‘Shifting the gravity of spending?’
Priority-setting for local authority public health commissioners

Thursday 4th July 2013 – 9:30am-1:00pm
D009 – Ebsworth Building, Durham University Queen’s Campus, Stockton-on-Tees

Why hold this meeting now? This Quarterly Research Meeting (QRM) comes at a pivotal point in a two year research project funded by the National Institute for Health Research School for Public Health Research (NIHR SPHR). The project explores methods for supporting public health commissioners in priority setting to improve population health and address health inequalities. Working closely with three local government case study sites across England, the project is assessing the feasibility and usefulness of priority-setting methods in relation to the ring-fenced public health budget as well as for public health investment across local authority departments.

Why is the topic important? The return of public health to local government has been largely welcomed. However, public health commissioners face challenges for investment – as well as for disinvestment - in a time of economic stringency and they will need to demonstrate transparency in decision-making in relation to local priorities for public health investment.

The July meeting has the following objectives:

- To bring participants up to date on this research project
- To present initial findings
- To learn from delegate responses and experience in relation to priority-setting and to the initial findings of the project
- To encourage participants to engage with the project after the QRM

Who should attend? This meeting is primarily aimed at Health and Wellbeing Board members, local government elected members, Chief Executives and senior officers, those working in Public Health England, those working in the NHS with an interest in public health, and members of voluntary and community sector groups. Some spaces will be reserved for applicants from these groups. Applications from other sectors and academia will also be welcomed.

More about the project… The project is funded by the National Institute for Health Research (NIHR)’s School for Public Health Research. The research team is drawn from Fuse (Durham, Newcastle and Northumbria universities); the School of Health and Related Research, Sheffield University; London School of Hygiene and Tropical Medicine; and the Centre for Health Services Studies, University of Kent. The project is led by Professor David Hunter (Centre for Public Policy and Health, School of Medicine, Pharmacy and Health, Durham University). Further details are available on the project website http://www.phine.org.uk/shifting-the-gravity-of-spending%3F

Programme details and speakers follow below

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Programme

09:30-10:00 – Arrival and registration

10:00-10:10 – Chair’s Introduction - Professor David Hunter (Centre for Public Policy and Health, School for Medicine, Pharmacy and Health, Durham University)
10:20-10:35 – *Priority setting in the new NHS and Public Health landscape* – Professor Brian Ferguson, Director for Knowledge and Intelligence (Northern and Yorkshire) Public Health England
10:35-11:00 – ‘*Shifting the gravity of spending – priority setting for local authorities’*
Dr Christianne Ormston, Post Doctoral Research Associate, Centre for Public Policy and Health, Durham University

11:00-11.20 – Refreshment Break – Room D10

11:20-11:30 – *Commissioners’ Knowledge Challenges* – Dr Mark Lambert, Consultant in Public Health Medicine, Sunderland City Council
11:30-11:40 – *Title TBC* - Mr Liam Hughes, Freelance Consultant (former National Advisor for the Healthy Communities Programme with senior executive experience in local government and the NHS)

11:45-12:30 – Table Discussions – introduced by Chair
12:30 - Feedback from table discussions – Key messages from facilitators
13:00 – Close and lunch courtesy of the Wolfson Research Institute for Health and Wellbeing in D10

fuse The Centre for Translational Research in Public Health

Durham University
Wolfson Research Institute for Health and Wellbeing

Finding Durham University Queen's Campus, Stockton on Tees

Directions from Thornaby Railway Station:

By taxi:

There is a taxi rank at the station. Useful taxi numbers: +44 (0) 1642 650200 **(**Regal Taxis), +44 (0) 1642 655555 (Royal Cars) or +44 (0) 1642 676676 (Stockton Cars). Journey time = 5 minutes.

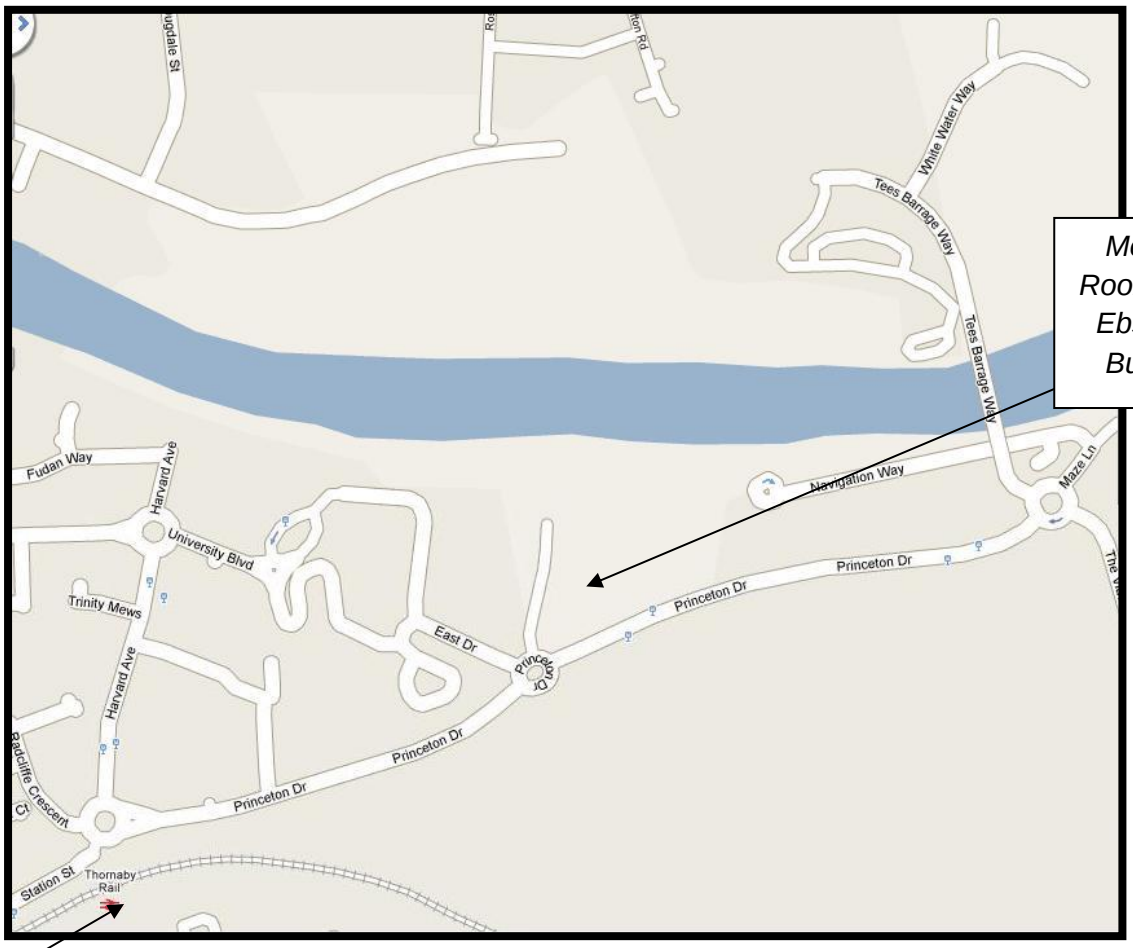
On foot:

From the station, go up onto the footbridge and turn right down the stairs, and then right onto Station Street. Follow this road to the roundabout and turn down this road towards the Infinity Bridge. At the next roundabout turn right and you will enter Queen's Campus. The meeting is on the ground floor of the Ebsworth Building. Walking time = 15 minutes approx.

By car:

On arrival at Queen's Campus (TS17 6BH) visitor parking is available in the central area of the campus, adjacent to the Ebsworth Building. Please note that some is reserved for staff. On arrival in the Ebsworth Building, you **must** notify your car registration to the main reception.

Map of the area



Meeting Room D009 Ebsworth Building

Railway Station

Shifting the Gravity of Spending?

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

Christianne Ormston

Post Doctoral Research Associate, Centre for Public Policy and Health, Durham University

This is an outline of independent research funded by the National Institute for Health Research's School for Public Health Research (NIHR SPHR).

Background to the Study

- Return of public health commissioning to local authorities
- Priority setting will take place within new organisational and cultural settings
- With ring fenced public health budgets, come difficult decisions about investment and disinvestment
- Increased urgency to demonstrate return on investment in relation to public health interventions

The Study

Key objectives:

- To identify decision making support methods appropriate for determining priorities in public health commissioning
- To identify which priority setting methods local authority commissioners find useful
- Assess enablers and barriers to decision making

The Study

- *Funding:* NIHR School for Public Health Research
- *Duration:* 2 years, November 2012 – October 2014; extension possible
- Methods :
- *3 case studies (3 English local authorities), applied research focus*
- *3 days of prioritisation support per case study site*
- *Support from External Advisory Group*

The Team

- David Hunter (PI), Linda Marks, Christianne Ormston, Durham University
- Luke Vale, Sara McCafferty, Newcastle University
- Jo Gray, Northumbria University
- Sarah Salway, Nick Payne, Praveen Thokala, Sheffield University
- Stephen Peckham, University of Kent
- Karen Lock, LSHTM

External Advisory Group Members

- Brian Ferguson, Public Health England
- Mike Kelly, National Institute for Health and Care Excellence (NICE)
- Ian Parker, NHS North
- Peter Marks, DPH, Leicester City Council
- Joanne Smithson, VONNE
- Kevin Bossley, Catalyze Ltd

Research Questions

- Which prioritisation tools do LA commissioners find useful for prioritising public health investment and why?
- What are the enablers and barriers for decision-making related to prioritising investment in public health?
- 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?

Lines of Inquiry

- How can social determinants of health and health equity be reflected in the priority-setting process at different levels?
- Are there particular tools and techniques that are more or less appropriate for use in investment and disinvestment decisions in health?
- What do we know already about the value of such tools in practice and the factors which facilitate or hinder their uptake in a health setting?
- Will fire fighting predominate with longer-term investment in health being marginalised?

Our Offer To Local Authorities

- Initial workshops
- Targeted decision-making support: a minimum of 3 visits per site
- Initial and follow-up interviews per site
- Emphasis on impact and knowledge to action

Knowledge to Action

- Use of the project website to engage with the research team and the other case study sites; keep up with project outputs
- Use prioritisation support to help embed tools for future approaches to decision-making
- Commitment to disseminate emerging findings during course of study.

Progress so far

- Initial ground clearing meetings held with Directors of Public Health in each site
- Scoping Review of Prioritisation Methods
- 3 Initial Case Study workshops – some delays due to local elections
- Commenced a small number of interviews in 2 case study sites
- Local Authorities now considering utilisation of prioritisation support

Emerging Findings

- Emerging findings from workshops and a small number of initial interviews
- Data collection ongoing – work in progress
- Detailed analysis yet to be undertaken
- Emerging findings can only be tentative and impressionistic

Emerging Findings

Prioritisation tools – mixed experience

- First case study site: limited understanding of tools;option appraisal, return on investment, PBMA; Interest in Portsmouth Scorecard
- Second case study site: more experience and understanding of tools; option appraisal, scorecard approaches, STAR, MCDA; Interest in Scorecard
- Third case study site: very knowledgeable; PBMA

Emerging Findings

- Differences in understanding among participants
- Continuation of historical budgets
- Issues around evidence – evidence requirements of tools and opportunity cost; credibility of evidence; organisational differences; risk around a lack of evidence that certain interventions work.
- Tools present opportunities for increased transparency in decision-making

Emerging Findings

- Sustainability of prioritisation support – do sites pick a tool which is quicker and easier to use and more easily embedded into the workings of the organisation, or do they take advantage of the opportunity to try something completely new?
- Indications show that 2 case study sites seem to prefer ‘fast and frugal’ tools – “don’t need a hammer to crack a nut”

Emerging Findings

- Embedding public health into current structures – issue for one particular case study site; broader issues around differing cultures
- Issues emerging around broader investment, impact and benefits – raising questions about i)where the local authority sites should focus investment and ii)how longer term investments should be considered?
- Austerity – presenting both threats and opportunities

Next steps

- Completion of the baseline interviews
- Delivery of the 3 days of prioritisation support
- Further data collection - Documentary analysis, National survey, follow up interviews
- Comparative evaluation undertaken
- Testing and dissemination of findings across practitioner and academic networks using project website and other means

The National Institute for Health Research's School for Public Health Research (NIHR SPHR) is a partnership between:

- The University of Sheffield
- The University of Bristol
- The University of Cambridge
- University College London
- The London School for Hygiene and Tropical Medicine
- The Peninsula College of Medicine and Dentistry
- The LiLaC collaboration between the Universities of Liverpool and Lancaster
- Fuse; The Centre for Translational Research in Public Health, a collaboration between Durham, Newcastle, Northumbria, Sunderland and Teesside Universities

How to Contact us

For more information visit

www.phine.org.uk/shifting-the-gravity-of-spending%3F-

Or contact Christianne Ormston

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"Shifting the Gravity of Spending?"
Priority-setting for local authority public health commissioners
Thursday 4th July 2013
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This is a summary report of the Fuse Summer 2013 Quarterly Research Meeting.

The morning was introduced by Professor David Hunter, Centre for Public Policy and Health, Durham University, and Principal Investigator for the "Shifting the Gravity of Spending" research study. He explained that the object of the morning was to introduce the study , share emergent findings, and enable participants to contribute to the future development of the project, as well as bringing their own expertise and experience, and especially within local government, into the time reserved for discussion on tables . He indicated that Professor Ferguson would provide context and assist in scene setting, to be followed by Dr Ormston, who would describe the project in detail and share the early findings, and then two discussants offering their own respective perspectives from practice prior to the time for table discussions. The "Shifting the Gravity of Spending" project is a two year research project funded by the National Institute for Health Research, School for Public Health Research (NIHR SPHR) (www.sphr.nihr.ac.uk). Fuse is one partner within SPHR which includes eight academic centres in all.

Priority setting in the new NHS and public health landscape – Professor Brian Ferguson, Director for Knowledge and Intelligence (Northern & Yorkshire) Public Health England (PHE)

Professor Ferguson explained that he was not speaking for PHE as such but from his background as an academic. His talk was structured around five themes; commissioning questions, culture, intelligence tools, the role of NICE (National Institute for Clinical Excellence) and requirements for better decisions. The questions he set out relating to the commissioning process, were around the central issues of what services should be commissioned and how they should be provided, the interface with other sectors, and key requirements for efficient commissioning. He drew attention to the Commonwealth Fund's Commission's work on the principles of a high-performance health system.

Overwhelmingly there is a need to work on culture, which Professor Ferguson related to his time working in clinical governance, and yet, despite the importance of clinical governance it was still possible in the health service for there to be major failures in the quality of care delivery as exemplified in Mid-Staffordshire NHS Trust. Professor Ferguson referred to an earlier research project he had worked on with Marks & Spencer, who in the late 1980s/early 1990s were held up as a good example of quality. How did they do this? One way they achieved their standards was through very regular conversations with their suppliers, as frequently as weekly. They did not have contracts but they had very detailed technical and quality specifications, amounting to a box file for a single product like, for

example, salmon fishcakes. They built up long term relationships with their suppliers and for Marks & Spencer their definition of the long term was 10-15 years. He contrasted this approach with the NHS, with a much less developed relationship with their suppliers, which would be a challenge for the Clinical Commissioning Groups.

Profesor Ferguson reminded the audience of the main points from the Kennedy Report (2001), which the audience were encouraged to think were still relevant today. A Don Berwick quote from 2001 was used to demonstrate the limitations of measurement alone as a way of informing improvement. Thus the Francis Report of 2010 encapsulated a system that went really wrong where the wrong things were being measured, but being measured well. The lessons of the past have not been learned, especially about weak clinical governance and audit in Mid-Staffordshire.

There are many intelligence tools, but Professor Ferguson illustrated that data flows are now very complex. He described current sources of health intelligence. Professor Ferguson showed variations in 23 programme budgets for England, for different health and/or disease categories across years and between the categories themselves. He demonstrated the same point at the former Primary Care Trust level, in a bar chart of variation by programme to benchmark and variance by PCT by programme. A summary of currently available spend and outcome tools was listed and is available as http://www.yhpho.org.uk/SPOT

Professor Ferguson was very positive about the role of NICE, commenting that health economic evidence was now a strong element of NICE work. Hence there is a move now from cost/QALY (quality adjusted life year) to wider cost benefit. However, measures like QALYs have to be applied, and the question is have they actually been used? He went on to talk about the importance of the cost effectiveness of decommissioning; however the socio-legal framework has to be right. Did PCT CEOs make a rationing decision? In the absence of a supportive socio-legal framework it was very difficult to do so. He listed requirements for better decisions:

- Effective and timely use of intelligence
- Integrated budgets
- Focus on systems and pathways
- Longer time horizons
- Alignment of incentives
- Genuine focus on quality and outcomes
- Freedom to do things differently and to take (calculated) risks

In respect of his conclusions, Professor Ferguson stressed the importance of doing primary care work more systematically, for example, because of the knock- on effect on secondary care. Professor Ferguson had heard of one Health and Well-being Board in London where 11/12 members were Councillors and asked whether this would give the Board concerned “teeth”, which he felt was important in order to have the ability to shift resources across health and social care and public health programme. It’s important to be able to think

about the impact on the NHS and the wider determinants of health over a longer timeframe, and for there to be scope to take a calculated risk.

Shifting the gravity of spending? Exploring methods for supporting public health commissioners in priority-setting to improve population health and address health inequalities – Dr Christianne Ormston, Post Doctoral Research Associate, Centre for Public Policy and Health, Durham University

Dr Ormston provided an abstract of her presentation, as follows:

There is increased urgency to demonstrate return on investment in relation to public health interventions and explore methods of decision-support for public health priority-setting. The return of the responsibility for public health commissioning to local authorities means that priority-setting will take place within new organisational and cultural settings, which presents new challenges. With local authority ring-fenced public health budgets confirmed, difficult decisions about investment, and particularly in a time of economic stringency, about disinvestment, will have to be made, not just within the ring-fenced public health budget but also across different departments of the local authority.

This two year study is supporting public health priority-setting in three local authority case study sites across England, through bringing together specialist input from health economics and public health in a series of seminars and targeted decision-making support for public health commissioners. The relevance of prioritisation methods and their impact on spending patterns within and across programmes will be evaluated through a series of initial and follow up interviews with decision-makers in each site.

The project is seeking to show which priority-setting tools local authority commissioners find useful for public health investment, assessing enablers and barriers to decision-making and deliver recommendations about appropriate decision-making support for determining priorities in public health commissioning within local authorities.

The slides Dr Ormston used in her presentation are also posted on the Fuse website.

First discussant - Commissioners' Knowledge Challenges – Dr Mark Lambert, Consultant in Public Health Medicine, Sunderland City Council

Dr Lambert began his reflections by explaining how he was linked in the post-NHS reforms world to a number of different organisations and explained that he would be taking a practitioner viewpoint. After any prioritisation exercise there is still a need to get things into practice. He gave an example of a success story – the reduction in circulatory disease in parts of the north east, which had been good news in narrowing the mortality gap with the remainder of the country, although there was some evidence of the drop now having stalled. This had been achieved by applying what was already known about at scale, for example, approaches to reducing the prevalence of smoking. As well as changing organisational roles to consider there is now a renewed focus on costs and prioritisation.

In developing a response to this there is significant research on use of research in both NHS organisations and in Local Authorities that suggest there are institutional biases in preferred sources of intelligence. And there are sources of authoritative insight that are being disregarded and undervalued, a particular concern where new solutions are being sought.

Returning to the success story of reductions in cardiovascular deaths, some of the success was due to applying existing knowledge about best medical care, contributing to 40% of this fall. One of the biggest potential contributors to this is still hypertension, so the logic is that irrespective of our other endeavours we should still seek out people for whom this risk factor can be better managed. Slides were used to illustrate a point that locally little more than half the population with hypertension were actually being found and potentially helped, and in South of Tyne & Wear this performance was better than the England average.

The lesson was that progress on any one programme is always likely to be limited with multiple competing priorities. A bar chart was shown to indicate the significant future potential for control of hypertension in the reduction of stroke incidence, far greater than many other initiatives that had received headline attention in health care. Equally, there are many other health priorities too – each demanding time and attention.

Therefore, a case was made for actively managing intelligence in determining priorities. There has been variable and poor use of research evidence historically amongst those charged with organisation of health and health care programmes. The challenge is to combine prioritisation with active management of intelligence, tailored to take account of historical institutional biases.

Second discussant – Mr Liam Hughes, Freelance Consultant (former National Advisor for the Healthy Communities Programme)

Mr Liam Hughes explained that he was now a chair of a Health & Well-being Board in Oldham, but had been a PCT Chief Executive and a Director of Social Services – which in modern speak made him a 'boundroid'. How do Boards know what to do? After a settling in period, there is always the moment when this question looms. In his particular situation, the Board had found that there were 4,000 line items relevant to public health and health and social care which could be resolved to 400 clusters, but still left an enormous task for a Board that would be meeting six times a year. As a result the Board looked for a framework to help and came up with a life course approach as a starting point to put 6/7 things that seemed important under each heading, which in turn needed to make some sense in the context of the 4,000 items, which was hard work. At that point the Board looked again for decision approaches and went back to qualitative methods – post-it notes on the wall. After the first iteration the public health department were asked to act as a critical friend to rule out some proposals the "nonsense", but this still left a competition between perfectly good ideas for which there was some evidence.

The backdrop to this work was that there were some fundamental planks to the existing partnerships in Oldham based on jobs, education, regeneration and health. The Board also recognised that within its membership it had considerable leverage, £500m of public expenditure was represented in the room. Actually, Mr Hughes proposed – Boards do have power and can influence but the building blocks are distributed elsewhere, in employment, resilience to the effects of the welfare reforms and planning – consequently people with expertise in these areas were imported onto the Board. Health was effectively, 'distributed' through the system. A sub-committee was set up for integration and also for health protection.

At the end of the process there were 6/7 themes under three headings within the life course. The evidence was used to highlight areas of concern. Elements that were doing well, for example, smoking and tobacco control are going to be 'left alone' to continue their good work, whilst areas of weakness will be where the Board will focus its efforts, for example, loneliness, and getting into employment and staying in work.

Mr Hughes then went on to talk about the different approaches to evidence of the people represented on the Board. He characterised this as GPs basing their idea of evidence on anecdotal accounts of patients and research read some years before, and that Councillors were similar where they took note of what had been said to them in their surgeries. It is importance to sift ideas, but sometimes actions need to be taken because they are the right thing to do. One important challenge for the Board was to get people who don't know research to value evidence and the credibility of the public health team in important in achieving a respect for evidence.

Mr Hughes drew the Stacey Matrix (which has agreement and certainty along two axes) to illustrate 5 scenarios:

(1) Areas of strong agreement and certainty – a small proportion of the landscape
(2) Areas of good certainty but debate about what to do, alcohol unit pricing being an example
(3) Areas where it is clear what should be done but poor evidence
(4) Areas of anarchy – where there is neither evidence nor agreement on what to do, which is where some issues in this category will be parked.
(5) An area corresponding to a complex adaptive system, where the problem changes as it is investigated. An example of this is pressure on A&E which actually stems from people in nursing homes being unwilling to lift elderly people who have fallen in nursing homes. A lot of issues are within this category.

Consequently the big issue in Oldham is lonely people in inadequately heated homes, and on these occasions there is a need for Boards to be courageous.

Table Discussions - Feedback

The content of the individual Table discussions are summarised in a separate document. This report records points that Table leaders wished to stress in their summing up of individual discussion groups work. (Numbering reflects the merging of tables which took place on the day, and whether Tables elected to report back)

Table 2

- It is important to embed public health advice and the public voice in the decision making process
- Cultural changes are needed to adapt to the new situation, for example, developing appropriate influencing skills, picking up new language and different systems.
- Theoretically the local authority is better placed as an elected body to undertake public engagement
- There is a need to translate datasets and intelligence into understandable narrative. (Members of the audience said when asked that this was not achieved by NICE public health briefings for local authorities.)
- In the NHS one moved in career terms from generalist to specialist, in local government it was the reverse

Table 4

- Felt some nostalgia for 'world class commissioning'
- Terminology can mean very different things in different contexts for example, value for money
- It is important to plan ahead for 2015 and to understand the effects of disinvestment in the broader picture.
- DsPH structural position in the local authority affects their ability to influence decisions

Table 6 (Supplied three key points in writing as below)

1. Getting research into practice is fundamental. Need a year-on-year increase on funding for the right kind of research of at least 1%.
2. Variance in quality of the JSNA itself and the way in which it is interpreted and used has a major effect upon the ability to make good evidence-based decisions: need tools to enable making the best decision even when evidence is poor.
3. 'Public health' is a term which may not be well understood outside of the PH community: need to refocus to emphasise and consider all impacts on 'health and wellbeing'.

Table 7

- If the politicians and the public disagree with the evidence base it doesn't happen, for example, in relation to the value of sex education
- Managing the message is key and a traffic light system could be useful

- The audience in local government is not unintelligent but needs to be assisted to absorb information quickly

Table 8

- Public health was "not being recognised" and needed to be integrated
- Within local government it felt like there were a lot of top down decisions (where top relates to the top corporate level of the Council and whether the DPH is part of the structure at that level being critical).
- Research and tools need to be developed and some were lost in the organisational transition. In some cases infrastructure was also lost and needed to be re-established within the host Council. A lack of access to information could be a problem except where there were shared service arrangements.
- Public health was seen as environmental health

AR/22nd August 2013