent it was found to be useful and of value, and whether, and how, stakeholders could benefit from it (section 6). In other sections, views are related to prioritisation more generally for key research questions including: the development of Health and Wellbeing Boards (HWBs); participants' understandings of how public health priorities were generated in their LA; the allocation of the public health budget; the public health role of LAs; relationships between public health professionals, elected members and other LA officers; barriers and enablers in decision-making around the priority-setting process.

The interview schedule is shown in Appendix 1. This was developed from the interim report of first-phase interviews.

Ethics approval for the study was obtained from the Durham University School of Medicine, Pharmacy and Health Ethics Committee.

### 2.2 Analysis

The site-based interviews were recorded and transcribed verbatim by an external transcription company. The transcriptions were analysed by an independent researcher, using thematic analysis.

### 2.3 Limitations of the research

Working with only three LAs out of 152 means that the study sites are not representative of all local government organisations in England. In our defence, since all LAs are different, reflecting widely varying local circumstances and contexts, arguably no sample would have captured the full range of variation. Notwithstanding this limitation we believe there is valuable learning which can be transferred.

The research was concerned with interviewees' thinking around prioritisation and experiences of priority-setting tools at a time when they and their organisations were still in the process of making sense of their public health responsibilities (these having transferred to local government from the NHS following the passage of the Health and Social Care Act 2012), and of how these were shaping everyday work and decisions of a local authority. It therefore presents a snapshot at a unique time in the reorganisation of the public health function. Local authorities were developing their own individual approaches to both integrating the public health function and to setting their priorities for their new responsibilities.

It is unlikely, therefore, that the findings are replicable or representative of all local authorities. However, there were several common issues raised by many interviewees – issues also emerging in the national survey of selected members of HWBs, carried out as part of the same study and running in parallel with the interviews (available in a separate report, <https://www.dur.ac.uk/resources/public.health/ResultsofShiftingthegravityofspendingnationalsurvey.pdf>).

### 3 Findings – research question 1: which prioritisation tools do commissioners find useful for prioritising public health investment and why?

#### 3.1 Specific tools

There was very little discussion on specific tools and reasons for their usefulness. Greater focus was on problems or good points about prioritisation tools in general. However, there were some comments relating to the tool used in the targeted workshop:

*You've got something that's tested that [investing in the right things to address health inequalities] out, and applying that methodology is, it's a relatively simple tool but that's good. I've always wanted something quite simple.* [Public Health representative, Site 1]

Some interviewees had used other specific tools and offered opinions on them. For example, talking of programme budgeting or the Spend and Outcome Tool (SPOT):

*I do think it's useful to have those other tools, to look at what you're spending, certainly what we're spending per head of population on different priorities compared to what other areas are spending as well is useful, things like that.* [Public Health representative, Site 1]

There were mixed views about some tools, for example the Socio-technical allocation of resources (Star) tool, which one interviewee had used in three areas – a particular cancer, dentistry and eating disorders:

*It was only really successful with the eating disorders area, but it did help us to take a different approach to how we commissioned eating disorder services, which I think has resulted in, well I know it's resulted in a bigger spend on earlier intervention, sort of day services in the city. The plan was that it would reduce the demand for people who needed residential time, inpatient time services, and that seemed to be what happened that there wasn't much of you until you got to a point where actually you were so ill with your eating disorder that you needed to go away to one of these specialist and really expensive places. And the Star process helped us to make that decision and helped to create some consensus in the community about that.* [CCG representative, Site 2]

In spite of the success of the Star tool in that area, it was not adopted as an approach to other areas of work in the interviewee's authority, because adopting it on all of the large number of projects in the commissioning plan would have been 'undoable'.

Tools had also been tried unsuccessfully by other local authorities.

*We've attempted to develop tools for priority setting in the CCG in the past and not found them to be useful. To the extent that the tools that we developed we stopped using because we just found that they were prolonging a process rather than helping it.* [CCG representative, Site 2]

#### 3.2 Barriers to the uptake of specific tools

In discussions about the workshops, some issues were raised in connection with barriers to the uptake of priority-setting tools. One concern was the need for an understanding of context: 'I think what that showed was that there needed to be a much greater understanding of the pressures and the context really of public health working; having said that, the tools were excellent and very interesting' [Public Health representative, Site 3].

Some of the barriers to decision-making in general (as discussed in section 4) apply also to the use of priority-setting tools within decision-making. There are also barriers or tensions related to the type of tool used:

*There's always potentially a tension between using that sort of rational methodology and the operational demands coming in from people who are in need or consider they're in need. And how you manage to hold a balance between the two. [LA representative, Site 3]*

Subjectivity and the difficulties of being objective were thought by several interviewees to be highly significant barriers.

*No matter how hard we try and make them objective, at the end of the day somebody's going to have to put either a three, a four or a five in a box, metaphorically speaking. And that, in my experience, has on occasions happened, where there's been an expert public health opinion that will probably score something at a five, and a more social model oriented person that would say 'no, I'm only scoring that a three'. And that may have a massive difference on a weighted model. So they do have their uses, but the important thing about any of those things is that the people that ultimately sanction those decisions, and have to live or die by those decisions, have to buy into the model. So there's no point developing a complex academic model with all the science in the world, if at the end of the day the people that are going to say yes or no to the money being spent that way don't buy into it ... At the end of the day these things always come down to somebody's opinion about scoring ... I remember hearing a comment very early on in the transition process from a politician that said 'well, the public health team can score it how they want, but at the end of the day ... if we don't like the scores that are there, we'll change them'. [Public Health representative, Site 2]*

The political element of decision-making in the local authority setting was raised by some interviewees in connection with the use of formal tools. One said that 'of course there's always a political element to decision making and I'm not sure always that, you know, being quite systematic and trying to nail down that political bit is very easy'. Another said that there had been discussion but ultimately the priority was decided by cabinet. Another saw the value of the formal tools but said they could not actually be used in practice because of political priorities:

*Well I would be very pleased if we could use some of these formal tools, but the reality is that in practice it's just not possible to, because at the end of day it's elected members who make decisions about where money is spent, and they are not terribly interested in there being these kind of formal assessments of the costs ... and there's different ways of spending the money and it's much more a sort of gut feeling and political priorities that determine that. So whilst ideally I think we would use those kind of tools, in practice it's not happening, and I can't see it happening for a while yet. [Public Health representative, Site 2]*

In one authority, a priority-setting approach had been used independently of the budget setting process more generally, 'so the elected members when they came to signing it all off they were a bit disgruntled because they felt that this had been done behind their backs without their involvement' [Public Health representative, Site 2]. This reaction might also reflect a wider lack of trust and ownership of the tool rather than the tool itself being problematic.

The need for local applicability of tools was stressed by one interviewee [Public Health representative, Site 2], who felt that there would be immediate questions raised about a technique that was found to work nationally, with the executive management team querying how well would it



work locally. Another [LA representative, Site 2] suggested that it was not only local context and local needs that had to be considered, but also local ambitions.

### 3.3 The practical relevance of priority-setting tools

The majority of interviewees appeared to feel that priority-setting tools could be of value. One interviewee suggested that people should use any framework that helps to inform a decision-making process, so long as there is evidence that the framework works. One interviewee felt that the prioritisation matrix used in the workshop was very relevant because it

*has got health inequalities as quite a major part of that, and that is a key thing around going forward that we need to address health inequalities. And everyone, like I said earlier, signs up to that, but it's actually putting the money into the right place and investing in the right things to achieve that.* [Public Health representative, Site 1]

Another pointed to their use in dealing with information.

*I think they're always useful. I think, I spend a lot of time telling people that we deal in facts and information. Our job is to deal in facts and information. So when everybody's getting upset, shouting and bawling and getting tense, my starting point is 'yes, but what's actually happening? What are the facts, what information do we have?' ... I think this kind of prioritisation approach is really, really useful when your decisions are likely to come under significant challenge.* [LA representative, Site 1]

In Site 3 over the previous year, risk stratification had been used quite extensively, as one of the public health consultants had developed a clear risk stratification model for identifying people with long term conditions. Importantly, the information was shared not only with CCGs, but also with social care, in terms of trying to identify people most at risk and most potentially in need of support in order to be able to continue to manage their care at home.

Some suggested that the techniques might be of even more value in the future:

*Our public health grant may well no longer be ring fenced. Once that happens, how do we ensure that public health priorities are seen as priorities? So that's going to be when it really comes into its own. So I think it will be useful, and I think we've just got to remember the importance of it when the situation is different to now really. So the situation's going to change in 18 months, and then I think the prioritisation tools will be really important. ... I think maybe in a year or two's time when the council and elected members have developed a better understanding of public health and what you can and can't do in public health and so on and so forth, then maybe yes, but at the moment no.* [Public Health representative, Site 3]

Several interviewees said that they would not be in a position to use the tools themselves but one felt it would be useful when scrutinising decisions to see how those decisions had been made using such tools. Another thought the tools would only be of use to the professionals using them.

Some interviewees added caveats or limits to their agreement that the tools were useful or relevant:

*... so long as you don't apply them too mechanistically. I think these sort of tools give you some really good questions to ask about priorities and it allows you to sort of start to rank them in order, but you've also then got to use some much richer intelligence than a fairly simplistic decision-making framework. But it's helpful. ... It's about setting values rather than*

*rules. And it's about identifying the questions you need to ask. So, you know, what's its impact? How easy is it to do? Does it affect lots of people for a small benefit or one person for a high benefit? You know, all those questions are great questions but how you then use them to frame it, it's almost a value judgement rather than an arithmetic one. [CCG representative, Site 3]*

*It is not really about spitting out some numbers which are obviously difficult to have full confidence in ... it's useful in terms of bringing the sort of structure, but obviously the quality of what comes out at the end depends very much on the people in the room and the contributions, not just on the sort of tools that we were offered to use there. [Public Health representative, Site 3]*

*I think seeing that kind of tool and having a real debate about it is in itself quite valuable and something that I would sort of welcome happening more. Because even though, I mean there was a very clear consensus in the room that the tool itself was never going to be perfect, no matter what you put where, you would never get to a position where the tool you used to do that job can do everything. But having a conversation about how to make it better and better is really healthy for how you make your decisions and actually to do that in more areas. And to do it in such an open way actually where you invite people to be part of a process where, you know, I think there's something valuable about people being involved who are stakeholders in the long term, but who also kind of leave their work hat kind of at the door and participate as a team of people trying to get something right. [CCG representative, Site 3]*

*I think they are useful, but they always have to be seen in line with the political priorities as well. [LA representative, Site 2]*

*There will be a real danger that it then becomes something like a tick box exercise for every decision you take. To me, I think it's better to focus on really getting to grips with our public health priorities ... and really getting the whole of the expenditure thinking through where we can make a real difference ... And it's seeing, it's actually seeing it in that context, which is where for me, should be our aim as a council, and then it will become seen as very much a valuable part of the whole, rather than at the moment it is very much on the side and siloed, except for the annual budget discussion, which doesn't help anybody, frankly. [LA representative, Site 2]*

*The exercise is under certain circumstances quite worth doing ... in terms of teasing out what are the things you can be rational about and what are the things that you're actually making assumptions about anyway. [Cabinet member, Site 3]*

*Actually using that as a tool around our prioritisation with the key stakeholders I think would actually, as long as it wasn't too gobbledegook, I think would actually be a good way into the debate. [LA representative, Site 2]*

In Site 2, there had been several training sessions around cost benefit analysis and an interviewee felt that colleagues who had attended believed that this could work for them, helping them to make decisions.

One interviewee felt there were problems around who could or would use priority-setting tools:

*You know, the politicians set policy, and it's the officers who implement the policy. That's very clear. Is that fair, otherwise what you're saying, if you want politicians to be playing*

*with that tool, we actually are becoming managers, which is what politicians are not supposed to be. We can say that we are a member-led authority, which is fine, but to actually say we are getting down to day-to-day management, I think that is where the line between elected politician and the professional could get very blurred. [Cabinet member, Site 3]*

### 3.4 Priority-setting approaches recently used or expected to be used

Where interviewees were aware of recent (in the last 12 months) changes in public health spending, they were asked how the decisions had been made about how to invest and disinvest money in public health. Many interviewees were unaware of priority-setting approaches having been used at all in their authority.

*Not locally, no - I'm sort of theoretically aware of those methods but I've not used them. [CCG representative, Site 3]*

*Not necessarily in public health, I know there have been in other areas that I've come across, but not so much in public health up to now. I think they've touched on it once or twice. [Elected member, Site 1]*

*We've not at any stage had a formal process of saying right well let's think what a long list of priorities might be and then narrow it down and then prioritise them. We've never actually done that. And I don't think we'd have come up with a very different set of ideas if we had done actually. [Public Health representative, Site 2]*

Some interviewees had little idea about how the decisions were made, or believed that priorities were just carried forward from previously identified priorities, sometimes updated when HWBs came into existence, sometimes developed by some unspecified discussion mechanisms.

*My perception, and this is only my perception -- is that the Council has a budget, a ring-fenced budget for public health spend doesn't it? But it also has a lot of things that it's previously funded that aren't funded by the public health but which can legitimately be considered to be public health activities. And with the shrinking of the Council's budgets they have to make decisions about what services they can carry on providing, and one of the things that they've done, I think, is try to get more efficiency and better outcomes out of the public health spend and try and free some of that up so they can use that money to protect things that might otherwise stop because of the budget cuts. And those decisions I think are largely political decisions, so they're made in Cabinet I guess by the Council and by the budget holders because there's a distributed model of public health in the Council, as I'm sure you know. So I think the decisions are made there. [CCG representative, Site 2]*

*I think we do at a level of talking about what needs to be done. I think, so actually having discussions around, you know, what should I say, the theory. Where I think it perhaps starts to fall apart is around actually how money is prioritised and deployed. Because ultimately, I mean, that's the decision made by the cabinet. [LA representative, Site 2]*

*I basically asked each of the portfolios, so the cabinet members and the officers to come forward with a list of projects, and then the Director of Public Health did some work on prioritisation and scoring - didn't always agree with that. [Cabinet member, Site 2]*

*We go through a sort of a pseudoscientific process that comes up with some outcomes, but we still then actually make decisions that are based on an either sort of clear financial stuff or clinical judgement. [CCG representative, Site 2]*

Many interviewees talked of the decision-making being done by cabinet.

*Well I guess what will happen is that when proposals come forward from officers they come to the cabinet members and the cabinet member, and then they come to our cabinet, the whole cabinet for discussion. If it's a decision on policy or a discussion on policy, that's how it comes through. And then it gets developed into specific proposals, decisions further down the line. ... Ultimately decisions are made by the cabinet yeah, depending on the size of the decision but yeah. Certainly about policy, that will come through. That would come to cabinet but it would also go to our labour group as well. [Elected member, Site 2]*

*What we've now got is a new grouping of officers that has been pulled together to work through this before it goes to the strategic outcome board ... It will then go to the strategic outcome board. It will then go from there to informal discussions with elected members in various groups and guises, and it'll go to the Labour group and the Labour executive group and so forth ... In parallel, it'll go to the executive management team which is the executive directors who will make a formal recommendation to Cabinet. But of course mindful of what's going on over here, because it's pointless making a formal recommendation to Cabinet if the political view is that that's not acceptable. So eventually something will go to Cabinet. [Public Health representative, Site 2]*

In Site 3, work was done with the public to look at different business cases for investment. It was felt that a very important outcome was getting the public to understand what prioritisation was about, and how a lot of aspects needed to be considered, such as expensive treatments with only limited success, or the difference between long and short term outcomes. The site developed its own prioritisation scoresheet, based on advice and examples from the workshop, using it to assess all the various programmes that were going on in the authority and whether they met the financial criteria set out by the Department of Health for public health grant expenditure, in terms of the reporting categories and the mandatory and non-mandatory elements.

Site 3 was reportedly unable to use a priority-setting approach for determining expenditure at one time because most of the budget had already been allocated [Public Health representative, Site 3]. Instead, a prioritisation approach was used for their joint strategic needs assessment, particularly around the children's services, to help to decide how to allocate scarce personnel resources, taking into account organisational and political priorities and resource capacity issues.

Other examples of the use of priority-setting approaches tended to be for specific areas of work, for example commissioning decisions around sexual health services.

Aside from the few examples described, interviewees tended to focus more on what changes there had been than on the methods of decision-making, for example talking of shifting more towards a community focus or driving productivity in existing contracts to get more for their money.

### 3.5 Future approaches to public health prioritising decisions

One interviewee thought that a prioritisation matrix would form part of future decision-making:

*Obviously we developed the prioritisation matrix, we haven't used that outside of those workshops that we've had, not yet. I think there is an intention to do that. So I think we want to now use the matrix in the next couple of months. [Public Health representative, Site 1]*

One interviewee felt that public health priorities were set by national government, with the public health outcomes framework. The interviewee recognised the importance of evidence:

*I think public health priorities are also set by the data, by the needs assessment data, and what emerges from that. So for example, at the moment we're picking up something quite interesting about young children and their mental health issues being linked with witnessing domestic violence. Now if we can show that in terms of our data, that's quite powerful, a powerful lever to ensure that there's resource tackling that. [Public Health representative, Site 3]*

The political processes were mentioned by interviewees, with one [Public Health representative, Site 2] saying that public health priorities in the future would be 'much more likely to be based on political imperatives than anything else' and the need for politicians to be able to show that they are 'making progress', which

*tends to mean that we wanted to get short-term wins rather than the long-term wins and do things that are politically acceptable and are obvious, you know, that they can demonstrate. So they like the idea of Coca-Cola organising physical activity sessions in parks, because then they can talk to the electorate and say look, look what we've brought ... without recognising the damage it's doing. [Public Health representative, Site 2]*

Another interviewee stated that

*the public health priorities in the future will emerge in just the same way that the priorities for anything else in a local authority emerge, and that's through discussions, through officers presenting papers and proposals. Sometimes those proposals being based on conversations with influential politicians, sometimes emerging from an officer's own individual opinion, and then working hard to develop a weight of evidence behind the proposal, but also a weight of support behind a proposal. [Public Health representative, Site 2]*

Several interviewees talked of the organisations that should or would be involved in future decision-making. Some of the points they raised are discussed in the later section on intra and inter-organisational issues (section 4.3). There was general agreement that a range of organisations was needed:

*Certainly think the Health and Wellbeing Board should be involved in that, and they should be aware of how that, the priorities have been set yeah. And as the CCG sits on the health and wellbeing board it should be part of that. [CCG representative, Site 1]*

## 4 Findings – research question 2: what are the enablers and barriers for decision-making related to prioritising investment in public health?

### 4.1 Politics

The effect of the political environment on the uptake of specific decision-making tools was mentioned in section 3.2. Politics was also mentioned by several interviewees with regard to general decision-making around public health expenditure.

The local authority setting is driven by local politics, with a high degree of power resting with the politicians.

*The politicians here are members of the public, that's the fact of the matter. That's local democracy, it's a beautiful thing. Whether we like it or not that is how it works. And if those people don't buy into the highest technical level advice, they may change it, because they may just go to their Labour group and say I don't like how this public health money is being spent. I want us to do this or that. And the fact of the matter is that if they want to do this or that, nine times out of ten that's what will happen. They go against officers' advice in planning circles, they go against officers' advice even in legal circles at times, and let's face it, public health is as much an art as a science. [Public Health representative, Site 2]*

*It is a democratic process, and the democratic process is quite important as a concept. Yes, so no matter what the priority setting tool might say, there's always that element of local democratic accountability. [Cabinet member, Site 3]*

Other interviewees agreed that even good evidence would not set the direction of travel:

*Do you know I guess there'll be lots of evidence about various things out there that would help support decision making ... A lot of the time decision taking, the decision making mechanism is between the officer and the cabinet member. And it's about priorities that the cabinet member might see that we need to deal with that would shape where we spend the money ... I'm sure there's lots of evidence that public health people will bring, but that's where the decision making goes. [Elected member, Site 2]*

*I suppose I keep coming back to the political thing that the Council has a budget for delivering services ... the public health budget is obviously quite a small component of that. It's ring-fenced and actually that sort of ring-fenced amount is increasing a little. But one of the barriers to sort of making pure sort of evidence-based decisions about how much you resist that tension isn't it that the Council have lots of other responsibilities to meet and has to balance them all. [CCG representative, Site 2]*

The complexity of the local government context can also make it difficult to understand exactly how and why certain decisions are made:

*I think inevitably in a local government context that kind of objective priority setting gets married with the political process, and it's the two things combined together that leads to the change. To try and delineate which one of those variables has the greatest causality on the decision making is probably beyond me. [LA representative, Site 2]*

## 4.2 Role of Directors of Public Health and of public health

Although it seemed to be generally regarded as a good thing, the move of public health from the NHS to the local authorities had created some difficulties, including the change in public health responsibilities and the need to ensure the public health role was properly understood.

One interviewee [LA representative, Site 2] spoke of a 'transfer of responsibility from public health experts to elected members and the diminution of the role of the director of public health as part of that' and commented that the DPH role had changed from being 'responsible for public health' to 'being responsible for giving advice'.

Some interviewees pointed out the problems caused when a director of public health 'did not have a seat at the top table alongside other directors' but reported to another director, thus reducing the importance of public health.

There were also perceived advantages to the transfer. Reference was made to a 'trade-off':

*previously we had a lot of influence over a relatively narrow set of uses of the budgets and approaches to public health, and now we have less influence but over a wider range of things.* [LA representative, Site 2]

More positively, one interviewee [CCG representative, Site 1] said that 'in the past there wasn't enough integration and people tended to work in their own silos with their own separate budgets.' Another advantage was described as the way the local authority usually has 'community insight, community assets and hard assets that can make more of that cash that the PCT ever could' [LA representative, Site 1].

Interviewees talked of the need for the public health role to be fully understood by the council. Only one felt that there were serious problems with this: 'people within the local authority could not understand or could not see the added value of having public health professionals within the local authority.' Pointing out that the councils had not asked for public health to be moved there, another interviewee [Public Health representative, Site 1] suggested it was not surprising that there would be some difficulties: 'suddenly they've got these public health responsibilities and didn't really know what all the implications were'. A clash of culture was mentioned, with one interviewee, who felt that changes were now happening to accommodate the difficulty, commenting on differences between responsibility of senior public health personnel and responsibilities of senior local authority personnel:

*Local government doesn't have this model of highly paid experts who are accorded a status of their professional expertise and high salary. ... I think that's been part of the clash of cultures that we've experienced with public health specialists going into local government, is that local government just doesn't quite get it in terms of seeing why they should be paying people an awful lot of money to do consultant public health jobs, when there are other directors who get paid less and have a wide range of responsibilities and managerial and personal resource to manage, financial and personal resource to manage* [Public Health representative, Site 2]

Another [LA representative, Site 1] felt that 'there's still a perception among some people that we're an external team that's kind of joining in as a sort of added extra to the Council rather than being an integral part of the Council structures and the way it does business'. In spite of this, generally interviewees felt that relationships between public health and other departments were now quite good or at least improving.

As well as ensuring that the council understood the public health role, interviewees commented on the need to ensure the council became (or increased its role as) a public health local authority, thinking of problems and services in terms of public health. Partnership working was seen as key to this, with public health working across all council departments and also with the CCGs, the NHS and third sector organisations. Different approaches were taken to working within the council, with one authority embedding its public health consultants across different departments, emphasising broader strategic frameworks and cross directorate working. However, lack of capacity was regarded as a big problem, one which was not likely to improve with the ongoing squeezing of budgets, so that different ways of working, particularly around joint commissioning, were becoming even more important to make the most of limited resources.

Interviewees often felt that councils could not accept the length of time some public health initiatives might take to show results and were more focused on shorter term results. One interviewee [LA representative, Site 2] said that in this respect the councillors have 'got to be educated around where this piece of the jigsaw – some of them already understand it – fits into the wider context of health and care'.

#### 4.3 Inter- and intra-organisational issues

There were mixed views as to whether there would be future tensions between public health and the rest of the council or other organisations, ranging from those who thought there would not be ...

*This council if anything will be wanting to push the public health team further and faster rather than wanting to wrestle the resource away from it or deflect them into other areas. We don't particularly want to be a direct service provider ... the whole council is moving increasingly onto a commissioning footing. Public health is clearly a part of that. [LA representative, Site 3]*

... to those who foresaw problems:

*One of the great joys of public health coming to the local authority is we can have a bigger focus on the preventative agenda, and that's what this has really been all about. So I think sometimes what the local authority wants and what the NHS wants might be something different, and I think there could be tensions there. ... any local authority has children and schools very much in its fore line. But of course the NHS has got this big preoccupation at the moment with the acute sector and older people, and very sick very old people being dragged into the acute sector, and how we bridge these two ambitions obviously will be interesting moving forward. [Cabinet member, Site 3]*

*The biggest danger that the public health team has is the council's impatience ... they want change and they want it yesterday. [LA representative, Site 3]*

Interviewees talked of the large range of organisations involved or affected by the decision-making. Directly involved locally might be the local authority (and sometimes also a county authority), one or more CCGs, several hospital trusts, local third sector organisations and also service users and the general public. On top of this there are various bodies imposing priorities, such as parliamentary scrutiny, national policy, a Department of Health (which, according to one interviewee [LA representative, Site 1], 'has very little influence in real terms day-to-day on what happens'), the Care Quality Commission, NICE and NHS England. Although some interviewees said that there were very good relationships between partner organisations, another said



*There is a consequent complexity in the thinking of everybody involved that reflects a variety of organisational agendas, a variety of organisational approaches and a kind of almost a rolling fashion for different models and different approaches. [LA representative, Site 1]*

The enormous complexity of the decision-making process was said by one interviewee [CCG representative, Site 1] to be not just because of the large range of organisations but also because of the large range of departments within a council that might be affected by the public health priorities. The same interviewee also pointed out that sometimes ‘people go round the side and make decisions outside of the formal processes and then you find decisions be made and you don’t know where they came from’.

Differences in culture and a lack of trust were mentioned by one interviewee [CCG representative, Site 3], who felt that it would be essential to build a common vision, saying this was fundamental in dealing with the significant levels of cuts to social care funding. A common vision is linked to issues arising with a possible lack of understanding of public health throughout the rest of the council, as discussed in section 4.2.

Particular disagreements over priorities might arise between commissioners and providers

*Sometimes I'm watching commissioners agree a set of priorities that they can't then make happen, and I'm seeing providers decide what their priorities are and then that's forcing the economics backwards. ... At the point at which I decide that I'm wasting money on health services in a foundation trust, actually, with the best will in the world, the moment I suggest I'm not going to pay them to do that anymore, there's a bit of a riot. ... The biggest tension's been a decision to decommission something and how unhappy one of my foundation trusts been with us decommissioning something. [LA representative, Site 1]*

With relation to difficulties with commissioners, one interviewee [Public Health representative, Site 2] felt that a good enabler to decision-making would be

*a very clear understanding of what commissioning you're paying for and clarity about the outcomes that you want to achieve and ideally a track record to show that if you commission this service you actually achieve those outcomes, which in some cases we have and in some cases we don't have, and a very clear understanding of how those outcomes improve population health.*

Recognising that tensions might arise ‘in terms of competing and different demands across the borough from different groups who are affected in different ways in terms of their public health’, one interviewee [Healthwatch representative, Site 1] said that this was a useful way of initiating discussion about what was really happening and what the priorities should be. In a similar vein, another [LA representative, Site 2] said that tensions were ‘how organisations make decisions’.

Differences in business practice, or in awareness of commercial behaviours, were identified by one interviewee [LA representative, Site 1] as contributing to some of the problems, who suggested that as providers, the trusts were not used to being told they were not going to get paid and as commissioners, the NHS commissioners were not treating that as a commercial relationship in the way that a local council would.

## 4.4 The role of the Health and Wellbeing Boards

### 4.4.1 Involvement and influence in developing public health priorities

Views of interviewees varied considerably, even within the same local authority, as to how much the Health and Wellbeing Boards were involved in developing public health priorities. Some interviewees felt the HWB had little or no involvement

*There's a lot of activity in terms of healthy living and public health going on in the borough, but I don't feel as if the Health and Wellbeing Board have had much influence over that, it has happened anyway. It happened despite the board, not because of it. [Healthwatch representative, Site 1]*

*The agenda of the Health and Wellbeing Board is so full of NHS and social care issues that I'm not sure it really has made much of a difference. [Public Health representative, Site 3]*

*I think it's a talking shop. I'm very disappointed with it. I don't think it's been allowed to have the influence which it could have. And I think that's because both the local authority, both the Council and the CCG, for slightly different reasons, have not wished to give up their autonomy over the spend and strategic direction and so on and so forth. [Public Health representative, Site 2]*

Some interviewees thought there was certainly some involvement:

*quite a bit, because the Health and Wellbeing Strategy goes through the board, and it is the board that determines the priority areas of that strategy. [LA representative, Site 3]*

Views also varied as to how much the HWB had actually influenced the setting of public health priorities. Some interviews stated categorically that it had not, whilst others said it had done. However, several felt that it did not have the power to influence, as that power remained within the council or specifically the cabinet.

Some interviewees suggested that progress was being made around the influence of the HWB, although two said it was very slow.

*I think the Health and Wellbeing Board initially struggled with its role, but I think it's got to grips. In the last six months I think it has actually bottomed out its role. [Elected member, Site 1]*

*I think the Health and Wellbeing Board is still trying to identify its role in relation not just to public health but to its other responsibilities ... I think I'd say that there's not a lot of evidence that it has been influential. [Healthwatch representative, Site 1]*

Many interviewees were unable to provide examples of public health-related decisions being made by the health and well-being board over the preceding year, or thought the HWB made few, if any decisions (commenting that final decisions were taken by the Cabinet).

*I cannot think of a single instance in which the Health and Wellbeing Board has set a strategic direction or determined an approach or determined how resources are going to be used relating to public health that wouldn't have happened anyway if the Health and*

*Wellbeing Board didn't exist. That's pretty damning isn't it? [Public Health representative, Site 2]*

However, a few examples were provided. These included: strengthening the CAMHS service; developing an emotional wellbeing strategy; addressing issues around the Better Care Fund; and agreeing the Joint Strategic Needs Assessment.

#### 4.4.2 Changes in HWB role, structure or membership

Interviewees were asked whether they felt that the HWB had been changing or evolving over the preceding year. Although one [LA representative, Site 2] said that it had not changed ('I think it's stuck to what it was doing'), and another [Public Health representative, Site 2] that it was 'still looking for a role' most seemed to think there had been changes. One [LA representative, Site 3] suggested that 'it's more developed and grown rather than changed – there's nothing dramatic about it, it's just continued its development and evolution, really'. Another [Cabinet member, Site 3] felt that although it was evolving, 'I don't think we've got it completely right yet, and I don't think any health and wellbeing board is completely correct, but I think we're getting there'. Seven interviewees said that partners were getting along better and one felt that the 'quality of the discussion seems to have improved'.

#### 4.5 Tensions over responsibilities for funding

There can be disagreement linked to the way services are funded (who bears the cost compared to who directly reaps a financial benefit). This can be between hospitals and commissioners or local authorities and the health sector. Good negotiation, joint commissioning, the Better Care Fund and devolution were mentioned as potential solutions, along with increasing contact and communication. (As one interviewee [Cabinet member, Site 3] put it: 'I think we've done the – in the old HR speak – we've done the storming, norming and forming part of the partnership'.) Sharing the same information and arriving at joint priorities was said to be an important enabler, so that parties would understand the reasoning behind the priorities.

Although a couple of interviewees reported few problems, most interviewees were very aware of recent or current tensions:

*I guess the key for me about how health economics becomes important is about the sort of prevention agenda, and how you manage to take money out of upstream treatment services into downstream prevention services. And that's always been difficult because hospitals have always been separate from PCTs, and PCTs have always been separate from local authorities. And therefore investing in something downstream or upstream, the people that see the benefit of that are the reduction in demand further downstream in the hospitals, in crude simple terms. And sometimes those risks and benefits aren't shared ... the idea of investing something in a prevention angle in a community setting may manifest itself in reduced demand for acute services, but that would not be reflected in acute services investing in that upstream intervention at a community setting, because the relationships aren't there. [Public Health representative, Site 2]*

*Everyone's budget is fairly tight. So no one's got any extra money and most people are looking to save money and reduce expenditure, so it doesn't make it very easy to share costs*

*where you're wanting to do work. So the funding model is a barrier.* [CCG representative, Site 1]

Other examples included the issue of discharging patients from hospital into adult social care (transferring costs from the NHS to Social Services) and disagreement over whether certain services (previously funded by PCTs) were clinical and should therefore be paid for by NHS England, not by the Local Authority's public health department. One interviewee [CCG representative, Site 1] felt there were difficulties between public health and the NHS because of the changes to the management of spending: previously public health spending and NHS spending were closely aligned (both managed to some extent by the PCT), but with the move of public health to the authority 'there's a bit of a sense in which they've taken over that and maybe haven't engaged with the NHS as much as the engagement would have been in the past'.

Although stating that integrated care would be an enabler to decision-making, one interviewee also commented that one barrier was the different budget lines, with their accountability structures and governance structures.

*I've got to report back to cabinet processes and county council, and of course how does that link up with the governance structures of the NHS?* [Public Health representative, Site 3]

Related to potential difficulties over budget responsibilities was the point that at a similar time, there were significant cuts in the local authority budgets, which would potentially distort where the public health money has gone.

#### 4.6 Data and evidence

The need for evidence was raised by several interviewees, some of whom also mentioned difficulties around timeliness or local relevance of evidence:

*And when we say that, for example if we keep people well, and that prevents people staying in hospital beds longer and so forth. I'm saying to the clinical commissioning group and the teaching hospital does that mean you'll shut a ward and invest upstream to ensure around the prevention? And they're saying until we get that evidence that suggests that this is happening, it's going to be really difficult. And I say to them that if we're just waiting for evidence, and what kind of evidence, then we miss the boat, we miss an opportunity, and I say to them taking a bit of a calculated risk, I'm not just saying we just go in blindly, that would be a foolish thing to do. But a calculated risk to look at areas of investment. ... And there's a lot happening if you get severe mental health problems and so forth. There's a lot of services out there, but there's nothing there at that lower level. And for them saying we're going to wait for evidence, you heard the stories from those young people that there's clear need out there now.* [Cabinet member, Site 2]

Even in a relatively controlled setting like the workshops, some participants recognised tensions between partners in relation to the different sources of evidence that might be used by different stakeholders involved in making decisions. Although one interviewee commented that 'but those are just political discussions really', it can have a significant effect on the process if some of the decision-makers do not trust or value the evidence of another group of decision-makers.

*There's different ways of collecting evidence and seeing evidence and evidence appearing. So members see a lot of what they would call evidence on the ground in their communities about what might be a public health issue. And they would see that as a priority.* [Elected member, Site 2]

*The evidence bases that are presented are not always that convincing, and even if they are convincing members will still remain the right to say actually we're just not buying into this. And, for example, it's not because they don't believe the evidence base, they just think that there are more important things in people's lives. [Public Health representative, Site 2]*

*We in the NHS look for evidence to support our decision making much more than the politicians do, because obviously they're politicians ... so for a CCG we wouldn't think about political considerations in the same way that the Council does. Although of course we should be thinking about public perceptions and acceptability of things kind of upwards, so it's a different sort of political consideration I suppose. [CCG representative, Site 2]*

One interviewee commented on the need for common sense with regard to data:

*In the data rich area of public health, sometimes you can get some very perverse data which doesn't necessarily lead you down the right path, and therefore how you cut through some of that stuff and apply common sense to the data rich environment is really important. [Cabinet member, Site 3]*

The need to communicate (public health) evidence well was raised by several interviewees:

*Well I think having a public health service that's able to take the strong evidence base and convince other people of its benefit and how it influences decisions is a clear enabler [to decision-making on priorities]. So as much data as you can get your hands on, as long as you know how to present it is a clear aid. [LA representative, Site 3]*

*I think the lack of data and lack of understandable data presented where it needs to be presented is a barrier. [Healthwatch representative, Site 1]*

*The enablers are the director of public health and their teams explaining and helping local authority be sharper about understanding the science, the clinical side of it. [LA representative, Site 1]*

*I think it's fair to say that one of the enablers about public health investment is inevitably the very strong evidence base that public health bring with them in terms of what that money should be spent on. But I think at the same time that evidence base is not always perfect, and in some instances the use of where evidence, this is an evidence-based service, at the risk of being simplistic just rub the decision makers up the wrong way in the local authority. So there's almost an intellectual high ground being claimed here by public health that can be counterproductive in terms of negotiation within a local authority. The sort of decision making process in a local authority seems to me much less clear. It's much about the softer processes of influencing and connecting and convincing, and it takes longer. So the idea of presenting a report that says here's the evidence, therefore we should do this, is not very often going to work in a local authority. There's a hell of a lot of lead up there that you have to do groundwork behind the scenes with influential individuals, be they members or officers. ... The evidence bases that are presented are not always that convincing, and even if they are convincing members will still remain the right to say actually we're just not buying into this. And, for example, it's not because they don't believe the evidence base, they just think that there are more important things in people's lives. [Public Health representative, Site 2]*

*So the enablers I think are a very clear preventative model. So to show, for example, if I can show both the local authority and the CCG that tackling alcohol problems with X investment*

*will actually save Y and Z over time, then that's quite powerful. So I think that's an enabler.* [Public Health representative, Site 3]

*one of the barriers is about the level of detail to go into ... to go into the detail of all of the different projects that you could end up funding, you know, at quite kind of grassroots level, some of them quite small scale, where you can't do that work in those sorts of decision making processes sometimes, where you're looking at quite top level.* [Healthwatch representative, Site 1]

#### 4.7 Outcomes – frameworks and measurement

One interviewee commented on the difference between the NHS and local authorities in terms of outcomes measurement:

*I think the local authority ... – the officers themselves – are pretty well versed in using the usual tools to kind of measure the success of things. I don't think the NHS were possibly as geared up to do that ... They tend to be more sort of volume based don't they? Let's get the throughput ... how many sore thumbs have we stitched up, how many heart operations have we done, that type of thing ... Whereas I think possibly the local authority is more geared up to more outcomes based approaches.* [Elected member, Site 1]

Several interviewees saw the Public Health Outcomes Framework as a useful influence in setting public health priorities, providing key measurable against which to deliver and allowing comparison with other local authorities. However, almost as many felt it was not yet very influential, with one suggesting it did not take account of local circumstances or was too generic.

*The general high level priorities are almost too high level to be useful. It can mean anything to anyone.* [CCG representative, Site 3].

*The public health outcomes framework is a very high level document. It's too high level to be applicable to a place without further prioritisation.* [LA representative, Site 2]

Another suggested that 'outside of the public health professionals it probably hasn't been terribly influential' and that

*decisions in the Council are clearly political decisions, and so I suspect there are factors other than the public health outcomes framework.* [CCG representative, Site 2]

#### 4.8 Budget arrangements

##### 4.8.1 Awareness of the detailed allocation of the public health budget

Although most interviewees were aware of the existence of the public health budget and some had been involved in discussions about how to deploy it, several were not familiar with its details and only a few had been involved in making decisions about its use. Comments were made by some to the effect that the decision-making would be done by the Cabinet anyway (as discussed in section 4.1).

#### 4.8.2 Use and legitimate use of public health money

Interviewees were asked about their definitions of a legitimate use of public health money. There was broad agreement, as exemplified by these quotes

*I think a legitimate use is where the activity is intended to deliver outcomes that are positive outcomes in terms of the public's health. That may not be the primary purpose of the activity but it demonstrably does do that. So, if you took something like exercise and using the children's centres as a vehicle for getting both mothers and young children to take specific exercise, that would be clearly aimed at a health outcome. [LA representative, Site 3]*

*I think it has to meet key public health objectives, it must be focused on the preventative agenda. [Cabinet member, Site 3]*

There was some concern about the public health budget being 'raided' (having funds drawn to be used elsewhere) but because the scope of public health was large, it was often difficult for interviewees to draw the line between legitimate and inappropriate use of the funds. One interviewee [LA representative, Site 1] pointed out that historically so much of preventive public health was done in the local authorities and that the local councillors had a great understanding of the health status and needs of their areas, walking round those areas every day, which – as a public health surveillance mechanism –

*is an incredibly powerful democratically elected asset. So when it comes to spending the cash, they've got quite a clear view on what works and what do we do.*

There were examples given of the difficulties about separating legitimate and inappropriate use of public health money, one interviewee [CCG representative, Site 1] felt that investment in housing improvement might be seen as either a legitimate use (given the strong links between poor housing and health) or an inappropriate use (because the council department dealing with housing improvement is a separate department). Another [Public Health representative, Site 3] found it difficult to say whether the secondary mental health social care services should increase its budget from public health money, recognising that although prevention is part of the public health agenda, the service was essentially a social services provision. Another commented that

*Truth be told I think there aren't many services within a local authority that don't have an impact on public health, either positively or in some cases negatively if they're not done properly. So it's fairly difficult to say that they're not entitled to public health money, but equally there aren't many of them that have got an evidence base to support significant investment. [Public Health representative, Site 2]*

The historical organisation of services was felt to make it difficult to identify legitimate use of public health money. Befriending had historically been seen as a social services problem, addressed by the social services budget, but the issues of loneliness and isolation are very much public health issues.

*So it's very easy then for local authorities to say well you know, if you take x% of our social care budget, and do all these things that social care used to do, that's now our public health team. You know, so you have to be quite clear, I think, in terms of what national government priorities are around health improvement, around our duties for emergency planning, our duties around communicable disease, all of these things, we need to take all of that into consideration, not just what local authorities can no longer afford. [Public Health representative, Site 3]*

Examples were offered to illustrate possible inappropriate use of public health money:

*Regardless of what of Sir Bruce Keogh might choose to say, I'm not about to spend it on potholes. [LA representative, Site 1]*

*When the Council was approached by Coca-Cola, Coca-Cola offering to sponsor some physical activity sessions in parks, the elected councillors decided that they would say 'yes we'll have their money'. Now my strong advice to them was that that was a very bad idea, but they took no notice of that and they decided they wanted to have the money in order to be able to put on some physical activity programmes within parks in the poorer parts of the city. [Public Health representative, Site 2]*

(The interviewee in the latter example felt this was inappropriate because the multinational organisation had probably had greater responsibility for the epidemic of obesity than most, if not all other, multinationals.)

#### *4.8.3 Pooled budgets*

Interviewees welcomed the pooling of budgets within the Council, although in some cases the processes were not yet fully established. Several advantages of pooling, both already experienced and anticipated, were mentioned.

*One of the things that will come into that I think is the decision making about privatisation and choosing what we invest in or more likely what we disinvest in and how we make decisions between things. ... I think that the pooling of our budgets for health and social care has helped set the public health budget more explicitly in the context of impact on demand for care, as opposed to the broader sort of 'we'd like our population to be a bit less fat and to exercise a bit more'. So there's that distinction between improving the general health and wellbeing and actually making a difference to demand for services, I think. And I think the pooled budget stuff has really focused our minds on prevention in terms of preventing demand which is what it's all about. [CCG representative, Site 2]*



## 5 Findings – specific research question 3: what difference does the use of specific decision-making support make to spending within and across programmes with reference to improving health and addressing health inequalities?

### 5.1 Reorientation towards prevention

Interviewees were asked to what extent they felt that spending across local authority areas other than public health had been reorientated towards prevention since public health had moved into local government. Although one felt this had not happened at all and one said there was still a long way to go, many responses were positive:

*I think we've achieved quite a bit in relation to children's services and early help in children's. So now quite a bit of that expenditure is coming under the public health budget. Similarly in mental health services, the mental health strategies around prevention are now clearly funded through public health funding. And obviously we've enthusiastically taken on the drug and alcohol budgets as well. [LA representative, Site 3]*

*Addressing prevention has been one of our key strategies, and everything we do is ensuring that the money that we have ... is used to deliver public health outcomes. [Cabinet member, Site 3]*

*From a public health point of view we've actively invested in prevention ... and aligned the commissioners to ensure that we have a much more integrated and joined-up offer for young people around emotional and mental health without the assumption that people end up in Children and Adolescent Mental Health Services as a default. 4b]*

One interviewee, [Public Health representative, Site 3], who felt that the majority of local authority work was inherently preventive anyway, said that because the local authority had to make huge cuts, it was less of a question of reorienting the budget towards prevention and more 'one of changing the way that the local authority does business'.

### 5.2 Changes in investment and disinvestment or in public health priorities

Some interviewees said that they were seeing changes in investment and disinvestment. For example, one local authority (site 3) was beginning to recommission all of its services and was moving its focus only to disadvantaged areas to help to deal with the squeezing of resources. Site 2 was moving more towards community development activity. Site 1 was also commissioning more services from the community and voluntary sectors.

Other interviewees talked of the difficulties in recommissioning because of the lack of available potential provider organisations. Although the private commercial market for sexual health services, for example, was said to be seeing sufficient profit potential, this was not the case for many services and one interviewee commented regretfully that

*We really found ourselves forced to continue to renew contracts to NHS trusts, and large NHS trusts, whereas we really wanted greater diversity ... There's probably huge economies and savings that could be made through greater competition. And we're really not seeing that competition out there yet. [LA representative, Site 3]*

Another interviewee talked about increasing investment in one area following at least partial disinvestment in other areas but felt it was a 'political decision', because

*... those were seen as being priority areas that needed investment, needed money, because the mainstream revenue funding for those programmes are being reduced. And rather than see those programmes cut back the elected members decided they wanted to take money out of the other public health funding activity and put it into that.* [Public Health representative, Site 2]

## 6 Supplementary findings: views on the economic prioritisation workshops

The project aimed to evaluate the impact of targeted interventions and questions on this topic were included as part of second phase interviews. However, there was a time lag between targeted workshops and the interviews (a year to 18 months later), allowing impressions to fade and possibly some confusion to arise in interviewees' minds between the introductory workshops (generally felt to be successful) and the targeted workshops. Also, only a small number of those attending workshops were among the interviewees and there was, therefore, a lack of continuity. Although the interviewees did raise some of the issues that project team members reported as having been raised during the workshops, interviewees appeared to regard these as issues that could be addressed, rather than as issues which negated the potential value of the workshop.

### 6.1 Overall interviewees' impressions of usefulness of workshops

Overall, interviewees who had participated in the targeted workshops had favourable impressions, finding them interesting and helpful, 'well-structured in terms of it being made easy to engage' [Healthwatch representative, Site 1], although one felt there was too much talk and not enough time for the exercises:

*I do remember thinking there was too much talk ... I did say that at the time. There was too much talk, which I think ... a little bit prevented people getting the value we could have done ... too many people being talked at for too long at a time.* [Cabinet member, Site 3]

Some interviewees said they had learned a lot, or at least had their knowledge refreshed. One [Elected member, Site 1] commented that the initial overview of the reasons for looking at shifting the gravity of spending for public health made him understand 'why it was so important, because it was transitioning from NHS into local authority, and why it was important that we understand how it could be measured, how we were getting more bang for our bucks basically, value for money.'

It was also thought that the training helped to show partners that there were tools available to help with prioritisation.

The scoring exercise was generally well-received, described as 'a useful exercise'. There were, however, recognised difficulties relating to the different types of evidence, as discussed in section 4.6.

The way that the exercise had people working together appeared to be valued, showing how important it was to have discussions among partners:

*I think looking at the framework that we looked at on that particular day led to some really interesting conversations about, well, what do we mean by this, and why is it important to know that, ... and should or shouldn't we have public engagement as a criteria at this part of the process or in this later part of the process.* [Healthwatch representative, Site 1]

*... going through that exercise together helped us share a common understanding of what the problems were.* [CCG representative, Site 1]

*There were times when it brought up conversations about trying to understand things better or justify different scores we were giving.* [Healthwatch representative, Site 1]

*I think it probably highlighted to all of us the complexity of partnership working. [Public Health representative, Site 3]*

The use of local data was praised by one interviewee [CCG representative, Site 1]: ‘so it wasn’t a sort of abstract or theoretical discussion, it was very much related to local issues. So I’m sure it had practical value for us, as well as being of academic value to the researchers. However, another interviewee mentioned a gap between the academic world and the real world:

*I think it was a laudable attempt to get a whole system partnership approach to this. However, I think it became clear really that I think the difference between the academic and the real world, well, not a sort of good way to put it, the practical day-to-day world don’t match, and I think it was very difficult to see the immediate benefit of the research question on our particular needs. So, for example, we had a whole system partnership group at the workshops, at all of the workshops I believe, yet not all of them were really interested in the research question. [Public Health representative, Site 3]*

One participant [LA representative, Site 2] felt that the workshop focused a lot, in some respects too much, on the public health grant expenditure, and not on the overall expenditure of the council.

In terms of what participants thought could be improved, aside from the one who felt there had been too much talking, one [Healthwatch representative, Site 1] suggested that continuity of participants would be useful across the series of workshops, so that the same people were involved throughout the whole process. However, that interviewee also felt that in some ways the inclusion of different people had not hindered the process but had been good in allowing decisions to be challenged. Several interviewees commented that it was difficult for people joining the workshops later to understand the rationale behind the decision-making.

## 6.2 Whether the techniques were later used in prioritisation

One measure of success of the workshops would be the ensuing use of the techniques in practice. There was a degree of uncertainty among interviewees as to whether the techniques had been used. Two or three appeared to say that they did not think they had used it or had perhaps used some of it in a different way. One [Public Health representative, Site 3] stated that ‘my view is that we didn’t particularly use it’, although this interviewee later said that it was used to ‘sort of prioritise’ how they were taking forward the Health and Wellbeing Strategy and to look at specific elements of using the money going forward, using ‘a bit of a matrix, although not quite as well articulated probably as we have used in the past to actually guide us on some principles of how we might apply this investment’. Another [LA representative, Site 2] initially said that ‘speaking frankly I don’t think that the prioritisation, the scoring and impact and so on that was done has greatly informed the changes’, then said ‘actually that’s probably slightly unfair’ and made reference to some scoring of priorities (by the Director of Public Health) that led to changes in investment.

Another interviewee [Elected member, Site 1] said that they now had a matrix, which they were going to test out on the next procurement exercise. Another [LA representative, Site 1] felt that the related discussions around prioritisation had been influential: ‘it’s quite clear to me that my colleagues in public health have been paying attention to the discussions they’ve been having, the debates around prioritisation’. This interviewee did not suggest that the techniques themselves had been used.

## 7 Discussion

As noted earlier, there are limitations to the generalisability of our findings; only three sites were involved and they were considered at a stage of significant ongoing transition. However, the 22 interviewees included individuals from a variety of backgrounds across each site, with a wide range of experience. Many had been through the transition period and were in a position to comment on the changes and to compare current processes with previous approaches to decision-making. There is commonality of views on several of the topics, irrespective of the particular circumstances of the specific sites.

### 7.1 Use of decision-making/priority-setting tools

The majority of interviewees felt that priority-setting tools could be relevant. The tool (score card) used in the workshop was praised for the way it focused on health inequalities. Interviewees talked of the usefulness of any proven framework to facilitate discussion of the available information and to provide a more robust approach, particularly when decisions were likely to be scrutinised or challenged. However, there was little evidence of systematic use of prioritisation approaches. Many interviewees were unaware of any priority-setting tools having been used at all in their authority. However, it must be borne in mind that interviewees who had moved from a public health NHS setting might have had limited time to have seen all methods that their authority used. Perhaps more significantly, some interviewees had little idea of their authority's current decision-making processes and interviewees were more likely to say that decisions were made by some unspecified discussion mechanisms ('We went into a room with the Health & Wellbeing Board and we agreed our priorities' [LA representative, Site 1]) or just by the cabinet:

*Well I would be very pleased if we could use some of these formal tools, but the reality is that in practice it's just not possible to, because at the end of day it's elected members who make decisions about where money is spent [Public Health representative, Site 2]*

Both national and local politics were felt to have influence over the likely uptake of prioritisation tools. One interviewee [Public Health representative, Site 3] felt that national government set public health priorities but several interviewees suggested that priorities would be based on local political imperatives and would therefore tend to be 'short-term wins' [Public Health representative, Site 2].

Factors that interviewees appreciated in tools included:

- simplicity of use
- ability to compare performance with performance in other areas (specifically for programme budgeting tools or SPOT (Spend and Outcome Tool))
- practical applicability, with findings acceptable to professionals and the community, particularly when local context and data could be considered.

The most valuable aspect appeared to be that tools could help to open debate, including discussions about facts/data and assumptions.

Perceived barriers to the use of tools included:

- scale or amount of time needed for an analysis ('tools were... prolonging a process rather than helping it' [CCG representative, Site 2])
- one size fits all –
  - failure to take into account the pressures and context of public health working

- based on success at a national level, failing to take into account the local context and local needs
- subjectivity of those using the tool ('No matter how hard we try and make them objective, at the end of the day somebody's going to have to put either a three, a four or a five in a box, metaphorically speaking.' [Public Health representative, Site 2])
- overriding decision-making of council members ('I remember hearing a comment very early on in the transition process from a politician that said "well, the public health team can score it how they want, but at the end of the day ... if we don't like the scores that are there, we'll change them".' [Public Health representative, Site 2])
- possibility of the approach becoming just a 'tick-box' exercise

In the light of these findings, it would seem that complex, highly developed tools would probably not be appreciated, as simplicity is highly rated. However, there might also be problems with simple tools, if their simplicity leads to them using very general assumptions or national data that do not allow the local context to be considered. Given both the desire to open discussion and the recognised subjectivity in using most tools, it would appear that the key success factor in any tool would be its ability to facilitate discussion using locally appropriate data and context.

## 7.2 Enablers and barriers to decision-making related to prioritising investment in public health

### 7.2.1 *Politics*

Once again, the effect of the political environment was highlighted by many interviewees. Local politicians might not accept technical advice or might have other priorities and 'if they want to do this or that, nine times out of ten that's what will happen. They go against officers' advice' [Public Health representative, Site 2].

The overall Council agenda was also said to lead to difficulties, with the council having many responsibilities and having to deliver such a huge number of services from their budget, of which the public health budget formed only a tiny element.

Any decision-making approach will need to take into account the local political context and agenda, acknowledging that the elected members will take the final decision. A key role for public health might be in the discussions leading to decisions, perhaps in raising awareness and putting forward evidence of the main benefits of the preventive agenda.

### 7.2.2 *Role of public health and relationships with councils and other organisations*

There were recognised problems around helping council members and staff to understand the role of public health. As well as feeling that councils did not necessarily understand their new responsibilities, there was felt to be some resentment towards the public health staff coming in with high salaries, being paid for professional expertise rather than for the managerial responsibilities generally associated with higher pay in councils.

However, the general feeling seemed to be that relationships between public health and the rest of the council were fairly good, as mutual understanding increased. Certain changes in the way councils are working were felt likely further to improve relationships, particularly the move from service provision to commissioning, where public health already has considerable experience.

The longer term nature of public health decisions was, nevertheless, still at odds with the shorter-term decision-making associated with the councils. The pressures to deal with the acute rather than the preventive agenda were also noted.

The complexity of involvement of a wide range of partner agencies was felt to cause problems, with agencies having different agendas and processes and being under pressure from elsewhere (such as having to meet CQC or NICE requirements or national policy). Cultural or historical differences among organisations can also lead to a lack of trust, to overcome which one interviewee, [CCG representative, Site 3] suggested it would be essential to build a common vision. Similarly, it was suggested [Public Health representative, Site 2] that difficulties with commissioners could be overcome by ensuring a good understanding of what was being paid for and clarity over outcomes.

There was little agreement among interviewees, even within the same local authority, as to the role and influence of the HWB. HWB influence was described as anything from none, through very little, to some (no-one suggested it had been significant). Most could not identify examples of public health-related decisions being made by HWB over the preceding year (with many reiterating the point that final decisions were taken by Cabinet anyway). However, interviewees recognised that the HWB were still developing and had perhaps had not fully settled in.

As suggested in section 7.2.1 above, part of the main public health role is likely to be in spreading the message about the value of the prevention agenda, using local evidence of a suitable depth to show particularly how a longer-term approach to priorities can lead to benefits beyond those available in the short-term. Integrated working is essential, creating ownership of decisions and vision and allowing organisations to help others to understand their issues.

### *7.2.3 Tensions over funding and budget arrangements*

Most interviewees were very aware of recent or current tensions among organisations. These included disagreements over who would fund a service, particularly when a different organisation would reap a direct financial benefit. When all organisations were working with tight budgets and looking to reduce expenditure, it could be even more difficult to share costs. Different budget lines, accountability and governance structures also complicated the way integrated care and joint budgets could operate. Sharing the same information and arriving at joint priorities was said to be an important enabler, so that parties would understand the reasoning behind the priorities.

Because the scope of public health was large, it was often difficult for interviewees to draw the line between legitimate and inappropriate use of the funds. Nevertheless, there was broad agreement among interviewees about what constituted the legitimate use of public health money (from the ring-fenced public health budget). For example, 'it must be focused on the preventative agenda' [Cabinet member, Site 3] or 'where the activity is intended to deliver outcomes that are positive outcomes in terms of the public's health. That may not be the primary purpose of the activity but it demonstrably does do that' [LA representative, Site 3]. Although most council activity was recognised as being beneficial, the links were sometimes felt to be more tenuous, so that one interviewee [LA representative, Site 1] said it would not be legitimate to spend public health money on pothole repair. Comments were made by some to the effect that the decision-making on expenditure would be done by Cabinet anyway.

The pooling of budgets within the council was welcomed and it was believed that this had enabled a focus on preventive measures, particularly in terms of activities that prevented demand for services.

Tensions over funding can be reduced when all organisations understand the reasoning behind the priorities. Again, this is something achieved in part by joint working and discussion. If the pooling of

budgets has indeed helped to change the focus to more preventive measures then it is an approach worth extending.

#### *7.2.4 Data, evidence and outcome measurement*

The timeliness of public health data or evidence was felt to be a key problem, for example out-of-date service information when there was a known current need for those services. The frequent lack of local data (at a suitable locality level) was also mentioned as an issue. Tensions around the source of data could arise, exacerbated by a lack of trust or understanding among organisations (mentioned above). Local councillors would be aware of particular issues in their own communities that might be far more significant to those communities than issues for which evidence was presented. Sometimes there was said to be a lack of 'understandable data'.

In spite of these problems, interviewees did talk of the need for evidence to inform priority-setting. Public health professionals were felt to have a role in ensuring that data (from what is a strong public health evidence base) were presented in an understandable way, at the right level of detail and in a way that showed how preventive action could be beneficial on many fronts.

Outcomes frameworks, particularly the Public Health Outcomes Framework, were seen by some as a useful influence and by some as something far too high level and ignoring the local context. Again it was stressed how decisions in the council are political decisions made by Cabinet.

With much public health data, it is not possible to obtain particularly up-to-date comparative figures. Again, public health will need to show the value of the longer term view so that even out-of-date figures are seen to have some value. Data from any time period need to be converted into useful and useable information or intelligence that is acceptable to both professionals and local communities.

### **7.3 Changes in spending to improve health**

Although it was recognised that much local authority activity is inherently preventive anyway, most interviewees felt that spending across other local authority areas had become more focused on prevention, particularly in the way that commissioning was now much more integrated and services more joined up.

Disinvestment and reinvestment were happening, with Site 3 beginning to recommission all of its service and changing its focus to disadvantaged areas, Site 2 focusing more on community development and Site 1 commissioning more services from the community and voluntary sectors. There was one comment [Public Health representative, Site 2] that partial disinvestment in one area was a 'political decision' to allow continued funding of another area.

Yet again, the local political arena is said to have a significant effect. If the focus of priorities is really moving more towards the prevention side, this is a move that can be supported and enhanced by the public health agenda. Communication of the benefits is once more key.

### **7.4 Views on the economic prioritisation workshops**

Overall, the introductory workshops were favourably received, interesting and helpful and well-structured. Some interviewees felt their knowledge had been refreshed or they had learned a lot, others said they now understood the importance of prioritising. Sites 1 and 3 found the scoring exercise useful, although there were concerns over the evidence/data, as discussed in 7.2.4. Site 2 had focused on a wide cross-directorate approach to public health spending, which might have reduced the feasibility of scorecard approaches adopted for the public health budget. The greatest



perceived benefit of the whole exercise was felt to be the way it engendered discussion among partners and the ensuing enhanced shared understanding of the issues and potential solutions.

There were a few suggestions as to how to improve the targeted workshops. They included: reducing the amount of talking (which, according to one interviewee, had left not enough time for the exercises); trying to ensure continuity of participants as it could be difficult for those coming later to understand what had already happened; and better information on the strategies and priorities already agreed across the council.

It was difficult to draw conclusions about whether the workshop techniques had later been used in practice. Interviewees seemed uncertain, with some saying they did not think they had used it or perhaps had used it in a different way. One felt that it definitely had not helped, another thought some useful scoring of priorities had been carried out and another said they had developed a matrix approach that was going to be tested. Rather than the scoring itself, it was suggested that the value of the exercise had been in the related discussions.

The importance of discussion is once more a key theme, with the main advantage of the workshops being the engendering of discussion and debate and the creation of a shared understanding. As we mentioned in talking of the use of specific tools, it would appear that approaches that allow discussion are viewed favourably and lead to the most successful outcomes.

## 7.5 Overall

Two very important themes have arisen throughout this exercise: the role of the council cabinet as final decision-maker and the importance of inter- and intra-organisational discussion. Whatever prioritisation approaches are used, the council cabinet will make the final decision on priorities and on spending. Discussion (and any approach that encourages discussion) helps to ensure shared ownership of and commitment to priorities. Public health will ideally bring helpful local intelligence to the discussions to facilitate understanding of the issues across all stakeholders.

## Appendix 1: Interview schedule (second phase interviews)

### **Before starting the interview:**

- Provide an overview about the study, its aims, (if required) and the purpose of the second-phase interview
- Explain why we are undertaking follow-up interviews
- Be ready to explain the priority-setting methods that have been presented at the workshops
- Ask the participant if he/she has got any questions and/or would like additional information
- Reassure the participant that we will treat the information confidentially
- Ask permission to record the interview

### **General background to the interviewee**

- A. What is your current role? Have there been any changes in role since the previous interview in July/August 2013?
- B. Have you attended any of our workshops? (If needed, provide more information about them, see above). How much do you know about our study and the support we provided/are providing?

### **Priority-setting methods (I will remind participants of the workshop undertaken, the tools presented, what actually happened)**

- A. Are you aware of any examples where a priority-setting approach has been used to support decision-making processes related to a) ring-fenced PH budget and b) PH-related spending over the past 12 months?
- B. Since July/August 2013, are you aware of any changes in PH spending following the decision-support input provided by our health economists, or by other decision-support initiatives? If so, can you give us an example? If not, why do you think that is the case?
- C. **For those who have attended the workshop(s):** Reflecting on the support provided by the health economists at the workshops: what did you find particularly useful? What would you have done differently?
- D. Have you got any advice for us to improve the support delivered in order to do better if we were to collaborate with other LAs in the future?
- E. In your view, to what extent are specific priority-setting methods relevant in practice?

## **HWB**

- A. In your view, how influential has the HWB been in the past 12 months? And specifically in relation to PH?
- B. How far has the HWB been involved in developing PH priorities? How influential is it in PH-related decision-making across the local authority?
- C. Have you observed any changes in the HWB membership? Voting rights? If so, how and why?
- D. Can you give a practical example of a PH-related decision made by the HWB, if any? What actually happened in practice?
- E. Do you feel the role of the HWB has changed/evolved over the past year? Can you describe that by giving us a practical example illustrating that change?

## **PH BUDGET**

- A. Are you aware of the detailed allocation of the PH budget? Are you aware/have you been included in discussions about how it has been deployed and how it has been used in other LA directorates?
- B. To what extent do you feel that the spending across other LA areas has been re-oriented towards prevention? Any examples?
- C. How would you define a legitimate use of public health money?
- D. Have you observed any significant changes in making decisions about investment/disinvestment/priorities in public health over the past year? Can you give us a practical example?
- E. Do you feel that past tensions, if any, between LA and the NHS in relation to 'who pays for what' have been resolved? Can you give us a practical example?
- F. In your view, what are the enablers and barriers for decision-making related to prioritising investment in public health?

## **PH PRIORITIES**

- A. To what extent has the PH Outcomes Framework been influential in setting PH priorities?
- B. In your view, how are PH priorities likely to be decided in the future? Do you feel that any tension may emerge, and if so, how could these be addressed?
- C. How could your local authority best develop your public health role in the future?


## **PH TEAM**

- A. What are the relationships like between the PH team and officers/elected members/ NHS professionals? Have you observed any changes over the past 12 months? If so, in what way?
- B. Have there been any changes in the organisational arrangements of the PH team? If so, can you describe them?

- C. Do you feel that the role of PH professionals is now established and clear to the stakeholders involved?

**ANY OTHER COMMENTS?**

- A. Would you like to add any further comments?  
B. Are there any documents that you think may be useful/relevant for our study?



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