



Shifting the Gravity of Spending – Mark 2: Final Evaluation Report

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The views expressed in this report are those of the authors and not necessarily those of the NIHR SPHR.

Executive Summary

Background to evaluation study

Local authority public health teams are required to make decisions about how best to prioritise the funds available to them in order to achieve the maximum health gain for their local communities which they represent. The investment and disinvestment decisions they make are even more critical at a time of shrinking budgets. In order to assist local authorities with their budgetary responsibilities, Public Health England (PHE) developed a new Prioritisation Framework (PF). Launched in March 2018, the PF tool is intended to assist local government public health commissioners and decision-makers with their decision-making in regard to budget allocations to support public health interventions. In particular, the PF is designed to help identify areas of service provision that might benefit from investment or, conversely, disinvestment.

In order to assess the value of the PF and experience in its use, a one year evaluation was funded with PHE's support, to assess the use and impact of the tool in three early adopter local authorities. The evaluation of Public Health England's (PHE) Prioritisation Framework (PF) launched in March 2018 draws upon a previously funded NIHR SPHR project entitled *Shifting the Gravity of Spending? Exploring methods for supporting public health commissioners in priority-setting to improve population health and address health inequalities*.

There are two components to the evaluation: (1) a qualitative study of the processes associated with adopting the PF in three different local authorities (LAs); and (2) a health economics study to understand the use and value of the PF in informing and influencing investment and disinvestment decisions where that is relevant.

Purpose of study

The primary purpose of the study has been to assess how the PF has been adopted by decision-makers in three early adopter LAs in England. A secondary aim has been to analyse the economic impact of the decisions where possible. This part of the study has been subject to the greatest risk given the way the PF has been used in the three case study sites and also given the short time available for the evaluation to be completed (January to November 2018).

Key findings

The evaluation found that overall the PF was welcomed by our three local authorities and was regarded as a useful tool. In particular, the PF provided the space for decision-makers to come together and in an open and transparent way seek to identify those areas of public

health where investment would most benefit local communities and improve their health. Conversely, the PF identified areas where there was potential to disinvest in order to enable those resources to be put to better use in other public health areas. The study also found that there were aspects of the PF which required attention and modification in order to render it even more useful to local authorities. Using the tool required considerable investment of time by public health teams and it was thought the process could be speeded up if PHE could assist in providing the evidence underpinning decisions to invest or disinvest.

All three LAs, albeit to varying degrees, completed the process of using the PF and made recommendations to change budget allocations. By utilising the tool, the public health teams engaged with a process that facilitated how to get the best value for money from the public health budget. Specifically, teams considered which programmes could offer the greatest value in the future (potential), the current state of programmes that were being delivered and how the budget was currently divided across programmes (current state), and, finally, how easy it was for programmes to change (feasibility).

Key emerging patterns in most but not all of the recommendations to change budget allocations were based on an assessment of potential, feasibility and levels of investment. Areas of low potential and low feasibility to improve in the future, and low or neutral investment were often recommended for decreases in budgetary allocations. Similarly, a programme area in one LA with a high potential and feasibility with low investment was recommended for an increase in budgetary allocation. Hence the majority of recommendations for budget changes were made based on an assessment of evidence and the scoring systems inherent in the PF. Some tacit knowledge however, was also considered as part of the evidence base.

Across all three sites it was acknowledged that adoption of the PF tool provided a systematic framework to structure and guide prioritisation decisions. Reflecting the ongoing financial pressures on public health budgets, and on local government spending more generally, our respondents acknowledged that the adoption of the tool could encourage transparency over investment/disinvestment decision-making in public health spending. Moreover, it was felt that adoption of the PF tool could help to raise the profile of public health teams and also to contribute to the wider understanding of the prioritisation process across the council.

Overall, all three LAs acknowledged that adoption of the PF tool provided a platform for greater collaboration between different public health professionals with the potential that this offered to improve investment/disinvestment decisions in public health spending. In particular, emphasis was given to the participatory nature of the tool which it was felt encouraged and enabled collective learning.

There was evidence from our first-hand observations of the workshops that the adoption of the PF tool facilitated conversations across different stakeholders which was considered to be essential if public health teams are to overcome the traditional silos in which they operate.

Although each site experienced a variety of types of engagement by key stakeholders, there was much praise for the role of the external facilitator as a ‘process owner’. Across all sites, PHE played an active role in the organisation and delivery of the workshops and it was considered critical to the adoption of the tool.

Despite these opportunities arising from the PF, our findings demonstrated that significant financial tensions and limited availability of resources, uncertainty around policy, and fundamental questions about the future of the ring-fenced public health budget could hinder the adoption of the PF tool and make decision-makers wary of its purpose and impact. In keeping with government pressures for efficiency savings, respondents stressed the difficulty in setting priorities for allocating a limited pool of resources.

From an organisational perspective, it was acknowledged that the adoption of the PF tool requires a significant investment of time and commitment from public health teams. In particular, concerns were raised over the time required to populate the evidence templates by programme area leads. Moreover, limited capacity among public health teams and challenges in getting the right people together at the same time were thought to be a major barrier to the effective adoption of the PF. For some respondents, uneven attendance at workshops could hinder the wider ownership and therefore successful adoption of the new tool. Some respondents suggested that having pre-populated evidence templates provided by PHE as well as ensuring continuity of participants could improve the adoption of the tool.

The effect of the political environment on prioritisation decision-making was highlighted by many interviewees. In particular, it was felt that the political context in which prioritisation occurs (i.e. local government) could hinder the adoption of the PF tool. Reflecting the political nature of local government it was recognised that any decision-making approach will need to take into account the local political context and organisational agenda, acknowledging that elected members will take the final decision. In this context, it was acknowledged that ensuring support and committed leadership from senior management was a key enabler to success. In particular, our respondents felt that elected members’ buy-in at an early stage could facilitate the adoption process and avoid problems of ownership at a later stage.

In terms of the prioritisation exercise, our respondents acknowledged difficulties in relation to the different sources and types of evidence that might be used by various stakeholders involved in making decisions. In addition, there was a general perception that limited availability of information and evidence in some areas (such as for mental health services) could hinder adoption of the tool. Of particular concern among all our respondents was the lack of national indicators in certain areas of public health and an absence of qualitative evidence to inform prioritisation decision-making.

Across all three LA sites the workshops were favourably received and participants considered them to be helpful, informative and well-structured. However, some respondents were more

critical and felt that the PF tool was too linear, mechanistic and deterministic in its design and thus risked failing to address the dynamic, complex and multifaceted nature of the prioritisation process in public health.

There were recognised problems around assisting both elected members and staff to understand the underlying principles of the tool. As well as a perception that local government often fails to understand the role of public health, our respondents felt that a lack of understanding of the PF tool's contribution to the prioritisation decision-making process could hinder its adoption.

In addressing these challenges, interviewees recognised that achieving a shared understanding of the benefits of the PF tool through meaningful engagement of all relevant local stakeholders could determine successful adoption. In this regard, respondents suggested that framing the value of PF tool in the context of the prioritisation process is as important as ensuring stakeholders' engagement. Some respondents proposed the provision of supporting documents and an instructional video in order to facilitate this process.

The recommendations made for investment and disinvestment decisions arising from the adoption of the tool are a transparent part of a process that is aimed at enhancing allocative efficiency. However, none of the LAs using the PF specified actual figures in terms of changes in budget. A crucial part of the PF that is deemed optional by PHE is the modelling scenario stage. Furthermore, currently the PF does not explicitly incorporate an assessment of the impact of changes in budget allocation on changes in outcomes separately. However, in regard to capturing the economic impact of the use of the PF in terms of costs and benefits, this stage is the most crucial. It is impossible to assess allocative efficiency if costs and outcomes at the margin are not captured and valued. This does not negate the current value of LAs using the PF.

Next steps

Looking forward, as the PF becomes more embedded and stakeholders become more comfortable with its use, the next logical stage in the development of the PF would be to include a modelling exercise to assess impact of budgetary allocations on outcomes at the margin as a key element of the process. In particular, an assessment of change in budget allocation and a modelling exercise to estimate the impact on key outcomes and metrics would facilitate the move towards recommendations/decision-making that leads to allocative efficiency gains.

Conclusion

In conclusion, although the evaluation of PHE's PF was confined to three sites, as they were the most advanced in testing the new tool, it yielded rich insights into the use and value of the

PF as well as suggesting modifications to its design in order to strengthen its appeal and impact.

Introduction and Background

Public Health England's (PHE) Prioritisation Framework (PF), launched in March 2018 (<https://www.gov.uk/government/publications/the-prioritisation-framework-making-the-most-of-your-budget>), has its origins in a larger study which was undertaken in two stages over four years from 2012-2016. The study, *Shifting the Gravity of Spending? Exploring methods for supporting public health commissioners in priority-setting to improve population health and address health inequalities*, was funded by the NIHR SPHR. The main study occurred between November 2012 and August 2015, with a follow-on study conducted between September 2015 and August 2016.^{1 2} The background to the study lay in the return of public health in England to local government in 2013 as a consequence of the Health and Social Care Act 2012. The budget for public health was ring-fenced and required difficult decisions about investment and disinvestment, especially at a time of austerity and fiscal squeeze. The public spending cuts introduced by the Coalition government in 2010 hit local government especially hard.

The purpose of the original study was to offer health economics support to local authorities making prioritisation decisions in regard to their public health budget. The study brought together academic expertise from health economics and public health in a series of seminars and targeted decision-making support sessions for public health commissioners. The relevance of prioritisation methods and their impact on spending patterns within and across programmes was evaluated through a series of initial and follow-up interviews with decision-makers in each of the three local authorities studied.

Following the main study, a 12 month follow-on study selected several local authorities to identify what helps and hinders the uptake and impact of adopted priority-setting tools and approaches. The sites were selected to enable findings from the main study to be tested and further developed in a rapidly changing local government context.

Several key themes emerged from the main and follow on studies but underlying all of them was the importance of context in all its manifestations – organisational, political and relational. It had a critical impact on influencing and shaping what happened in practice. Four key themes from the study merit comment. First, there were variable approaches to priority-setting – from the adoption of methods and tools, to discussion and reaching agreement; second, there was a tension between encouraging the uptake of prioritisation tools and their perceived value; third, there was a preference for approaches that were viewed as 'fast and frugal', with the emphasis on keeping it simple; and, fourth, different views existed over what constituted evidence between public health teams and elected members.

In none of our case study sites (six in total) was there evidence of a sustained commitment to, or embedding of, prioritisation approaches or adopting them routinely. Constant churn within local authorities posed a barrier to using prioritisation approaches and support tools in a

¹ Hunter D.J et al., (2016), The potential value of priority-setting methods in public health investment decisions: qualitative findings from three English local authorities, *Critical Public Health*, 26(5):578-587

² Marks L et al., (2015), The return of public health to local government in England: changing the parameters of the public health prioritization debate?, *Public Health*, 129(9): 1194-1203

systematic manner. A key learning point was that more attention is required concerning the purpose and value of adopting the decision support tools and being clear about the types and/or level of decision-making where they might be useful.

Influenced and informed by the research findings, PHE recognised that local authorities needed more health economics input to guide them through the prioritisation process. There was also an acknowledgement of the need to balance tacit, experiential knowledge and political judgement with robust evidence from reliable sources. While public health evidence was generally felt to be sound it was often not regarded as specific enough for elected members interested in particular local priorities. Allied to this was a view that elected members would simply ignore the evidence if it did not support their own ideas or the views of their constituents. Finally, ownership of the process was critical especially by Cabinet members who were the local authority leaders.

The findings and insights from the *Shifting the Gravity of Spending?* study were shared widely with PHE and other relevant bodies, including the Local Government Association. They were used by PHE to inform the development of its new PF. It was agreed following discussion with the health economics team at PHE that an evaluation of the PF by a sample of early adopter sites would yield valuable lessons for taking the tool forward after its pilot phase. A successful application to SPHR for a one year evaluation study followed to be undertaken by a team based at Newcastle and Northumbria universities (two of whose members had co-led the earlier study). The purpose of the study was twofold: to explore how far the lessons from the original study had been taken on board in the adoption of the PF by three selected early adopter sites; and to assess the experience of using the PF in different local authority settings.

The research therefore sought to build on the earlier research findings, briefly noted above, in order to evaluate the impact of the new tool in regard to the ring-fenced public health budget. The study reported here, therefore, both provides continuity with, and is a logical extension of, the earlier research especially as the findings had informed the thinking by PHE's Chief Health Economist and his team both at national level and regionally. They were supportive of the evaluation of the adoption of the PF and the research team held regular update meetings with the architects of the PF throughout the evaluation study.

While PHE has had no direct involvement in the analysis and presentation of research findings, we are confident that these will assist in any future modification of the PF and its accompanying guidance prior to being rolled out across local authorities in England.

The report consists of four parts. Part 1 outlines the aims and objectives, context and methodology for the health economics and the qualitative component of the evaluation. Part 2 provides the results from the health economics. Part 3 presents the analysis of the qualitative interviews. Finally, Part 4 takes the form of a discussion of the key issues that are common across all three local authorities, drawing out any emerging lessons to be learned from the implementation process with a view to informing the future design and adoption of the PF tool.

Part 1: Aims and Objectives, PHE Prioritisation Framework and Methods

Aims and Objectives

There are two components to the evaluation: a qualitative study of the processes associated with adopting the PF in three different local authorities; and a health economics study to understand the use and value of the PF in informing and influencing investment and disinvestment decisions where that is relevant. The primary purpose of the study has been to assess how the PF has been adopted by decision-makers. A secondary aim has been to analyse the economic impact of the decisions where possible. This part of the study has been subject to the greatest risk given the way the PF has been used in the three case study sites and also given the short time available for the evaluation to be completed.

To fulfil the main purpose of the study, case studies were conducted in three early adopter local authority sites which had embarked on testing the PF in order to evaluate the impact of the tool on decision-making in regard to investment and disinvestment decisions. To a large degree, the sites were self-selecting since they were the most advanced in testing the PF. Although a few other local authorities had expressed interest in the framework and were keen to adopt it, at the time of commencing the research they had not made sufficient progress to justify being included in the sample of sites for closer inquiry.

Our purpose in studying these three sites was to explore the value of the PF to them – how useful was it and to identify any barriers and/or enablers affecting its uptake and impact. We are not therefore primarily concerned with comparing the sites which in any case, and judged against various criteria, were quite diverse and distinctive in their approach to using the PF. The analysis has therefore focused chiefly on the key issues, insights and learning points to be derived from our sample of three sites.

The original proposal also included provision for an online survey of all early adopters of the PF. The survey was intended to supplement the ‘deep dives’ to be conducted in the three case study sites. However, in the end the survey had to be abandoned because the PF, following its ‘soft’ launch in March 2018, had not made sufficient progress in terms of its adoption by local authorities across England. Our focus, therefore, was confined to the three case study sites where a mix of workshops were observed in each site combined with semi-structured interviews with those actively engaged in testing the PF. It was not possible to observe every workshop in each site because some had occurred prior to the research getting underway. However, we were able to observe activities in all the sites which provided helpful information on the state of play in those sites and also assisted in identifying individuals for interview.

Emerging findings were shared and sense checked at a Fuse Quarterly Research Meeting on 4 October 2018 which was chaired by the Chief Health Economist at PHE, and attended by a mixed group of academics and policy-makers and practitioners from the North East region.

Application of economic principles to priority setting

The notion that public health resources are scarce relative to needs and demands of publically funded goods and services is not new. Two important economic principles relate to this, opportunity cost and marginal analysis. The principle of opportunity cost is derived from the notion that when having to make choices over limited resources, certain opportunities will be taken up while others must be forgone. In other words, within the constraints of a fixed budget, a decision to provide one service may result in another service not being provided due to lack of resources. The benefit lost or forgone due to a service not being funded is the opportunity cost. Thus knowing the resources used and benefits of various services or interventions within public health allows comparisons and choices to be made in order that the combination of the services invested in maximises benefit from the fixed budget. In economics, the focus of this is at the 'margin'. This refers to the extra unit of benefit gained or lost (i.e. marginal benefit) or the extra unit of cost invested or disinvested (i.e. marginal costs). Using these principles, all other things being equal, benefits can be maximised within the constraints of a fixed budget if resources are moved from services of low to high health benefit per monetary unit spent. This is known as efficiency. Public Health resources should therefore be allocated in such a way to maximise benefit for a given level of resource input or achieve the same level of benefit for a reduction in the amount of resource input both within (to achieve technical efficiency) and across (to achieve allocative efficiency) public health services.³ The use of economic principles in public health priority setting facilitates a mix of service provision that provides the best outcomes for the funding available.

One method of facilitating the application of health economics principles to public health priority setting is through the use of Multi-criteria decision analysis (MCDA). MCDA is a domain of operational research that is beginning to be used in healthcare decision-making. The technique recognises that decision-makers employ multiple and disparate criteria when making decisions (for example, introducing new health care interventions or facilities), and that it is important to make explicit the impact on any decision of all the criteria applied and the relative importance attached to them. In MCDA, criteria affecting a decision are identified and weighted using explicit, transparent techniques. Different options (strategies, interventions) are scored against each criterion and the weights are used to provide summary scores for comparative purposes. It helps to make more transparent assumptions underpinning decisions, which in principle may improve accountability and consistency of decision-making.⁴

Transparent decision making facilitates the provision of clear explanations being given for decisions that have been made. Transparency can also give the opportunity for observations to be made whilst discussions are carried out and gives the opportunity for everyone involved

³ Bate & Mitton, (2006), Application of economic principles in healthcare priority setting. *Expert review of Pharmacoeconomics and Outcomes Research*, Vol 6(3), pp. 275-284

⁴ Multi-Criteria Decision Analysis (MCDA), (2016), York Health Economics Consortium. Available at: <http://www.yhec.co.uk/glossary/multi-criteria-decision-analysis-mcda/>

in the decision making process to have a say.⁵ It has been argued that increased transparency is known to benefit those who are making important decisions when it comes to health care targets as it enhances efficiency when making those decisions. Furthermore, it also has a positive effect on society's acceptance of the decisions that have been made and strengthens trust in those who are making the decisions. As a result, sources and PFs have been developed to help make transparent priority setting process possible. MCDA (multi criteria decision analysis) is one of these and can be used to effectively support decision making throughout health care decision making processes. Originally the health care sector was slow to implement MCDA but as more practitioners became aware of its benefits there has been a huge increase in the use of it within health care decision making.⁶

The PHE Prioritisation Framework

The PHE Prioritisation Framework (PF) was developed to help decision makers decide how public health budgets should be spent. It provides a platform to aid local authorities using the PF to make decisions regarding budget allocations in a structured and transparent manner. PHE based its PF on MCDA largely because MCDA methods have been used effectively to support strategic decision making in many different public health circumstances such as multi agency working.⁷ The PF allows for consideration regarding the programmes that can offer the best value, the current states of the programmes, the budgets and how they are currently allocated across programmes and how easy it could be for the programmes to change and improve. The process allows public health programmes to be scored on the potential state, current state and the programme budgets while, at the same time, considering what is achievable. The purpose of this is to be able to make informed recommendations on whether to increase, decrease or maintain budget spending in each public health programme.

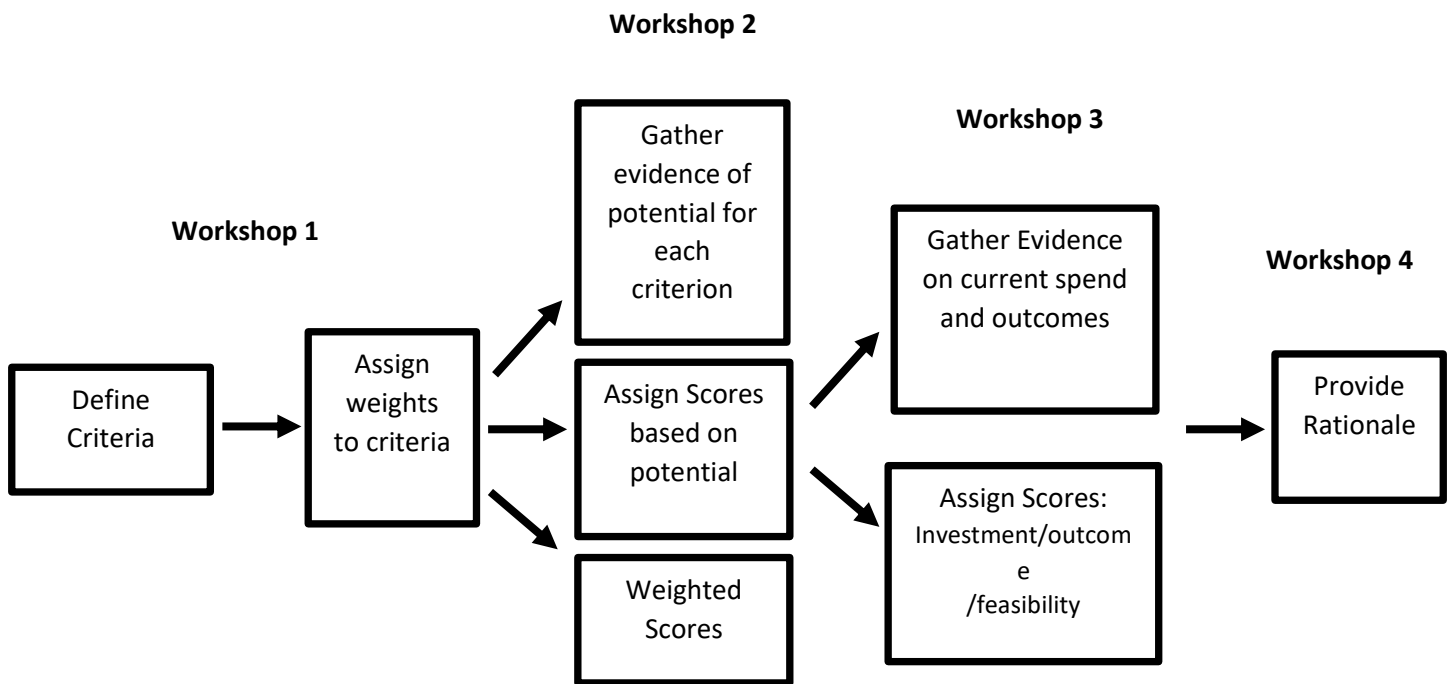
The PF comprises eight essential steps that can potentially take place over a number of workshops. Those taking part in the workshops would ideally be stakeholders from each different health programme under consideration. Step 1 is to define the criteria against which programmes will be evaluated. Operational criteria are selected during this stage of the process representing key factors of what is to be achieved within each local authority and weights are then applied to each of the criteria in step 2. The weights that are assigned to each represent the importance of each criteria relative to all others with the total score summing to 100. Step 3 involves gathering evidence from each programme area that is relevant to the criteria. The evidence gathered relates to what could potentially be achieved by each programme area against each criteria. Step 4, after collecting evidence, is to rate each of the programmes from 1 to 5, 1 representing the poorest and 5 the best. The higher the score indicates which programme areas have the best potential to achieve positive outcomes. During Step 5 the weights that were assigned to the criteria and the scores given to the programme areas are combined to calculate an overall score. This final score represents the

⁵ de Fine Licht, (2013), Transparency actually: how transparency affects public perceptions of political decision-making, *European Political Science Review*, 6(02), pp.309-330

⁶ Thokala et al., (2016), Multiple Criteria Decision Analysis for Health Care Decision Making—An Introduction: Report 1 of the ISPOR MCDA Emerging Good Practices Task Force, *Value in Health*, 19(1), pp.1-13.

⁷ Public Health England (2018), *SPOT PF*, PHE

overall outcome of what could potentially be achieved by each of the programme areas. Step 6 is used to gather evidence regarding the current expenditure and outcomes of the programme areas. Step 7 is assigning scores, this time the scoring is based on the evidence of the current performance of the programmes against 3 measures investment, outcomes and feasibility. Each programme is given a score from 1 to 5 against each of the measures. Overall it gives a clear representation of how the programmes are currently doing in a numerical form. Finally, in Step 8, the PF facilitates the provision of recommendations on whether to maintain, increase or decrease the current budget allocations. The stakeholders then have the option of following what has been advised or to decide their own actions in the light of other contextual factors. Below is a process diagram representing the different stages:



Health Economics Methodology

A descriptive analysis was undertaken using relevant documentation obtained from each site, including populated screenshots of the PF, in order to assess the use and value of utilising the PF from a health economics perspective. Specifically, this focused on the use of evidence, scoring and decision recommendations that were made as a consequence of using the PF in relation to allocative efficiency.

Qualitative Interviews

Qualitative data were collected through face-to face semi-structured interviews (30 in total; see Table 1) between January and July 2018 with key informants in three early adopter local authority sites, supplemented by participant observation of PF workshops. A brief summary of each local authority health profile is provided in Table 1.

Table 1: Local Authority Health Profiles

Site	Geographical status	Population (2016)	Health in summary	Life expectancy	Health inequalities
1	Urban	556,000	Worse than the England average	Lower than the average	Life expectancy is 7.7 years lower for men and 7.1 years lower for women in the most deprived areas of the County than in the least deprived areas
2	Rural	338,000	Better than the England average	Higher than the average	Life expectancy is 6.9 years lower for men and 3.8 years lower for women in the most deprived areas of the County than in the least deprived areas
3	Urban	645,000	Better than the England average	Higher than the average	Life expectancy is 6.3 years lower for men and 5.0 years lower for women in the most deprived areas of the County than in the least deprived areas

Source: <https://fingertips.phe.org.uk/profile/health-profiles>

Interviewees were purposively selected according to their role and involvement in the PHE PF project and included Chief Executives Directors of Public Health; Programme Leads; Commissioners and well as Elected Members. In addition to the above interviews with key stakeholders from each early adopter site, interviews were conducted with PHE Centre officers at regional level who played a key role in supporting the implementation process within each site. The aim of the interviews was to explore respondents' perceptions and experiences of using the PF tool as well as identifying any barriers and facilitators to its adoption.

An email invitation was sent to all project leads for distribution within their PH teams. The interviews were scheduled at participants' convenience in terms of location and time. Participants were provided with information sheets in advance, and consent forms signed prior to the start of the interviews. A topic guide was developed to guide the interviews but the emphasis was on encouraging participants to discuss and reflect upon their own perspectives and experiences (see Appendix A). Interviews took approximately 30-60 minutes to complete. With the permission of interviewees, all interviews were audio-recorded and transcribed. Those agreeing to be interviewed were able to withdraw at any time during the study although none did.

Table 2: List of interviewees

Site	No. of interviews	Interviewees
Site 1	8	PH Consultant x2 Portfolio Lead x 2 PH Consultant/Project Lead Senior PH Consultant/Specialist Strategic Commissioning Manager Director of PH
Site 2	8	Deputy Director of PH Development and Implementation Lead Director of PH PH Manager Senior PH Information Analyst PH Lead x2 Councillor/Elected Member
Site 3	11	Head of PH Business Programmes PH Consultant x3 PH Director Senior Finance Business Partner Councillor/Elected Member x5
PHE	3	PHE Regional Manager x3
Total	30	

Interviews were supplemented by observations of 5 workshops across the sites (Site 1 x 3; Site 2 x 1; Site 3 x 1) where public health teams actively engaged with the implementation of the PF tool. Because the workshops were already underway in the sites prior to the study having commenced, it was not possible to observe all the workshops held in each site. The workshops took place within each LA's offices and involved the participation of a wide range of stakeholders from public health and other departments. In one site, elected members also participated in the workshops. All workshops were chaired by the Director of the Public Health or a senior PH consultant with the support of a PHE Regional Manager and often involved lengthy discussions among stakeholders. There was a degree of uncertainty and confusion among some of the stakeholders about the contribution of the tool to the prioritisation process. Often these meetings would be dominated by certain PH consultants, but the Chairs of the workshops would attempt to counteract this through soliciting the views of others.

A positive ethical opinion was obtained from Newcastle University Faculty of Medical Sciences Ethics Committee (ref: 1443/2629/2018). NHS Research Ethics approval was not required for this study. Research approval was gained in each site.

Data Analysis

Transcribed interview data and fieldwork notes were analysed using thematic analysis to generate category systems and repeated themes⁸. Drawing upon an interpretative approach, themes were developed iteratively and inductively, breaking down and reassembling the data through a coding process. For reasons of confidentiality, all those taking part in the study have been anonymised.

Limitations of the Research

Our study is confined to three early adopter sites. Therefore, findings are not representative of all 152 LAs in England. But then regardless of the sample size, no study would be wholly representative given the diversity evident among local authorities. Local circumstances and context are therefore more than likely to influence adoption of the PF tool

⁸ Boyatzis, R.E., (1998), *Transforming qualitative information: Thematic analysis and code development*, Thousand Oaks, CA: SAGE

Part 2: Economic impact of the PF tool

Introduction

This part provides a health economics analysis of the use and potential value of the PF tool across the three local authorities in informing and influencing investment and disinvestment decisions.

Site 1

Background

Before using the PF and allocating new budgets within the LA, the baseline budget allocations and associated outcomes were identified for 2017-2018. Health checks were reported to have a budget allocation of £560,585 which was larger than several of the other programme areas. Domestic abuse received £227,362 with evidence that 78% of adult outreach clients felt safer and that on average 92% felt safer at exit from the service. Drug and alcohol had a budget allocation of £6,974,160 with evidence that there has been a 3% rise in deaths registered as drug related. Furthermore, it was estimated that there were 2,155 dependant opiate and crack users living within the county with the level of unmet need being less than national rate. Tobacco received £1,985,195 with encouraging evidence that the prevalence of adult smoking had reduced from 22.2% to 17.9% and that hospital admissions due to smoking had dropped from 2,293 to 2,223. Sexual Health had £4,516,472 allocated to it and was a well performing service where targets were being met and there was positive user feedback. Workplace received £108,933 with evidence suggesting that more investment would enable greater reach as the services were close to capacity within their available resources. Suicide prevention was allocated £342,000 with evidence of this being a low spend with poor outcomes. Obesity, Oral Health and Adult Wellness received £625,000, £60,000 and £2,592,710 respectively. Lastly Children and Young People was the programme allocated the biggest proportion of the budget (£11,597,000) with evidence that under 18 conception was statistically higher than the UK average. Table 1 below shows the programmes of work within the public health budget and the associated budget allocations.

Table1: Programmes of Work and Budget Allocation 2017-2018

Programmes of Work	Budget Allocation
Children and young people	£11,957,000
Drug and alcohol	£6,974,160
Sexual health	£4,516,472
Adult wellness	£2,592,170
Tobacco	£1,985,195
Obesity	£625,000
Health checks	£560,585
Suicide prevention	£342,000
Domestic abuse	£227,362
Workplace	£108,933
Oral health	£60,000
LGTB	£48,000

Details of each of the workshops involving the use of the PHE PF are described below.

Workshop 1

The aim of the first workshop was to identify, define and weight the criteria. Seven criteria were identified as follows:

1. Local need – focusing on need that was strategically aligned to existing objectives.
2. Health inequalities – aim to close the gap in healthy life expectancy between the national average and the county.
3. Evidence of impact – focus on the quality of evidence and the theoretical underpinnings of programmes as well as evidence in prevention.
4. Value for money – need for assessment of the costs and benefits that would be realised by implementing particular programmes of work.
5. System benefits/interdependencies - focus on the impact and level of connectedness between programmes.
6. Building community strengths – assessment of how community-centred the programme was.
7. Public health responsibilities - focus on the degree to which the programme was a mandated function or contributed to a statutory LA function such as safeguarding.

Once the criteria were defined, the processes of weighting these took place. In order to weight the criteria, each individual taking part in the workshop was split into one of three small groups and each group allocated 100 points across the criteria. These were collated and where there was similar scoring across the whole group there was little discussion about the decision that had been made. Where there was a large variation between the scores there was a discussion and those taking part were advised to reconsider their decisions. Table 2 below shows the overall scoring results.

Table 2: Category and Criteria Weights

Category	Criteria	Category Weight	Criteria Weight
Health Benefits		68.5711	<i>Sum of weights should be equal to category weight:</i>
	<i>Local need</i>		15.8112
	<i>Aim to address inequalities</i>		25.6932
	<i>Evidence of impact</i>		15.3171
			11.7406
Cost		10.6725	
	<i>Value for money</i>		10.6725
Social Aspects		15.8111	
	<i>System benefits/interdependencies</i>		7.115
	<i>Building community strengths</i>		8.6961
Required		4.941	
	<i>Public health responsibility</i>		4.941

Workshop 2

Once the criteria had been developed and weighted, evidence was gathered for each public health area regarding what could be achieved within each criterion, and not what was currently being achieved. The aim here was to provide each programme area with information regarding the benefits that could potentially be achieved. This evidence provided the basis for rating each of the programme areas from 1 to 5 with 1 being the worst evidence for potential impact and 5 being the best. Scores were then combined with the weights that had been previously assigned to the criteria thus providing an overall score regarding potential, as shown in the results in Table 3 below. The results suggested that after combining the scores and the weights, health checks were rated the lowest ranking and children and young people were rated the highest. The potential is based on the programmes' ability to improve current outcomes and the ability to meet the criteria which was identified in the first workshop.

Table 3: Total scores and ranking of each of the programme areas

	Health checks	Domestic abuse	Drug & alcohol	Tobacco	LGBT	Sexual health	Workplace	Suicide prevention	Obesity	Oral health	Adult wellness	Children & young people
SCORE	56.09	77.49	79.53	78.32	65.09	68.27	75.07	66.54	73.89	78.74	85.81	90.61
RANK	12	6	3	5	11	9	7	10	8	4	2	1

Workshop 3

Prior to the workshop, further evidence was collated regarding current budget allocations and outcomes within that particular health programme and each area was scored again.

Programmes were scored across three areas: current investment (the current budget allocation) and current outcomes (current outcomes being achieved) relative to other LAs, and feasibility (the possibility of reaching the potential for that particular health area). For investment, a score of 1 represents a very high investment rate within that particular health area, 2 indicates a high investment rate, 3 indicates spending that is neither considered high or low, i.e. neutral, 4 indicates a low investment rate, and a score of 5 for investment shows that very little investment has been made within that area. For outcomes with a score of 1 indicates that the current outcomes for a particular health area are very poor, 2 indicates poor outcomes, 3 is neutral, 4 is high, whilst scoring a 5 indicates that outcomes are very high.

Both scores for investment and outcomes were then added together to produce an overall total. The lowest score possible to attain is 2 which indicates a bad performance; the highest score possible is 10 which indicates a high performance. This leads to the ranking where the total scores are taken into consideration and ranked from highest performing programme area to worst. Feasibility as a criterion stands alone and is not added to the total score. Again the scoring for this means that 1 indicates a very low possibility of reaching potential state, with 5 indicating a very high chance of reaching potential state. Table 4 shows the results of the scoring. Health checks scoring was low for investment, neutral for outcomes and feasibility. Domestic abuse obtained neutral scores for both investment and outcomes and a high score for feasibility. Drug and alcohol obtained a neutral score for investment and a poor score for outcomes but scored very high for feasibility implying that it had high potential. Tobacco obtained a high score for both investment and outcomes and scored 5 for feasibility which was considered very high. Sexual Health scored 3.5 for investment implying it was just above neutral, a high score for outcomes and a neutral score for feasibility. Workplace scoring was low for investment and a high score for outcomes and with high potential feasibility. Suicide prevention scoring was neutral for investment and high for outcomes and feasibility. Obesity was low for investment and neutral for outcomes and feasibility. Oral health was neutral for investment, poor for outcomes with a feasibility score indicating high potential. Adult wellness scoring was neutral for investment, high for outcomes and very high for feasibility. Lastly, Children and young people obtained a very high score for investment, a neutral score for outcomes and a high score for feasibility. The results of the overall scoring suggest workplace had the highest ranking in terms of investment and outcomes and had high future

potential in terms of feasibility with the lowest ranking programme area being children and young people still scoring high on feasibility

Table 4: Scoring for Current Spend, Investment and Future Feasibility

Scoring methodology:

<i>Investment</i>	Very High	High	Neutral	Low	Very Low
<i>outcomes</i>	Very Poor	Poor	Neutral	Good	Very Good
<i>Feasibility</i>	Very Low	Poor	Neutral	High	Very High
<i>Current scores</i>	1	2	3	4	5

Current scores	Health checks	Domestic abuse	Drug & alcohol	Tobacco	LGB T	Sexual health	Workplace	Suicide prevention	Obesity	Oral health	Adult wellne ss	Children & young people
<i>Investment score</i>	4	3	3	2	3	3.5	4	3	4	3	3	1
<i>Outcomes score</i>	3	3	2	4	3	4	4	4	3	2	4	3
<i>Total</i>	7	6	5	6	6	7.5	8	7	7	5	7	4
<i>Rank</i>	3	7	10	7	7	2	1	3	3	10	3	12
<i>Feasibility</i>	3	4	4	5	3	3	4	4	3	4	5	4

Workshop 4

As a result of the previous scoring processes, this workshop focused on making recommendations on whether to increase, decrease or maintain the budgets within each of the specific programmes. The recommendations for Site 1 were to decrease the budget allocation to health checks. Domestic abuse was advised to maintain their current budget as there was evidence to prove that the programme made a significant difference to those who received support from it. Drug and alcohol were advised to maintain their budget, as current outcomes were felt to be positive. Tobacco was advised to decrease their budget. It was decided to maintain the sexual health budget given that levels of investment within this area were good along with local outcomes. It was decided to increase the budget allocation to workplace due to a lack of current budget allocation to support this important area. It was decided to maintain budget allocation to suicide prevention but it was agreed that there was a need for increased emphasis on enabling access to primary and secondary NHS adult wellness to ensure an improved journey between services. Obesity was advised to decrease the budget. It was decided to increase budget allocation to oral health as it was felt that there was potential for this particular area to expand their services. There were seen to be opportunities to expand fluoridation, subject to technical appraisal, full public consultation and political approval. Furthermore, it was judged that this scheme would narrow inequalities in oral health outcomes and offer better value for money. It was decided for adult wellness to increase their budget allocation largely due to the fact that the programme was seen to have potential to support all other programmes. Lastly, children and young people were advised to maintain

their current budget as this was seen to have to have high potential value and good outcomes. The budget allocation decisions are presented in Table 5 below.

Table 5: Budget Allocation decisions

Health Area	Potential Score	Rank	Current Score	Rank	Feasibility Score	Current Spend	Recommendations
Health checks	56.1	12	7	3	3	£560,585	Decrease
Domestic Abuse	77.5	6	6	7	4	£227,362	Maintain
Drug & Alcohol	79.5	3	5	10	4	£6,974,160	Maintain
Tobacco	78.3	5	6	7	5	£1,985,195	Decrease
LGBT	65.1	11	6	7	3	£48,000	
Sexual Health	68.3	9	7.5	2	3	£4,516,472	Maintain
Workplace	75.1	7	8	1	4	£108,933	Increase
Suicide Prevention	66.5	10	7	3	4	£342,000	Maintain
Obesity	73.9	8	7	3	3	£625,000	Decrease
Oral Health	78.7	4	5	10	4	£60,000	Increase
Adult Wellness	85.8	2	7	3	5	£2,592,710	Increase
Children & young people	90.6	1	4	12	4	£11,597,000	Maintain

Concluding Remarks

Overall, the recommendations either to maintain, increase or decrease budget allocations were largely agreed by the stakeholders who took part in the workshops. A large portion of the programmes were advised to maintain their current budgets.

The increase in budget allocation was only advised for three programme areas: workplace, oral health, and adult wellness. These three particular programmes all had high feasibility scores and oral health and adult wellness were relatively high in terms of the potential to improve with an increased budget. In terms of current scoring, workplace had low investment and high outcomes, oral health had low investment and poor outcomes with adult wellness having neutral investment and high outcomes. Overall, budgets were increased in areas where current spending was not high but had high feasibility to improve. The recommendation to

increase budgets in programmes with high feasibility and potential could be seen as a move to improving allocative efficiency.

The programmes that were advised to decrease were: health checks, tobacco and obesity. Health checks and obesity both had neutral feasibility scores with low investment and neutral outcomes. Health checks obtained the lowest rank in any potential to improve with obesity also judged relatively low. It could be argued lowering budgets in programme areas with neutral feasibility and low potential to improve could aid efficiency, the rationale being that these programmes have achieved their optimum performance. Tobacco, on the other hand, had high spending and high outcomes and had high feasibility scores. The rationale to reduce budget allocation in this programme area is less clear in terms of improving efficiency.

Overall, and with the exception of tobacco, feasibility and potential to improve in the future seem to be a key factor in driving recommendations regarding budgetary changes. Identifying programmes with low feasibility and potential and reducing budgets is likely to improve efficiency of the use of the public health budget rather than an alternative option of reducing budgets across all programme areas regardless of performance either now or in the future.

Site 2

Background

Prior to engagement with the PF, the baseline budget allocations and associated outcomes were identified for 2017-2018. These are detailed in Table 6 below. Children's public health had the greatest budget allocation with workforce having the lowest. Table 6 below shows the programmes of work within the public health budget and the associated budget allocations.

Table 6: Programmes of Work and Budget Allocation 2017-2018

Programme Area	Budget Allocation
Children’s public health	£3,572,820
Sexual health	£1,634,190
Healthy weight	£1,005,180
Tobacco control	£290,000
NHS health checks	£200,000
Mental health	£163,000
Oral health	£75,000
Workforce	£60,000

Workshop 1

The aim of the first workshop in Site 2 was to identify and weight the criteria. The identified eight criteria were:

1. Effectiveness – the extent to which a programme area gets the results intended.
2. Cost effectiveness - the cost of the programme area compared with benefits and cost savings.
3. Local need - evidence of local need and the size of the population affected.
4. Community strengths - the extent to which a programme strengthens the community to support public health outcomes.
5. Connectedness – the extent to which a programme area impacts on other programme areas and other services.
6. Inequalities - the extent to which the programme area narrows the gap between those with the best and the poorest health and wellbeing.
7. Deliverable - the extent to which a programme is politically acceptable, technically possible, legal, environmentally sustainable, socially acceptable, and the workforce and market capacity exist or can be developed.
8. Innovation - the extent to which a programme has the flexibility to embrace opportunities to improve current practice thereby better meeting identified local need.

Each of these criteria were subsequently included in one of the following categories: effectiveness, communities, wider links and process. In order to weight these criteria, 100 points were allocated across all criteria. The criteria and the associated weights are shown in Table 7 below.

Table 7: Category and Criteria Weights

Category	Criteria	Category Weight	Criteria Weight
<i>Effectiveness</i>		27	<i>Sum of weights should be equal to category weight:</i>
	<i>Effectiveness</i>		14
	<i>Cost effectiveness</i>		13
<i>Communities</i>		30	
	<i>Local need</i>		18
	<i>Community strengths</i>		12
<i>Wider links</i>		23	
	<i>Connectedness</i>		10
	<i>Inequalities</i>		13
<i>process</i>		20	
	<i>Deliverable</i>		11
	<i>Innovation</i>		9

Workshops 2 and 3

During the second workshop, each of the service areas were asked to gather evidence from published literature regarding the benefits that could be made from changing and improving the service. A further workshop was scheduled to give time for those taking part to allow for a better understanding of what was being asked of them. The evidence collated provided the basis for rating each of the programme areas from 1 to 5 with 1 being the worst evidence for potential impact, and 5 being the best. Scores were then combined with the weights that had been previously assigned to the criteria thus providing an overall score, as shown in the results in Table 8 below. These suggest that substance misuse and tobacco control were ranked the highest programme areas for potential improvement and that NHS health checks had the lowest.

Table 8: Total Scores and Ranking of Each of the Programme Areas in terms of potential

	Sexual health	Children public health	Substance misuse	Mental health	Workforce	Tobacco control	NHS health checks	Healthy weight	Oral health
SCORE	74.00	77.80	78.20	77.80	63.80	78.20	57.60	73.20	66.80
RANK	5	3	1	3	8	1	9	6	7

Workshop 4

During the fourth workshop, programme areas were considered and scored on the basis of their current position in terms of levels of investment, the outcomes achieved and feasibility for future improvement. The algorithm for scoring was that advised in the PF and the results are included in Table 9 below.

Tobacco control and oral health obtained the highest ranking with very low Investment scores and good outcomes. The results from the feasibility scoring indicate that both have a poor feasibility relative to the other programmes. NHS health checks and Healthy weights obtained the lowest ranking with high investment and good outcomes for health checks but with poor feasibility. Healthy weights had a low investment with poor outcomes and a very high feasibility to improve. In addition, children's public health, substance misuse and workforce also had a very high feasibility score.

Table 9: Scoring of current investment, outcomes and feasibility

Current Scores	Sexual Health	Children public health	Substance misuse	Mental health	Workforce	Tobacco control	NHS health checks	Healthy weight	Oral health
Investment	4	5	4	3	5	5	2	4	5
Outcomes	4	3	3	4	3	4	4	2	4
Total	8	8	7	7	8	9	6	6	9
Rank	2	2	3	3	2	1	4	4	1
Feasibility	4	5	5	3	5	3	2	5	2

Workshop 5

During the final workshop, recommendations were made over whether to increase, decrease or maintain the budget allocations within the different programme areas (see Table 10).

Those taking part were asked to consider the changes in funding based on the potential for improvement and local performance. Recommendations were made to maintain budgets in most programmes. The exception was NHS health checks and Healthy weight. NHS health checks were recommended to decrease their current budget as outcomes are good and current investment high with a low score for feasibility. Healthy weight were recommended to increase current budget as both investment and outcomes are low but the potential to reach future state for this programme is very high.

Table 10: Budget allocation decisions

Health Area	Potential Score	Rank	Current Score	Rank	Feasibility Score	Current Spend	Recommendations
Sexual health	74.0	5	8	3	4	£164,190	Maintain
Children's public health	77.8	3	8	3	5	£3,572,820	Maintain
Mental health	77.8	3	7	6	3	£163,000	Maintain
Workforce	63.8	8	8	3	5	£60,000	Maintain
Tobacco control	78.2	1	9	1	3	£290,000	Maintain
NHS health checks	57.6	9	6	8	6	£200,000	Decrease
Healthy weight	73.2	6	6	8	5	£1,005,180	Increase
Oral health	66.8	7	9	1	2	£75,500	Maintain

Concluding Remarks

Recommendations to maintain budget allocations were made for the majority of programme areas with the exception of healthy weight and NHS health checks, with the former recommended for a budget increase and the latter a budget decrease. An increase in budget of the health weight programme - low investment and outcomes and very high feasibility - could potentially improve allocative efficiency. NHS health checks had high investment with good outcomes and poor feasibility indicating that a cut in budget may not have an adverse effect on outcomes below a neutral position. High Investment in areas of poor feasibility to improve may not contribute to allocative efficiency of the public health budget.

Site 3

Background

Before using the PF and allocating new budgets within the LA, the baseline budget allocations and associated outcomes were identified for 2017-2018. The costs and outcomes were identified when an analysis of the SPOT PF took place. The SPOT (Spend and Outcomes Tool) is an online document that gives an overview of expenditure and outcomes across different health areas for local authorities and clinical commissioning groups. This

gives the ability for public health teams and commissioners to see where the current budget is being spent and the current outcomes (Public Health England, 2018). The evidence showed the budget allocation for drug misuse was £4,474,000 with the current outcomes being similar to national averages. The successful completion of drug treatment for those within Site 3 was 6.9% and was close to the national average of 6.7%. The current expenditure for alcohol misuse was £1,555,500 with outcomes for this area proving to be above national averages. It was reported that the current proportion of people completing alcohol treatment is statistically similar to national averages and there has been a positive increase over the last six years of individuals completing treatment, with an average of 36.9% in Site 3 compared with a national average of 38.7%. Furthermore, the number of people being admitted to hospital due to alcohol misuse is lower in Site 3 than national average. Public mental health received a budget allocation of £726,000. The outcomes within this area show that hospital admission for intentional self-harm is higher than the national average and self-reported wellbeing for those with high anxiety is 19.0% just below the national average. The budget allocation for sexual health testing and treatment was £3,957,000 and detection rates of certain sexually transmitted diseases were lower than the national average. Sexual health-contraception and promotion/prevention/advice received £1,344,000 with outcomes for this particular health area being higher than the national average. Budget allocation for Obesity and physical activity was £1,487,000 with outcomes within this area proving to be higher than the national average. The amount of children within Site 3 with excess weight was showing an improving trend with weight decreasing and the amount of physically active adults being above the national average. NHS health checks received £826,000 with relevant outcomes meeting national averages. Evidence suggested that those who are aged 40 or above and have received a NHS health check is higher than national average at 36.5%. Smoking and tobacco had a budget allocation of £1,282 with outcomes either meeting national averages or falling just below. The healthy child programme (0-5) received £7,756,000 with current outcomes mostly above the national average. Children who are overweight at reception age was drastically lower than the national average and children having good level of development at the end of reception had seen an improving trend over the past few years. Lastly Healthy child programme (5-19) had a budget allocation of £1,804,000 with outcomes for this area mostly hitting national averages or above. The amount of under 18 conception was decreasing and again children aged 10-11 had lower excess weight. Table 11 below shows the programmes of work within the public health budget and the associated budget allocations.

Table 11: Programmes of Work and Budget Allocation 2017-2018

Programme Area	Budget Allocation
Drug misuse	£4,474,000
Alcohol misuse	£1,555,500
Public mental health	£726,000
Sexual health testing and treatment	£3,957,000
Sexual health – contraception and promotion/prevention/advice	£1,344,000
Obesity and physical activity	£1,487,000
NHS health checks	£826,000
Smoking and tobacco	£1,282,000
Healthy child programme (0-5)	£7,756,000
Healthy child programme (5-19)	£1,804,000

Workshop 1

The main aim of the first workshop was to identify and weight the criteria. The identified eight criteria were as follows:

1. Cost effectiveness – extent to which the programme provides value for money.
2. Health inequalities – extent to which the programme has potential impact on reducing inequalities in health.
3. Focus prevention – extent to which the programme has a focus on early intervention and prevention.
4. Evidence of effectiveness – extent to which the programme achieves intended improvements in outcomes, also considering the quality of evidence.
5. Linkage with other parts of the system – extent to which other public health interventions had links with other council work.
6. Acceptability – extent to which the programme is deemed to be acceptable politically and to local residents.
7. Scale of population impact – proportion of resident that would be expected to benefit from the programme.
8. Policy/ strategy/ mandate: local or national – extent to which programme is aligned to national mandate or local policy/strategy.

The criteria were then weighted and these are presented in Table 12.

Table 12: Category and Criteria Weights

Category	Criteria	Category Weight	Criteria Weight
<i>Cost effectiveness</i>		19.75	<i>Sum of weights should be equal to category weight:</i>
	<i>Cost effectiveness</i>		19.75
<i>Health inequalities</i>		18.75	
	<i>Health inequalities</i>		18.75
<i>Focus on prevention</i>		15	
	<i>Focus on prevention</i>		15
<i>Linkage with other parts of the system</i>		10.75	
	<i>Linkage with other parts of the system</i>		10.75
<i>Acceptability</i>		8.75	
	<i>Acceptability</i>		8.75
<i>Scale of population impact</i>		8.5	
	<i>Scale of population impact</i>		8.5
<i>Policy/strategy/mandate-local or national</i>		4.5	
	<i>Policy/strategy/mandate- local or national</i>		4.5

Workshop 2

The main aim was to score the different programme areas from 1 to 5. The scores were based on the potential benefits that could be produced from changing the programme, and were based on evidence was gathered with the score of 1 being the worst evidence for potential impact, and 5 being the best. Scores were then combined with the weights that had been previously assigned to the criteria thus providing an overall score, as shown in the results in Table 13 below. The results show that smoking and tobacco ranked top with sexual health-contraception and promotion/prevention/advice coming second. NHS health checks ranked bottom as 10th with healthy child programme ranking 9th.

Table 13: Scores and Ranks based on Potential Benefit

	Drug Misuse	Alcohol misuse	Public mental health	Sexual health testing & treatment	Sexual health-contraception & promotion/prevention	Obesity and physical activity	NHS health checks	Smoking and tobacco	Healthy child programme (0-5)	Healthy child programme (5-19)
SCORE	70.72	74.23	71.53	70.91	79.57	75.89	65.93	82.03	75.65	70.03
RANK	8	5	6	7	2	3	10	1	4	9

Workshop 3

The aim of the third workshop was to assess the different areas against three different measures: current investment, current outcomes, and feasibility (see Table 14 below). Sexual health testing and treatment, smoking and tobacco and healthy child programme (5-19) were all ranked the lowest with neutral or just above investment and neutral or just below outcomes all having neutral or above feasibility. Sexual health contraception and promotion/prevention/advice and healthy child programme (0-5) obtained the highest ranking for feasibility with neutral investment and neutral or good outcomes.

Table 14: Scoring for current investment, outcomes and feasibility

Current scores	Drug misuse	Alcohol misuse	Public mental health	Sexual health testing & treatment	Sexual health contraception & promotion/prevention	Obesity & physical activity	NHS health checks	Smoking & tobacco	Health child programme (0-5)	Health child programme (5-19)
Investment	3	3	3	3	3	3	3.5	2.5	3.5	3
Outcomes	3	3	3	2.5	4	3	3	3	3.5	2.5
Total	6	6	6	5.5	7	6	6.5	5.5	7	5.5
Rank	3	3	3	4	1	3	2	4	1	4
Feasibility	3	3	4	3	4	4.5	3	4	3.5	3.5

Workshop 4

During the final workshop, recommendations were made regarding changes in budget allocations. Sexual health testing and treatment, NHS health checks and healthy child programme (5-19) were recommended to decrease their current budgets. These programmes were more or less neutral in terms of current scoring for Investment, outcomes and feasibility but were not the lowest ranked programmes in terms of future potential. It was recommended to maintain budgets across all other programmes. The range across all programmes regarding the current scoring was small with a wider range across programmes for potential scores. This indicates that most programmes differed very little in terms of their current performance but there were greater differences for individual programmes in terms of reaching their potential.

Table 15: Budget allocation decisions

Health area	Potential Score	Rank	Current score	Rank	Feasibility score	Current spend	Recommendations
Drug misuse	70.72	8	6	3	3	£4,474,000	Maintain
Alcohol misuse	74.23	5	6	3	3	£1,555,500	Transformation required
Public mental health	71.53	6	6	3	4	£726,000	Maintain
Sexual health testing and treatment	70.91	7	5.5	4	3	£3,957,000	Decrease
Sexual health- contraception and promotion/prevention	79.57	2	7	1	4	£1,344,000	Maintain
Obesity and physical activity	75.89	3	6	3	4.5	£1,487,000	Maintain
NHS health checks	65.93	10	6.5	2	3	£826,000	Decrease
Smoking and tobacco	82.03	1	5.5	4	4	£1,282,000	Maintain
Healthy child programme (0-5)	75.65	4	7	1	3.5	£7,756,000	Maintain
Healthy child programme (5-19)	70.03	9	5.5	4	3.5	£1,804,000	Decrease

Concluding Remarks

With the exception of health checks, the programmes recommended for a decrease in budget were ranked the lowest in terms of their current performance. These areas were also ranked low in terms of a lack of future potential. This would suggest that the use of the PF and the associated evidence and scoring has been a key driver in terms of the rationale for budgetary changes. Reducing budgets in areas of little potential to improve are less likely to adversely affect outcomes than areas with high potential. In the absence of information regarding the extent of these budget reductions, impact on outcomes and any reallocation to other areas, very little can be inferred regarding allocative efficiency within the LA.

Part 3: Organisational opportunities and challenges

Introduction

This part provides an analysis of the qualitative interviews across the three local authorities, with reference to the organisational opportunities and challenges from the implementation of the PF tool. Although inevitably, given the importance of local context which helped shape and determine how the PF was used, there is some analysis of each implementation site, our primary focus is on identifying common issues and concerns across all three sites. In order to capture these fully, including the nuances expressed, we have made extensive use of quotations from those we interviewed. Unless otherwise stated, the quotations used reflect the general view expressed by our interviewees.

Organisational Opportunities

Encouraging transparency over investment/disinvestment in public health spending

The overarching context in which the PF tool was adopted reflects the financial pressures on public health budgets and the need to encourage transparency over investment/disinvestment decision-making in public health spending. Such a context proved receptive to adopting the PF and exploring its potential utility and value.

I think it was seen as being a good opportunity given the pressures and the challenges around the public health budget (PH Consultant 1, Site 3)

Clearly, we are having to demonstrate, if we haven't got as much as we had, then what decision-making process are we adopting to determine, well, how best do we use the money available to us? Yes, I think it does facilitate a transparent view of how we've come to that decision. (Strategic Commissioning Manager, Site 1)

I think it gives a bit more rigour to the process, rather than just being told that's what we do, at least you can follow the trail of how those decisions have been taken...That's not to say that if I ask the questions and challenge them, they wouldn't show a transparent process that has reached the decisions for the commission now. But I have never asked that question, so it's interesting. (Councillor, Site 2)

Across all sites, respondents felt that the uncertainty around the future of ring-fenced public health budgets, which were always intended to be a short-term measure, was the main driver in the adoption of the new PF tool.

We're going through a period of change, so there's an organisational change...The future of the public health ring-fence grant, we're uncertain about that... we wanted to use a more systematic way of assessing and evaluating our priorities for both our time and our limited budget...As we move forward and we get towards the finishing of the ring-fence grant, we're very mindful that we need to future-proof what our budget looks like...I think it starts as a

financially-driven exercise; I think our situation has been a bit unique because we haven't got a pressure of a savings target, at the minute, for us... (PH Consultant/Project Lead, Site 1)

To be completely honest, I think there's a fear that once the public health ring-fence is taken off in local authorities, the funding will be spent on other areas, which may not be evidenced based public health priorities. This would be a useful shield to protect the public health spending... It all comes down to business rates and when public health will be funded out of local business rates. How much will go back to the centre and how much will come back to a local authority is the key question. (Deputy Director of PH, Site 2)

I think as we move within the local authorities and the ring fence comes off the public health grant and we move to business rates and different types of income, then tools like this will become more important as part of the spending review... to review budgets and spending and prioritisation as the grants are reduced or as the, the ring fence comes off and public health has to fight more within the local authority for its budget... (PH Lead 1, Site 2)

In keeping with the uncertainty surrounding the future of public health budgets, interviewees reflected on the potential opportunities of the PF to respond to government pressures to produce efficiency savings and the need to improve the quality of services for the local population.

Austerity, reducing budgets, makes the use of these tools even more important because as the money goes down you've got to make increasingly difficult choices. You can't do what you've done in the past when budgets were more generous, therefore something has to go. We may decide we need to do more things rather than cut things or the impact of austerity across the wider population would mean we might need to recalibrate what we do and refocus on more vulnerable populations. (PH Consultant, Site 1)

I think, obviously, the main drivers were probably a mixture of financial necessity and needing to make savings, because the Public Health grant is reducing each year, but also, the business planning process shouldn't just be about looking at the numbers, it should be about how you deliver the services as well. So, I think the drivers were probably, sort of, 50/50 really between we need to make savings and we need to make them in the best way to still deliver a good service (Senior Finance Business Partner, Site 3)

Improving collaboration and shared learning between different public health professionals

There was evidence from our observations of the workshops that the adoption of the PF tool provided a platform for greater collaboration and shared learning between different public health professionals with the potential that this offers to improve investment/disinvestment decisions in public health spending. In particular, emphasis was given to the participatory nature of the new PF tool which it was felt encouraged and enabled collective learning.

I think there's a benefit in doing it as a collective across the whole public health team and engaging with commissioning colleagues and performance colleagues and finance colleagues, partially from an initial understanding perspective so people actually understand how the grant is used and the balance across the public health grant. Some of that is simply

historical, was never necessarily based on any priorities. I think that's a benefit in terms of doing something as a collective... (Director of PH, Site 1)

It was very much geared towards a collective thinking, rather than individual. So from my perspective I came away thinking about that. Yes, it really pushed people towards more of a group collective way of thinking. (Senior PH Information Analyst, Site 2)

After all, the rating of priorities and the priorities themselves were agreed by us, so, in a way, you could see, in one sense, this being a massive exercise in groupthink, which is just worth considering. (Elected Member, Site 3)

In this context, interviewees felt that the tool could act as a mirror on, and a window into, a stakeholder's perspective, thus facilitating the nurturing of a consensus over investment/disinvestment decisions.

I think it validates, I think it informs, I think it gets us to hold a mirror up and do a bit of a sense check, but I think it also gets us to be aware of the constraints that we have as well, because the constraints are as important as the opportunities. (Senior PH Consultant/Specialist, Site 1)

As a lead for an area, you're almost a bit of an expert. I guess the assumption is that everybody else in the public health team who doesn't lead on that area also knows something about it, and I think sometimes that's a bit of an assumption. It might be different if I had done that prioritisation, so for suicide, with the suicide prevention lines, where all of the stakeholders are invested in that work and know something about it. It's not quite like that necessarily within the public health team...I think that was really helpful. (Senior PH Consultant/Specialist, Site 1)

I think to look at these areas in detail is really good and I think to compare them to how much other areas spend is really good...And, to look at that value for money is good, because it narrows their focus. Even if they haven't had personal experience of it, they now know a bit more than they did before to inform their decision making... (Senior Finance Business Partner, Site 3)

In keeping with the opportunities for collective learning, interviewees felt that the new tool provided a unique opportunity to deliver better conversations among public health teams to inform evidence-based decision-making.

It's not just about the tool, as you know, it's all about the conversations around the tool and it's all about the relationships that you build around that. There could be a danger, if you just have a training manual and a tool, it can become a very dry process...the workshops that we had with the team, from my perceptions, were quite an engaging and motivated discussion. (PH Consultant/Project Lead, Site 1)

I think we talk about prioritisation as a very black and white term but, actually, in the end, it helps people understand that it's a toolkit that helps to facilitate the discussion. The discussion, actually, I think, is more important often than the actual final output. And to

recognise that we can talk about cost effectiveness but, actually, that in itself has its limitations, that is there evidence out there on the cost effectiveness in the first place?...And so I think, in the end, it helps to facilitate that discussion, it helps to flush out the uncertainty in a lot of what we do, and maybe it helps us bring together a joint decision making process rather than just a single group on our own. (PH Consultant 1, Site 3)

So it's not just about that final output, it is about the process that we go on together, and I think that needs to be made really clear, because, if not, I think it might turn people off from doing, because they're thinking, "Actually, I've not got much flexibility, I kind of know that we're doing the right stuff and, therefore, is it really worth me doing it?" (PH Consultant 1, Site 3)

Promoting effective relationships and communications across different stakeholders

There was evidence from our observations of the workshops that the adoption of the PF tool facilitated conversations across different stakeholders. In particular, it was recognised by interviewees that the adoption of the PF tool has the potential to further improve stakeholder engagement and communications. In this regard, having representatives from different departments take part in the workshops was considered to be important.

I think we absolutely made the right decision to involve more than just the public health team; I think it was a real win bringing finance and commissioning and corporate colleagues into the room for us. Certainly, from a commissioning perspective, I think they've seen a different way that we think about managing budgets, and I think they are interested in how we could apply the tool to some other areas, say adult social care, for example, that they're currently grappling with some savings on...I've had very positive comments back. Similarly, from the public health team, previous budget savings have been done at a senior management team level; I've never been comfortable with that, so for me and my beliefs of management, doing it with an inclusive approach has had much benefit. (PH Consultant/Project Lead, Site 1)

I think what has been said is, actually, that it has helped to bring a wider discussion about the things we don't just commission. Because obviously the area I work in, where I spend a lot of my time, there aren't any commissioned services at all; I'm putting my effort, and I suppose the question is the opportunity cost of me investing my time in the programmes...so I think that's something that has been more broadly thought about around how we prioritise our wider resources, not just the services we commission ourselves. (PH Consultant 1, Site 3)

Silo working within public health teams was felt to be a real barrier to good prioritisation. In this context our respondents acknowledged that the adoption of the PF provides an opportunity to improve communications across different programme areas which was considered to be essential if public health teams are to overcome the traditional silos which often remain a feature of local government.

I think it has been a very positive process. It has helped the team to really understand different areas of public health that perhaps they didn't before because they're only focused

on their own area. I think it's helped to increase understanding from other parts of the council and I hope that we do use it to inform decisions. (Director of PH, Site 1)

I don't know, in the past, if we've been guilty of not, perhaps, collectively sitting down together and going through financial aspects, through some of the key things that this tool potentially could bring out. Because it was very challenging for people. I don't think people had been through that environment before, actually systematically going through a tool, and potentially thinking how this could affect their commissioning. So, from my perspective I thought it was a very useful overview, and introduction for some people who've possibly been used to working in perhaps their own silo, and not considering wider consequences. Because everyone's got different projects, and I think sometimes people just consider their own, and don't consider knock-on effects...it's certainly never been done before, as far as I'm aware. Don't get me wrong, most people felt like a fish out of water, but for me I could see it was challenging. But it was introducing something new, and something that possibly needed to be done. (Senior PH Information Analyst, Site 2)

It was recognised by all our interviewees that the adoption of the tool could improve understanding of public health spending and also contribute to reducing the level of protectionism across programme area budgets.

I think it's fairly timely. I would say in the past there's been an attitude, this is corporately, of working in silos. Different departments being quite precious about their own priorities and what services they commission or what services they manage and how that works... Because we're portfolio leads and we have those specific areas, you're quite protective of that area, so you would always argue the case to keep it, "This is really important because it's my area and I'm precious about it." I think that was the case with some of the other services...I think in the past we maybe wouldn't have got that. Now because everybody knows money is tight and it isn't a bottomless pit that you can keep chucking at different provision, we do need to prioritise it. I don't think it would have worked previously, but I think now it's really timely. (Portfolio lead, Site 1)

Instead of just having competing priorities, because all the things that they do are important, you can have a more logical discussion about where we're spending more or less and for what reason and what outcomes we're having and have a more informed discussion, I suppose, rather than just pinions or just looking where we spent less than we budgeted last year, for example... (Senior Finance Business Partner, Site 3)

Raising the profile of public health teams

Although respondents across all sites shared a view that public health teams had good relationships with the rest of the local authority, it was felt that the adoption of the PF tool could help to raise the profile of public health teams and also to contribute to the wider understanding of the prioritisation process across the council.

I think in public health we're not having the impact on the wider organisation to the extent that we might. Is this a way of demonstrating our approach, the rigour that we apply to evidence and how we handle uncertainty? Is it a demonstration of the capabilities and the

skillsets that public health have? I think there are enablers, there are opportunities and there are threats. With it there'll be new people coming with fresh ideas and fresh thoughts. (PH Consultant, Site 1)

We are going to present the process to a meeting of the chairs and vice-chairs of all the committees that is down for September, whether that goes well or badly is another question, they might say, "What were you wasting your time on that for, you should have been getting on with us." But it has done a bit of profile raising, I don't think we'll know until after that meeting whether it has happened or not. There are other political meetings where it is helpful to have it at your fingertips. (PH Director, Site 3)

Some interviewees supported the wider adoption of the PF across the local authority to inform budget decisions in other areas.

I think that tool should go out to other... Or that tool aid could go out to other departments within this local authority to help them prioritise on their services. I think it's great even if it just makes them sit around the table and talk ...I know for a fact that the director of public health has spoken to the chief executive and they want to tell the senior management team, put a presentation to the senior management team about this tool. (Elected Member/ Chair of the Health Committee, Site 3)

Then it's about, as we come towards the end of the ring-fence grant, the justification of what we're spending public health money on, or could this exercise from Public Health England be done against the whole council budget from a public health perspective? Because, really, is the council owning their public health responsibilities at large?... (PH Consultant/Project Lead, Site 1)

I think as a model going forward, if you want to embed it in the organisation, it's no good just embedding it in public health. It needs to be another directorate as an approach. I think social care does not have the same tradition... think a lot of the directors, particularly the one key director who is very interested in evidence and wants the evidence for it. I think that would be quite useful and it would really give value for money in terms of the tool. How realistic that is, I don't know. It might be aspirational. (PH Consultant, Site 3)

Improving elected members involvement in the prioritisation process

Interviewees acknowledged the importance of having elected members involved in the prioritisation process although in fact only one of the sites had elected members engaged from the outset when the PF was adopted. For some interviewees, elected members' buy-in could determine successful adoption of the outcome of discussions.

The decisions are made by the politicians. People pay their taxes and active members of the Cabinet sign off the contracts. So, that contract needs to have a decision record with it. The decision record would have a business case in it...In terms of who decides the balance between what you spend on one thing and the other, it's not the council officer's recommendations, it's the Cabinet, the politicians who decide what the priorities are within the council. (Deputy Director of PH, Site 2)

I think all I could say is, that having elected members on board with it, is useful because you could otherwise spend a lot of time doing the work, but someone just doesn't believe the... Yes, I think having the councillors, elected members involved was helpful... and we have a mixed council, so getting everybody on board with it, it was a useful way of doing it. (PH Consultant 2, Site 3)

Their view was that it was going to be used by officers, but her comment was, very sensibly, that, actually, in the end, although officers influence, the decisions about the spend are made by councillors. Therefore, if the councillors were not involved, there would be much less understanding of how to use the tool and what the value or otherwise of using the tool was. (Elected Member, Site 3)

The opportunity to improve the nature of conversations and discourse surrounding prioritisation was also shared among the elected members who contributed to the prioritisation process.

The discussion was fantastic, because we – being the group that we are – we went down all sorts of avenues. In fact, in the last meeting, one or two of the really technical guys from Public Health England at one time called us back, “I think we’re going off track, here.” But from that perspective, that’s what I found so useful. And we did go down a few blind alleys, long blind alleys. But I think that the group actually benefitted from that. So, I guess I would say that, “Is it the tool that’s useful, or is it each group involved in making these decisions having a structured time to discuss what their priorities are?” (Elected Member, Site 3)

Whereas in the past I think...they’ve had pretty free rein to decide how they wanted to spend their budgets and I think this will be quite a useful tool in terms of us, as politicians, now saying, “Well what might have been okay in the past, might not be alright in the future.” This will be a good tool for them to use to prove to us that they’ve gone through a structured process and come up with- rather than just going on pet projects. (Councillor, Site 2)

Providing a framework for evidence-based decision making

Across all three sites there was recognition of the need for a system-wide approach to priority setting. In this context, it was recognised among those interviewed that the adoption of the PF tool provided a systematic framework to structure and guide prioritisation decisions.

At least we’ve gone through a systematic process. We’ve taken into consideration a range of factors and come to a consensus across the team that this particular programme does not represent good value or shouldn’t be a priority over and above other things that we would want to focus on. There may be some potential conflict there. It’s then how we use the tool to convince others that we know our business and this is a way of capturing it. (PH Consultant, Site 1)

I think it gives a structure to be able to talk around. So, rather than just having a conversation that’s quite open and it’s, “How are we going to make savings? Where are we going to spend less money?” I think it focuses in on particular areas and gives a framework

to be able to say, "Well, actually, if we compare to other areas, this area looks like this, whereas this area looks like that." ... (Senior Finance Business Partner, Site 3)

I think, benefits as I say, it's got a structured approach. And when you look at it and when we read the briefing document to start with, you think it gives you that sort of objectivity that you're picking some criteria and going through that process... So it's actually going through that process trying to take some of the subjectivity out of that prioritisation process... (PH Lead, Site 2)

Across all three sites interviewees highlighted the important role of using evidence in prioritisation decision-making, in particular in cases where decision-making was based on anecdote and opinions.

I think that the tool provides an opportunity to try and do that in a more systematic way, which will also provide an evidence-base, rather than just say, "Well we thought this was important," or, "We thought that was important." I suppose it's an attempt to try and quantify the levels of priority that each of those areas are given, and that's really important in the time of reduced resources. It'll be quite interesting to see how it's regarded here in the local authority because I think, in the local authority, quite often they make decisions on the basis of something sounds good, rather than having the evidence base behind it... Yes, there are political pressures. (PH Consultant, Site 1)

I think it did open the eyes of some of the councillors in terms of instead of using their own opinions or their own observations that might not have been on a wide scale and may be narrow observations. I think it did help them to look at the wider view and not necessarily their own personal views. Because, we do get quite a lot of that in the Health Committee actually...so I think to look at these areas in detail is really good and I think to compare them to how much other areas spend is really good... even if they haven't had personal experience of it, they now know a bit more than they did before to inform their decision making. (Senior Finance Business Partner, Site 3)

Well that's what I meant about the inherent tension. It's like the health committee chair has a great fondness for the health check programme because he had one of his own and it changed his life. We were throwing back the evidence, which is still good, it's improving and it scored very low. There are those types of things where it might have helped him personally but if you're thinking about the population health then I think it's making that shift. It's the shift from their local population. (PH Consultant, Site 3)

Our respondents stressed the important role of drawing upon evidence-informed policy and expert involvement (including elected members) to ensure that effective decisions are made for local populations.

The benefit, I think, for our team was that as individual team members we had a lot of the evidence base and the health economic evidence base, and the outcomes and delivery we were getting, we had that in individual heads, but the exercise forced us to get that down on paper and take an overview of what we were doing...I can now speak very confidently in a sense about what we are doing on the basis of the evidence that we amassed. Whereas before

it was more we've been doing this a long time and we've got all sorts of evidence accumulated in our heads, but we haven't got this clear structure. A second thing that was very positive is that by going through the process we shared much more of that structure with each other to some extent, but also with our elected members. Although the elected member didn't take part in all of it, it was a very good development exercise at getting the officers and the elected members on a similar page. It was very constructive in that way... (PH Director, Site 3)

There's certainly objective health economic evidence...a contribution to the decision making process and a contribution that offers an objective degree of decision making. So, for example, in xxx, there was some debate about...decision making on spending of the public health grant...One comment from a councillor was that there was no evidence base behind the decisions that were made. (Director of PH, Site 2)

So, from a commissioning perspective...I think the tool has provided an opportunity for the programme leads to go back and actually have that refresh, with the evidence base. Not that they're not doing it, but it's put it in a bit more of a context and framework, to enable them to do that in a very consistent, logical way. Much of the evidence was obviously already known by them, and then we've got to bring in the fact that we've got local context that has to be fed into that as well. But I think it was a very logical tool, and it made sense... (Head of PH Business Programmes, Site 3)

Reflecting on the growing financial pressures to which all local authorities have been subjected since 2010, it was felt that evidence-informed action could help public health teams to protect particular programme areas.

It might help reinforce, ensure, that if pressure is put to make even greater cuts that, actually, say, "Well no, these are important programmes." So in that sense it might provide more evidence and support...To make sure we're still- to validate what we are already doing and to show that, actually, we're not just doing what we fancy doing, there is a clear rationale behind why we do these things. As I say, I think- so that might be important in itself, to support that process. (PH Consultant 1, Site 3)

In this context, interviewees pointed to the benefits of having a national tool to inform prioritisation decision-making and thereby promote an objective rationality over investment/disinvestment decisions.

I think having a consistent framework that is potentially then comparable for other areas is really helpful. Having the opportunity to use a national tool, but also a tool that's got all of the process in one place and option to collate all of our evidence in one data set is really valuable for us. Just the quite linear and structured format of the tool, as well, walks us through the process, so they were all some of the key benefits. (PH Consultant/Project Lead, Site 1)

Well, locally, using the tool helps to ensure that there is some degree of more objective rationality to the background to making funding choices and changes in the way things are funded. Nationally, I mean, it's the same. It's putting a degree of rationality on... Especially

given that public health budgets are being squeezed ... Well, there isn't really an existing tool to do that, because it tends to be done more in an informal way, more based on political choices... (Director of PH, Site 2)

I think people might suddenly jump on this sort of thing because they'll say, "It's come from Public Health England, so it's got that national stamp to it and other areas are doing it." It's almost like an approved way of doing something. Something that's got some rigour and structure to it rather than just a local process which may or may not be discounted by the past. (PH Lead, Site 2)

Organisational challenges

Introduction

This section provides an analysis of the qualitative interviews across the three local authorities, with reference to the organisational challenges arising from the implementation of the PF tool. In discussions about the organisational and political context of priority-setting a number of issues were raised in connection with the barriers to the uptake of the PF tool.

Uncertainty around the future of PH budget (ring-fenced grant)

From a policy perspective one of the main barriers was thought to be the uncertainty over the future of the ring-fenced public health budget.

We're going through this quite complex process while people are thinking about their future and where they might be. They're talking about priorities, but in the back of their mind is, "Will I have a job? Is this my job we're talking about?" It's not been a barrier, but it concentrates the mind a bit if you're talking about what the future direction or what the options are when you don't know whether you've got a job to pay your mortgage at the end of that process. It's part of a moving conversation about where public health is going... (PH Consultant, Site 1)

I suppose one of the other key things that we are aware of, being in the climate we've been in, of reduction on reduction on reduction, and the coming of business rates, it was looked at suspiciously to start with. What was it going to be used for? Yes, there was certainly an element of suspicion there. Rightly so, to be honest, because your timing for it isn't the best in the world. And that's human nature. Let's be honest. (Development and Implementation Lead, Site 2)

Given the context you could understand there were people who were a bit suspicious and a bit cautious about it... Because jobs, money, future, was this just another back door way of getting rid of people? People will assume the worst... (PH Consultant, Site 1)

Across all three sites our respondents felt that political pressures to achieve efficiency savings can hinder the adoption of the new PF tool. It was acknowledged that policy changes are frequent and often make it difficult to maintain progress.

The continuous squeeze has meant a lot of change. If anything, it would be change exhaustion. You get to a point where people say, "I've had enough." Again, I suppose you might say it's how it's introduced. That relates to the flexibility and the ease and the time effective of the tool. It's quite important because there has been so much change, "This is another new thing." "We want you to spend x number of days on doing it." It's not fundamental I think... (PH Consultant, Site 3)

The speed at which integrated commissioning is moving at now is absolutely... I can't even keep on top of it, and I've been on top of it for eight years. The integration agenda alone, health and social care, they're very, very different beasts to start with, and they come with very different agendas. So whilst the tool may say that, "Service A is the best option," you've got the politics behind that, with, "Okay, that might be as a stand-alone service great. Does it actually fit with everybody else's agenda and politics as well?" If you've got health saying, "We want this," and, "We want to do that," and, "We want to do the other," actually we can't stand alone anymore, because we fall flat on our face. We've got to be able to accommodate each other. And it would work exactly the opposite. If we were to turn around and say, "A does that, according to our tool. Health, you've got to do this," It's not going to happen. That's the reality of it. (Development and Implementation Lead, Site 2)

I will be really interested to see what happens with it and whether there are barriers to the implementation of it because of the political pressures, but also the pressures between the different directors and nobody wants to see their area of work reduced... (PH Consultant, Site 1)

All respondents stressed the difficulty in setting priorities for allocating a limited pool of resources. For some participants limited available resources could hinder the adoption of the PF.

I mean, these cuts have been going on for several years, as you know. What happened in the first waves of them is that you cut all the fat there was. There isn't any fat left now. People are cutting down to the bone. So, in that situation, saying, "Well, we might save £30,000 here, £100,000 there and so on," is welcome, but it's not really going to solve the problem. I'm not sure that the tool itself is going to help the officers and the councillors to think any more intelligently or even any more effectively about what to cut. (Elected Member, Site 3)

The fundamental problem with the tool for me is that because we're second lowest funded in the country, we're good value in everything... So, it's shifting around tiny amounts. Also, the budget is declining and we've got big cuts coming in...So, it's naive to say you can move money in the year, you've got to wait until the end of the contract. (Deputy Director of PH, Site 2)

There are a few things around the implementation here, but I think one of the most important ones is that we don't have much money anyway. So, we've got the second lowest per capita public health grant allocation in the country here. So, a lot of the things that we've done have been based on driving out efficiency and doing things as efficiently and effectively as we can. So, having done that, that reduces the scope then of the utility of the tool to find that out... (Director of PH, Site 2)

The political context of local government

The political element of decision-making in the local authority setting was raised by some interviewees in relation to the use of formal prioritisation tools. In particular, respondents highlighted the political context in which prioritisation occurs (i.e. local government) which, in their opinion, could hinder the adoption of the PF tool.

There's also the issue of political preference as well because, in a way, we're a political organisation, with a small 'p', and politicians don't always make decisions based on evidence, either locally or regionally, and nationally they make decisions based on their own preferences and their own views and what, sometimes, their constituents want in certain communities...we know that all the time, that's not to do with evidence or necessarily effectiveness. So I think that's an issue. (Senior PH Consultant/Specialist, Site 1)

I think from a political perspective, there will always be a political element that will need to be overlaying with any prioritisation process in terms of what's important politically. How do you balance that with what's come out of the tool? (Director of PH, Site 1)

The political context could say that we're going to do something anyway, regardless of you using your tool, but we're going to ignore the results. That could be the wider council political environment...My only worry is, will they get listened to at the end? What influence will they actually have? Will the powers that be just do something else anyway? (Senior PH Information Analyst, Site 2)

I think if you were working in a non-political environment, you would be very much focusing on what evidence we have in terms of effectiveness, in terms of cost benefits and so on. In a political environment, I think one of the challenges has been, since working with a local authority, is to work with members, for them to take these factors into consideration. I think probably you can be rather more focused on your constituency and constituents as an elected member. I think there is an inherent tension in this type of approach...at the end of the day, perhaps the outcome of that consideration might not reflect a local politician's main interest or the interest of his or her constituents. (PH Consultant, Site 3)

I think as well, it might be that the figures and the scores and the comparisons might tell us one thing, but politically it might still not be a popular decision to make. That could be a barrier in that, okay, this is what the data is telling us but actually, politically, you know, we're not going to get good publicity if we take money from that area there. There might still be a conflict between those ideas... (Senior Finance Business Partner, Site 3)

In this context, some respondents highlighted the key part played by local government culture and the potential resistance to change.

I don't know whether it will, because that depends on the political pressures that come about, or individual... So, on the one hand, there's the political system but then there's also, within the council, the different territories, different powerbases within the council. So although we might say, "We think we should disinvest in this piece of work aimed at children," it may well be that councillors object to that, but it may also be that the Director of Children's Services objects to that as well. So I don't know how it will pan out...I think there are dangers of some of the recommendations being changed, or people saying, "No, we're not going to do that." (PH Consultant, Site 1)

It's quite traditional...I think it's about managing confrontation, potentially because to change or make radical change to things, people don't necessarily like change particularly if it involves a change to what they've established, their role and what they do and how things are done... (PH Lead, Site 2)

I really like the idea of trying to find health economic tools that can work in local authority. It needs some anthropology. You need to go around being a local authority and suppose that's what you're doing, to see how the power dynamics work, how decisions are made and how multi-decision analysis is done in planning meetings, in Cabinet meetings. It's that the dynamics of the individuals and the context differs so much (Deputy Director of PH, Site 2)

Limited time and resources

Across all three sites it was acknowledged that adopting the PF tool requires a significant investment of time and commitment from public health teams. There was a common perception that the limited time and resources available to public health teams could hinder the adoption of the tool.

I think, if people haven't been used to using quite a rigorous and time-consuming approach, there's a certain amount of work that needs to be done to explain and prepare people so they know, a, why it's being done, some of the benefits of doing the new tool but also some of the limitations as well, so I think people clearly need to be briefed. I think time was critical, I felt quite rushed, in some respects, with the time; we're a very, very busy department, we've got lots of priorities... I think if we're going to do it, you have to allow enough planning time, enough time for people to be able to provide a good level of information. I think several of us felt just a bit rushed by it, we were kind of cramming it in and I think, if it's going to be valuable, valued, people have to have a bit of time to do it. I think that was a particular issue. (PH Consultant/Project Lead, Site 1)

Again, it was quite resource heavy, in terms of the workload you've got on with this on top of it, and if you can't make all of them, and suddenly you miss a bit of it, where are you? Does that mean that that service is less tangible a benefit? I don't know. (Development and Implementation Lead, Site 2)

It's just the amount of time it takes and the number of sessions it needs to pull everybody to get in to do it, and it's one of these things, again, it's about investing in time to do that. So I think an organisation has to be invested in doing this to take it forward. So that's always a balance, about the quality of what comes out of it; as I say, you could do it very quickly

sitting at a desk on your own, but necessarily the quality of the output wouldn't be very good. So it's a trade-off, I think... (PH Consultant 1, Site 3)

Realistic timescales, I think the first session we maybe only had half a day booked in. It was quite obvious after the first 10 minutes that it was going to take a lot longer than that, so that would have been good. They were the only issues really. (Portfolio lead, Site 1)

Apart from time and resources issues, limited capacity among public health teams was thought to be a major barrier to the effective adoption of the PF.

There are several issues about doing it: I think we're a small department, we've only got 18 people as a whole, within the Public Health Team. I think that capacity is one issue, and I think had we had more capacity it might've been easier to do it. Because, the way that the tool is designed is you get somebody at a fairly senior level, sort of a consultant level, to be able to deliver... To be in charge of running the tool, and chasing people up, and doing their things. So, we haven't got the capacity for that... So, I think if we'd had more capacity there would've been more time for briefing, more time for understanding. Well, we were never going to do that anyway. We'd never have that capacity (Director of PH, Site 2)

I think the way the tool was advertised initially didn't quite take into consideration the amount of time that some of the leads needed to put in to ensure that the evidence was gathered and populated it in the right way to then actually be able to be evaluated by other members within the team...I had four topic areas that were selected as part of the tool, so it was quite intense trying to ensure that you gathered all of the information for each of those different topic areas where some other colleagues only maybe had one topic area or didn't have any topic areas included. (PH Lead 1, Site 2)

It was acknowledged that most of the respondents who had attended the workshops did so on top of their day jobs which again was felt to pose a potential barrier in getting 'buy-in' to the process.

We've got a relatively small range of services compared to some of the big budgets, and we found it quite difficult to get all that together in the timeframe...Well, yes, because you're trying to do this on top of your jobs. Do you have a set number of hours for budget setting? No, you don't. It goes in and around what you're already doing. So you're trying to do your job, and set the budgets, and all the rest of it. I suppose that's one of the reasons that they're happier to leave it to other people to do, but if you're going to have the involvement of the people doing it then you've got to give them the time to do it. Otherwise it will get rushed, and it will be inaccurate, and it will be useless. (Development and Implementation Lead, Site 2)

Certainly it needed that time invested to make that tool work, and I think some people would find that their time was perhaps interrupted. They could have been doing something else that they were more comfortable with, and perhaps they felt pressurised into utilising this tool, when they didn't really understand it, and they didn't want to do it anyway. (Senior PH Information Analyst, Site 2)

Challenges in getting the right people together at the same time

Across all three sites, there was much praise for the very high levels of participation shown by public health teams in regard to working with the PF. However, despite there being a lot of committed people within each site, interviewees noted that not all key corporate stakeholders – senior management – had fully signed up to engage with the new tool.

I would like to see a wider awareness, from corporate level of the work that we were doing. Organisational as a whole, because it's a very positive approach to be able to stand up in front of the elected members of the public to say we've gone through an auditable process here to make a rational decision based on the best available information to hand, and I think we've perhaps missed a bit of a sales opportunity there. (PH Consultant/Project Lead, Site 1)

I queried whether the process had been as inclusive as it perhaps could have been...In terms of whether we should have had strategic representation from children's services, adult services, colleagues and, potentially, education, housing (Strategic Commissioning Manager, Site 1)

I don't think we have probably kept our senior management teams, perhaps, as up to date with this as what we could have done. As we've done the process, we perhaps could have been taking things into our management teams...Perhaps, on reflection, we could have just kept keeping people up to date, which might have been a little bit better, so it's not coming too much as a whole shock for them. Even if they've had members or their teams there, the more senior staff probably haven't recognised that it's taking place. (Director of PH, Site 1)

I think it would have been good to involve more of the team even though perhaps most of commissioning sits with me...I think I would have made sure that more consultants were there because I think it builds that kind of culture of working with members because they all have to work with members... (PH Consultant, Site 3)

For some respondents uneven attendance at workshops could hinder the wider ownership and therefore successful adoption of the new tool.

The downside is the team that started the process isn't the team that's going to complete the process. We don't have the luxury of doing it sequentially, so we've got to make the best we can. (PH Consultant, Site 1)

Also, participation started to dwindle towards the end. People had to go and had other priorities, so you would question whether we were as rigorous with the final few... yes, as we were at the beginning of the process. Obviously, mental/physical fatigue was setting in as well, so you could question, were people less inclined to want to challenge and discuss and debate towards the end of the process? Something about breaking that up more. (Strategic Commissioning Manager, Site 1)

People dip in and dip out. Also, because of time pressures, I think, not everybody was able to attend all the workshops. So you don't get that stage of seeing the process through, either. That means you're trying to catch up because you missed what was said last time. (PH Lead, Site 2)

Similarly, respondents noted that not all elected members had fully signed up to engage with the new tool. In discussions about the workshops, some issues were raised in connection with elected members' involvement during the prioritisation process.

It is that debate about weighting various areas. As I say, that's where I think it will be interesting to be more involved in the future, maybe at the theoretical stage rather than perhaps just- because most of our work programmes and health and wellbeing strategies are done through quite intensive workshops. We bring everybody around and I think this will be useful to have a similar input from an elected members perspective into some of that balancing of- or bringing in a wider team of people to be involved in the weighting. (Elected Member, Site 2)

I think the challenges for us, because we opted for a model that would include the members, was to ensure that the members were engaged throughout the whole process. So, we had quite a high turnout for the introduction workshop, but then we tended to get kind of drop-off attendance. The last workshop...attendance had come up again, but it wasn't necessarily consistent. So, some of those members that were at that meeting, hadn't done the first workshop...and that is the problem I think, when you're working with elected members, is that you are very much driven by their availability... So, if you bear in mind we've probably only had about 50% of the committee's attendance at these workshops. So, we've still got a bit of learning. So, we have to do a bit of catch up with the 50% that weren't there, so... (Head of PH Business Programmes, Site 3)

I think it would be nice to have slightly more councillors, because there were, sort of, three-ish...Yes, a few more maybe and maybe get the dates set out in advance, so that people could commit to coming to all of them. So, some of the councillors only came to some of the sessions. (Senior Finance Business Partner, Site 3)

Across all sites, patient and public involvement was considered integral to the prioritisation process. However, some respondents reflected on the lack of such engagement in the adoption of the PF tool. In particular, the need for improving public and patient involvement in priority setting was noted among the interviewees.

There is also the question of the public and whether the public may have a view on the prioritisation of funding against certain objectives and are we technically making the decision on their behalf as well? Perhaps there's something that needs to run parallel with the public in terms of where they feel money should be prioritised in relation to public health. (Strategic Commissioning Manager, Site 1)

I'll tell you one of the things that really caused a lot of debate – and that was acceptability. We had lots of debate about, “What might be acceptable to the public, quite often, flies in the face of what is really important.” And, how we would manage that. So, sometimes, would we suffer temporary unpopularity in order to do what was right? So, there was a lot of that sort of debate. It was very good debate. (Elected Member, Site 3)

You have got then public itself. We have brought in, for example, a new service which is supposed to respond, or to help us to respond better, to what public wants. Now, if that's the case then actually you've got the public setting, or to a degree setting, an agenda, not a tool. Because the tool is designed purely around finance and benefits and impact on the population. It doesn't take into account, "Actually, what do the people on the ground want?" We're setting a priority trying to use what I class as a systematic approach, but systematic approaches do not necessarily reflect what a community wants itself...I think that's probably one of its shortfalls. Right across the country we're looking at social prescribing asset based community development, and this tool doesn't actually allow for any of that....It's very scientific, in that, "That's what it costs. That's what the impact is. That's the price per person. That's the price. That's the overall outcomes." Not, "What does that community want to happen in its community?" (Development and Implementation Lead, Site 2)

Availability and acknowledgement of multiple forms of evidence

Interviewees acknowledged that any decision should be informed by a variety of different evidence sources to ensure that effective decisions are made for local populations. However, there was a general perception that limited availability of information and evidence in some areas could hinder the adoption of the tool.

The other thing that I think is that, because there is more of a history of working in some areas and more of an evidence base of working in some areas, that those things are advantaged...I think it's much harder to make a case whereas, of course, if somebody comes, and there was a bit of that going on, I think people come with sack loads of evidence and put it on the table and everyone goes, "It must be a five," or whatever, you know, whereas if somebody comes with a small green chute...there isn't so much gravitas to that work... Yes, it is difficult because if there's NICE guidance and there's this and there's that, somehow has a more weighted evidence than the fact that I've been working with this particular community and they've told me these things. And I can understand that there are objectives and subjectives and there is a hierarchy to the evidence base, but I think sometimes that can get in the way of a more community-based approach. (PH Consultant, Site 1)

I think, because the evidence for a lot of public health intervention is not, so for example, the treatment services, there is good evidence. Alcohol and drug treatment services, there is the more preventative stuff, for example. The children's work, like health visiting and school nursing, the evidence base on actual cost-effectiveness is not there. I think because the different service areas, the level of evidence, is not comparable. For some things like smoking and alcohol, you have a very good level of evidence. For some of the more preventative, more complex areas, the evidence just isn't there and that doesn't mean that they're not good. They get skewed and they get ranked lower. In terms of if you look at the economic evidence...for some of the cost-effectiveness there isn't the cost-effectiveness evidence, to the high level that it is there for simple things, like smoking cessation. Straightforward interventions, I think, the evidence was good and it was easier to do. Some of the more preventive stuff, there is only advise...Again, we were not comparing like-for-like...I think that is the problem, that a lot of public health evidence it is strong for the individual treatments and drug treatments, but much weaker for the more wider, more complex public health problems. (PH Consultant 2, Site 3)

I mean, one of the fascinating things for me that it threw up was that where you'd got long-established programmes – and this is the upside and downside of the evidence, really – where you've got a very, very strong evidence base for what works, then you can be confident. Where you've got a relatively poor evidence base, you can't be confident. Actually, neither of those things necessarily relate to the scale of the public health problem... On the other hand, what it mustn't mean is that because the evidence base is not very strong, we shouldn't be doing things. (Elected Member, Site 3)

One of the problems we had in the process was that we didn't have cost benefit evidence for a lot of the areas which we looked at in terms of the programmes that we currently commission... Like PHE did a lot of the evidence review and it was quite difficult to find some of it. I think we're still stymied a bit because of that gap. (PH Consultant, Site 3)

In this context, respondents acknowledged that a lack of national indicators in certain areas of public health could be a barrier to the effective adoption of the tool.

It's a way of comparing national spend against our spend... well the problem with that for suicide is there is no national spend profile, so you can't- there is for things like obesity and weight management services and stop smoking. So if I'm the person who's leading the tobacco control work, it's easier for me, then, to look at what the spend is and the outcomes compared to what the spend in Hertfordshire is and outcomes. But you can't do that for suicide and you can't do that for mental health because it's not available. So it falls down a little bit in that regard because, basically, you're being asked to effectively demonstrate spend and outcomes where, actually, that data isn't available... (Senior PH Consultant/Specialist, Site 1)

If you were to use the national evidence, which is what they use, it throws this all out, because we know that some of those national databases are not as good as they ought to be. And they are measuring different things. So now you're comparing apples with pears.... There's one particular service I can think of that we would have done it that way. We would have certainly looked at it, and the evidence delivered would not have been as robust as some of the other services. Because the evidence sources are different. It's measuring different things. It's done for different things. (Development and Implementation Lead, Site 2)

Some respondents expressed concern over the lack of qualitative evidence to inform prioritisation decision-making.

People do focus more on numerical data collection rather than qualitative information that you get from actual people... I collect a lot of information on case studies, so I get a lot of case study information about particular families who have been through a process. Then when we're using the tool, you can't really bring that in, there's nowhere that can come in... I think any kinds of social areas like that it would be the same issue. It's almost like the clinical services have a really stringent data collection, so that is much stronger. Whereas the social types of things, like domestic abuse and potentially mental health, there's not as much data collection. (Portfolio lead, Site 1)

I think that some people didn't essentially buy into it, but maybe because of those reasons, and wanting a more rounded sort of... I mean, we've got some people with qualitative research backgrounds who feel that they want a bit more of a nuanced approach to things, taking a whole variety of different views into account in a different methodological way... (Director of PH, Site 2)

The vast majority of commissioning decisions, budget setting decisions are based on what we would class as hard evidence. The quantitative stuff. Qualitative stuff, when it comes to bean counters and playing with money, they're not really that happy to use that. (Development and Implementation Lead, Site 2)

What counts as evidence from a local government perspective was also an area of concern expressed by some of the interviewees.

I guess my other thought about the evidence is, what evidence counts? What do we count as being good evidence? And I think a lot of it was cramming stuff, as much in as possible from lots of different sources. It might have been better just to say, look, it's got to be NICE evidence or it's got to be NICE guidance and it has to be limited and there have to be some criteria around that. Because I certainly found it difficult, looking at some people's templates, to determine whether the evidence was robust and rigorous and whether it was actually the right sort of... Do you see what I'm getting at?...So my thing was, well it might have been better to say, "Look, we accept national guidance, so if we've got NICE guidance on us, we've got Public Health England guidance on it, that's a good start so we should look at the policy and guidance on it." Because that is as important as evidence because sometimes we have to do it, but we should also have some kind of criteria for what it is we'll accept because, in a way, if we're making an argument that we should support that programme because there's this bunch of evidence, is that evidence good enough? Is it the right evidence? So I did struggle a little bit with that, I've got to be honest. (PH Consultant/Project Lead, Site 1)

It's a business case. It's like 'Dragon's Den', but lots of different ones. You're selling the stuff. The tool could be useful in that context, but not so much. It has to be trusted because people will just pull a thread. They'll say, "Well, where do you get the evidence for that? That's three years old and it doesn't apply in our area." They don't want to accept it... You have to take all the tools you've got, and reliant upon a centralised, evidence-based EBM stuff that worked in the NHS. It doesn't apply in local authorities. They see evidence, but the word 'evidence' is very different. Evidence in a council is what we did last week. The number of bins we emptied, the number of people who were admitted to a care home. That's their evidence, not relative risk, or obs ratios on a potential study of RCT. (Deputy Director of PH, Site 2)

Some respondents highlighted the important role of local knowledge/evidence for prioritisation decision making.

I think you can look at evidence because it's, a lot of the time, based in academia. Actually, when you're working at the coalface, does it really work or not? Is that the best that you can make it?...It's that one size doesn't fit all... I suppose it's the knowledge base and experience of knowing what works and what doesn't, so it can't just be as raw as saying, "Oh, the NICE

guidance says we've got to do X, Y and Z," because it's never as simple as that when you look at how you configure it at a local level... And the different needs and what structures you have around you, what's happening in children's services, what's happening in adult services, what the CCG are willing to pay for or not, as the case may be...It isn't until you have that knowledge base, that depth of knowledge, that you can then say, "Actually, on this paper exercise, we're doing X, Y and Z, but I know, actually, we also need to throw in A, B and C." (PH Portfolio Lead, Site 1)

So that did become a bit of an issue when you couldn't find or when there isn't national indicators or evidence around that. Obviously, we have service indicators and we work locally so within our areas that we commission, we can use our own key performance indicators or reports from service providers to inform the evidence as to what's happening locally here on the ground...I think some of the national indicators, the problem with those is the time that they're usually a couple of years behind by the time all the data's got collected and put together where, locally, you can have much more up to date information from your services that you can put into the tool. (PH Lead 1, Site 2)

As I say, as an indicator and I mean a very rough indicator, yes, probably useful. But why would you want to go to all that trouble if you've got these five or six people that have got a good idea of the area, the knowledge, the local on the ground? Why would you go through that process just for the sake of going through it? It would have to be very, very accurate. (Development and Implementation Lead, Site 2)

Others expressed a more pragmatic view when it came to using evidence to inform priority setting.

I think the key one is about the priority setting and how you evidence it. I think that needs to be tied down tighter, because again the person with the loudest voice will often win out on that one, even though their evidence may not be as good as some of the other services... We're an organisation. We're not all at the same level. We don't all get the same budget. We don't all use the same systems. It's the inequalities of the human race, unfortunately, and you can't change that I'm afraid. Well, if you could I would like to see how you come up with the answer for it, but I don't think you can. (Development and Implementation Lead, Site 2)

Reflecting back, I think when I look at certainly my team and the personalities of my team involved, it does lead me to think that sometimes potentially the process might be influenced around personalities. Actually, you get some very persuasive personalities who are very eloquent and able to express themselves and communicate at a high level, pack a load of information in and say, "This is where we need to put our funding." Whereas, you might get more potentially introvert characters within your team that actually can't articulate as well. Does it mean that that service area doesn't have as much, I suppose, value given on it because people don't think that's it's been sold enough. (PH Portfolio Lead, Site 1)

I almost say in naivety with the tool, in local government it is a political environment. Things change and you have to be able to react to those opportunities. Having a linear, positive approach to, "Here is the evidence base, this is best practices, there's a good ROI and I'm sure that committee will accept it," isn't the way it works. The vested interests between different groups, there are long term contracts that people are already in. There's even

competition between directorates. So, just having a simple, “This is the evidence base, this works, you are in the top or bottom quartile,” influences debate a bit, but it’s not often the key factor. The key factor is often the influencing skills you’ve got, to shape what that budget will be. At a time where a lot of local authorities are massively cutting their spending power, 50%, 60% reduction, there are a lot of people arguing for their areas. Public health need to be aware of that and be in the trenches with the people, showing where you can make differences. (Deputy Director of PH, Site 2)

Tension between national evidence vs local needs

A number of interviewees pointed to the benefits of being able to draw upon the support of PHE regional teams but there was evidence of a tension between national pressures on the one hand and the need to maintain locally driven change on the other.

I mean obviously we have to abide by national guidelines, national standards and things within any of the services that we commission, but then we need to have the case that the need is here within the xxx and that we’re appropriately meeting the needs of the residents within the xxx... (PH Lead 1, Site 2)

One of the challenges there is obviously those agendas are very different dependant on demographics, geographics, infrastructure, deprivation levels. There’s a whole host of things that affect each of those individual groups, community groups that are saying, “We want this, and this is why.” Those are actually barriers to us, because it’s not a one size fits all, which this tool really is. It’s assuming that everybody within a given population are pretty damn similar, and we’re going to come up with one idea that fits them all, or one service that would do all of this. And it doesn’t. (Development and Implementation Lead, Site 2)

In terms of the modelling, of the impact. You’d say, “What would be the return investment of this versus that?” I think quite a bit of it is dependent on assumptions about... You know, the effectiveness in the laboratory is very different from the effectiveness in xxx... That variation needs to be built in as well... We have very isolated rural villages with all the issues around rurality, around transport and access, and all the little cultures that go on. A scheme that would work in the centralised city would not work in a rural area. So, you have to tailor it, cut the cloth to fit the shape. Ours is very different... (Deputy Director of PH, Site 2)

In particular, interviewees felt that an emphasis on national mandatory services and contracts could hinder the adoption of the PF tool.

There are mandated services, statutory responsibilities that public health have, things the government have put into statute legal responsibilities. From a public health point of view we may not necessarily agree with that. In our assessment we may rank things much lower on the basis of evidence, health impact and equalities, other criteria. There may be a mismatch between what the government believes we must do and what we believe we should do... One of the areas I’m particularly involved in where I think we should rank very low... we can’t avoid it and we can’t ignore it. I think the process we followed through this tool will put a figure on that and rank it against everything else we should be doing, but it’s a statutory responsibility. Whether anybody would sanction us if we just gave it far less priority, who knows? (PH Consultant, Site 1)

What seemed to make quite a swing in some areas and not others is the mandated function as well. I think some areas had that it was mandatory that the council actually provide this service. For my drug and alcohol service, it's not completely mandated. It's partly mandated... There is a list that public health have to deliver, but there's also so many other things that we don't. It's about some of that clarity on almost the justification of why some things are on one list and not on the other. (PH Portfolio Lead, Site 1)

The tool is quite restrictive and it's just picking what's within the public health budget, and what's within the mandatory services. I think the mandatory services were set, purely because the Government thought local government wouldn't fund them. So, health checks which I'm still quite dubious about in terms of its qualities, isn't what I would have prioritised. Certainly, measuring children, their weight and height is okay, but you've got to do something about it. Just shifting resources around, and what I see as potentially an old medical model, is missing the opportunities you've got in the local authority. (Deputy Director of PH, Site 2)

Stakeholder acceptability

Some of our respondents felt that the tool was too linear, mechanistic and deterministic in its design and thus risked failing to address the dynamic, complex and multifaceted nature of the prioritisation process.

I also think the thing that we've always got to be careful of in public health is not being labelled as being too academic and too technical and we do, to a certain extent, get a little bit of that label in local government. So I think those are some of the barriers and I think, for lots of people, they might find it just a bit too technical and a bit too long-winded. (Senior PH Consultant/Specialist, Site 1)

I think some people didn't buy into the model on academic or philosophical grounds. The principles, seeing the model as too positivist, and as being a mechanistic way to determine prioritisation which maybe didn't take enough other factors into account. (Director of PH, Site 2)

It's the idea that if you had an ultimately evidence-based rational tool, then you'd solve the problem. I don't know whether PHE is really... I mean, has it really got to grips with the implications of public health being in local authorities? I'm not sure even now it has, actually. I do have a little feeling that, with the tool, you sense that, "Here is a technical solution which, in a way, we can then template across England and, therefore, make sure that people are doing similar sorts of things." There's a sense in which it could be seen as a kind of rationality or rationalisation tool, because what you can then do, you see, is start to say, "We've got to look at things like cost-effectiveness and value for money from local authority to local authority." That way lies a potential for centralised rationality, which is, I think, quite dangerous. I worry about it, I suppose, in a way. (Elected Member, Site 3)

In particular, some respondents felt that the tool was too rigid and inflexible which could hinder its wider adoption.

I wouldn't, no. I would want to use it if it was more refined, so people could use it as adaptable to... It needs to be like a Swiss knife, rather than a saw. It needs to be able to just pull the bits out... (Deputy Director of PH, Site 2)

At the moment I don't see a main driver as such, other than an indicator... My view is, to be quite honest, having looked at the flexibilities within it, it is very, very limited in its flexibility. It isn't able to quickly allow you to adapt to an ever-changing environment, which is what we're operating in at the moment... internally it doesn't allow the flexibility of the wider organisational agendas, because they're not always, shall we say, as open as you might think. (Development and Implementation Lead, Site 2)

Others felt that the tool risked resulting in a silo-based approach to prioritisation.

Public health is actually part of the council, and the council have responsibilities not only for public health but for social care. Again, it's trying to separate them out, when in actual fact what we're all trying to do is integrate them closer. Which seems to be totally the opposite direction to what everybody else is going in. What we're saying is, "It's stand-alone." It's not stand-alone. If it doesn't work with social care, and it doesn't work with the wider health environment now, it doesn't work. (Development and Implementation Lead, Site 2)

We've worked really hard over the last sort of four or five years to ensure that we integrate a number of our contracts so it becomes difficult to pick out which budget covers which bit, so when you're talking about children and young people's, but you're then talking about obesity at the same time, actually a lot of the work that happens in children and young people's, affects some of the obesity budget at the same time. So although we have set amounts that you clear, "You spend this on that," we've worked really hard to integrate them, so it becomes that competition of defending your budget. You don't want your budget to be reduced, but then in line with that, locally, I don't want, say, the young people's budget to be reduced because then that will have a knock-on effect to my obesity budget. I think it removes one barrier but then almost puts it in another one, if you can see. So it's removing some of that competition around protecting it, but then you're putting in another barrier that you have to almost separate out all the different work that you do where you've worked really hard to integrate it together. (PH Lead 1, Site 2)

Across all sites, respondents felt that framing the value of PF tool in the context of the prioritisation process is as important as ensuring stakeholders' engagement.

If you come along and say, "We've got this really new tool and we want you to use it," that's one thing, but if you come along and say, "Look, we know how strapped and strained for cash you are. We know how difficult things are. Here's a resource that could help you, and we will work with you to make it work," that's a very different way of putting it. It's partly what the approach is, isn't it? It's what the approach is and how much people feel this is going to save in time and effort without taking away their autonomy, which they must have, with political and local expertise autonomy, to make decisions. I think it's probably in the positioning as much as anything that's important. (Elected Member, Site 3)

I suppose it was initially framed as an economic tool that we were to use as part of, I suppose, our wider roles. Then, once you started to look at the tool, obviously it looked at the

different details within that, but it was the initial framing was, we were sent the information about the tool that I think Public Health England had put together that gave you a little bit of information as to what was going on in each of the workshops. Then there wasn't any more sort of background information to that. So I think we all turned up to the first workshop not really knowing how we were going to use the tool within our local authority and quite how it would affect or if it would affect our commissioning decisions. (PH Lead 1, Site 2)

Some respondents thought that low levels of engagement were due to lack of understanding of the PF tool's contribution to the prioritisation decision-making process.

The tool is quite complex. For people who are not familiar with the concepts, it took a while to feel confident that people understood what we were trying to do. (PH Consultant, Site 1)

I think from the initial workshop there was a bit of uncertainty as to quite how the tool was to be used and what was required by each of the participants that were involved within that... I found that the tool itself, the way that it was used...was very sort of simplistic and almost siloed each of the different topic areas. So it became quite difficult to evidence some of the outcomes from some of the topic areas when you were just considering that small area and you weren't looking at some of the wider stuff that was going on. So I became quite frustrated with that I think as the workshops went on. (PH Lead 1, Site 2)

I think there was a lot of challenges, in that people upon first seeing the tool could be very intimidated straight away by the potential complexities without understanding it...Another challenge was people perhaps not wanting to really adapt to another system, or another procedure, or another way to do something...Perhaps the challenges were people not quite understanding, and maybe some of them not quite wanting to. Once some of them saw this as just an exercise, and it wasn't going to be a reality. The exercise and the work that we're doing, I think we were told that perhaps this wouldn't be the only evidence that will be used to change the service. (Senior PH Information Analyst, Site 2)

A lack of understanding of the PF tool's contribution to the prioritisation decision-making process was particularly the case in the site where the tool had not been fully adopted.

Well, it was always introduced as a pilot as such, but it wasn't clear throughout the workshops whether or not it was going to be until, I think, we probably got to the later workshops that it was considered more of a strategic tool to inform or to consider as part of wider evidence. Budget setting in the future. So the first couple of workshops I think we're at a little bit muddled and maybe some of the more senior managers had a clearer idea as to what they thought we were going to use with the tool, but that maybe wasn't clear to some of the commissioners and leads who were actually populating and spending time gathering the evidence. (PH Lead 1, Site 2)

I think it was more about the spend and the prioritisation of spend in the future. I mean, I actually asked a question quite early on, "Can I just check how live an exercise it is? Are we just doing it to test out the pilot of something or is this going to be our prioritisation exercise for the year?" It was tending towards the trying out the pilot but it would probably generate

some useful insights that we might be able to use as background to prioritisation decisions in the future. Then, in the event, it appears that what we were previously doing as a prioritisation exercise hasn't happened this year, so it does seem to have replaced what else we might have done. So it seems as though it's become more live. I don't really know...I started off thinking it was an exercise and that actually it might actually be a live process. And more of a live process than it was...You engage with what you think is one process and then if you think, "Maybe my understanding of the process is not what it was..." then you could see, in a couple of cases, people withdrawing from the process. (PH Lead, Site 2)

Usability and training

Overall, respondents considered that the format and design of the PF was user friendly and easy to navigate. However, some felt that the terminology used was too technical and sometimes unclear.

I think there is something about, as I say, some of the terminology in there, maybe on the criteria side of stuff, to try and get some help around the understanding around that would probably be helpful. But I think, actually, if it's going to be worth doing, then it needs to be simple enough that at least semi, kind of non-specialists should be able to use it... (PH Consultant, Site 3)

I would get the definitions much clearer at the beginning because I think when we did the first bit of work we didn't really understand exactly what was wanted in terms of the potential scores. It was a bit vague... I don't think enough effort went into explaining that at the beginning because I think it was in the economists' minds but actual doing the potential scoring bit was quite messy because we were all doing different bits of it and most of us weren't entirely clear what it meant...I think it was probably there in a health economists' heads but I'm not sure the rest of PHE was that sure either, to be honest. I think that is quite a health economic concept and it needs to be much clearer. (PH Director, Site 3)

Some of terminology that was in the templates that we had to fill in wasn't probably as clear as it could have been. That might be just me. One of the issues I found, when you were trying to pull the information together it wasn't really as clear as it could be around what it was you were trying to get into the template that we had. I think some of that could have been better. Because it wasn't as clear as it could be, when we were going into the workshops and everybody was going over their areas, people were almost presenting different information. It wasn't as standardised as it could be...Yes, it was about how you interpreted the question in the template as to what you provided. I think there was a bit of confusion around whether the information you were looking at was against programme budgets and what was the actual service that's there or the wider issue. Yes, that was difficult...Yes, some of the terminology could have been clearer and more standardised I think. (Portfolio lead, Site 1)

Moreover, some respondents suggested that the provision of supporting documents could facilitate the adoption of the tool.

You needed to have a lot of background reading and knowledge, there were no supporting documents. (PH Consultant, Site 1)

I would request the reading material to be forwarded to me prior to the actual sessions... (Strategic Commissioning Manager, Site 1)

A bit of guidance and even some case studies, some of the local authorities that have used. The different experiences that they've had and some of the outcomes that have come from that. (PH Lead 1, Site 2)

Of particular concern among all our respondents was the time required to populate the evidence templates by programme area leads. It was felt that having some guidance to facilitate the population of the evidence templates could be helpful for public health teams.

I think it might be about the local national, it might be that you just have a bit more clarity of guidance and say, "In this template you might want to put these things," and maybe say something like, "Maximum, three sides of A4, whatever it is, just to give some sort of guidance about what exactly do you want, how much do you want... So if there was a bit more guidance about, "Here's a model answer. This is what it might look like. And it's taken account of these five things." Then you go away and think, "Right, I'm looking at those things, and it's about that much." Then you can do it more quickly. I think if you want something to be done at that speed, and for people to not feel that it's taking hours and hours then you need that guidance. Maybe before you start, it would be about saying, "These are the sources that you might be wanting to refer to, to get the evidence together." (PH Lead, Site 2)

I think people filled them in differently; they put different narratives in, different levels of information, I mean people do that to a certain extent and approach them from a slightly different viewpoint and angle... I don't think there's a lot of support for us, I think the instruction was we were public health, people would just be able to do it, and I think that was an assumption... there were times, when I was going through the template, I was sat there thinking, "Well how much do I put in here? How much detail and information do I put in?" And some of the templates were very, very succinct and very clear, and other ones were large and long-winded and quite dense and incomprehensible. So I think, to do it, there have to be some kind of rules around it and some support. (Senior PH Consultant/Specialist, Site 1)

I would have liked something to read beforehand. I would have liked more information... because I know my learning style is heavily reflective..., I felt I didn't have all the information that might have helped... well, I would certainly consider introducing more information beforehand. I think that's the most important thing for me. I just felt a bit, 'dropped in at the deep end'... (Elected Member, Site 3)

Some respondents suggested that having pre-populated evidence templates provided by PHE could improve the adoption of the tool.

So, the templates, I think in particular, that's the bit that took us the longest amount of time. And I think there could have been some time saved around the evidence base, if we were going to pick at that nationally. Because the programme leads were asked to kind of complete the whole templates on each of the criteria that we'd selected, and I think some of that criteria could be obtained from a national- perhaps that's where Public Health England

comes into, in the future...I think that was quite a challenging workshop.(Head of PH Business Programmes, Site 3)

The evidence gathering; again, with public health, we're skilled and competent at collating the evidence, the background information for the tools. What would be hugely advantageous is if some of the core evidence was pre-populated in the tool...from national, from PHE, because actually the evidence is the evidence for some key areas. So, in effect, it's either a duplication of effort or a waste of time asking each individual team, at a local level, to search for the national evidence when that could be pre-populated and then you would be able to draw it out for a local perspective. And then you could enrich that with your more local evidence or grey literature. (PH Consultant/Project Lead, Site 1)

Some respondents felt also that some of the definitions around mandated or non-mandated services were problematic.

I think I would have been a little bit more clear on some of the definitions, especially the health inequalities one, which I think nobody could seem to agree on what that meant, so therefore how could you score it if we didn't know? The mandated, not mandated one, I would have just taken all the mandated services out because we have to do them anyway. The issue, then, comes down to, well, what do you spend on doing them? That's a different discussion. I think, even though the briefings were relatively good, it probably might have been little bit clearer about what the expectation was. Because I think some people went in, like me, with an expectation that what we'll end up with incremental change, I think others went in thinking this was a real opportunity to really shift the public health budget... (Senior PH Consultant/Specialist, Site 1)

Although each site experienced a variety of types of engagement by key stakeholders, there was much praise for the role of the external facilitator as a 'process owner'. Across all sites, PHE played an active role in the organisation and delivery of the workshops and it was considered critical to the successful adoption of the tool.

Having a very good facilitator, not one to impose his view and kind of stepping back. That's been crucial having somebody in the team with a passion about this, supported by Public Health England and a team manager, director, fully behind it. All of that was crucial. (PH Consultant, Site 1)

I think having the input from Public Health England has really helped to enhance and hold the process together...That partnership with Public Health England learning from what had happened in South Tyneside, what had happened in Gateshead, what was happening at a national level, I think was extremely valuable. (Director of PH, Site 1)

It was certainly very helpful. We could've done it without them, but it wouldn't be as good. (Director of PH, Site 2)

I think that we needed Public Health England's support to get this through. And we needed their guidance. I don't think we would have had capacity to have done this without Public Health England's input at that early stage... (Head of PH Business Programmes, Site 3)

While all respondents acknowledged the important role and support from PHE, some felt that earlier involvement on its part could help with the adoption of the tool.

I think from Public Health England's side, we did get the health economists in to help with looking at the value for money stuff, but I think maybe to get them in at an earlier stage to, sort of, influence what was...Because, I think, on some of the programmes, we ended up not being able to score cost effectiveness straight away, because of lack of information, so, I think to try and get that information at an earlier stage...(Senior Finance Business Partner, Site 3)

I think it would have been difficult without it...having Public Health England there was certainly an assistance trying to explain things...they were very helpful in making things understandable, but they seemed very much on the sides. They would only interject when they needed to. Some of us felt like they could have interjected more, and explain things a lot more in layman terms, and helped the team a bit more... (Senior PH Information Analyst, Site 2)

And we did really want more support perhaps from Public Health England, around the evidence. And the cost effectiveness criteria. Some of the criteria that they could do nationally and provide us with that information, may have speed things up. Whereas the local context is where we're good at, because we obviously know what our programmes do locally, so we can put that bit in. (Head of PH Business Programmes, Site 3)

I thought that we could have done with more information from public health level...more help in understanding some of the evidence base as to the effectiveness of various programmes...So, I fully accept there's a lot of difficulty involved in it all. But, we as members are highly unlikely to be as informed as officers are in having that as background knowledge. (Elected Member/ Vice-Chair of the Health Committee, Site 3)

In this context, it was felt that organisational support and strong leadership from PHE could facilitate successful adoption.

I say a crucial element, we've had his leadership from the top. The director of public health has to be fully behind it...That would be, I think, don't even start. Don't use it as an academic exercise and hope something is going to happen. If the director of public health is not confident about this tool as being a means to an end then there's no point embarking on it... (PH Consultant, Site 1)

They probably need tool champions within PHE who come out and do office support to local authorities, do a bit of training, identify the lead person, train them up. I don't think it is going to happen without PHE putting a data pack behind it. I think if PHE did those things it would get adopted more widely probably, but without that additional stuff I think it is still a bit off-putting.. (PH Director, Site 3)

It's not just putting what is best practice in a document and sending it around, is it? It's actually so much more than that that you need to seed new ideas. I hate that word 'champions', but they need people who will work with them to champion the ideas. People need to understand that it's going to help and support them rather than just be extra work, or indeed just doing things in a different way which people don't want to do if they're really working too many hours anyway. (Elected Member, Site 3)

Training was considered to be important to help those taking part familiarise themselves with the new tool.

I think it will always depend on the skills and potential interests of the lead person; some people are really astute and up to speed on health economics and are very comfortable and proficient, others might have touched on it through a single module and then that's it ...So you could go and do an hour tutorial or an hour webinar, I still think there's something for me about local PHE centres having an advisory role to play in, if a local authority would want it, that support mechanism. (PH Consultant/Project Lead, Site 1)

For some participants, an instructional video was proposed in order to facilitate the adoption of the tool.

I think it's safe to say there was a little bit of lack of parity in some of the workshops. If you were going to do that again, and further develop it, you would probably be better developing some videos. Because we saw it from our side, but we don't know what they've done down the road, and the message does change all the way down. So we were asking questions, and had there been a video there that gave you the key issues developed over time it would have been better. (Development and Implementation Lead, Site 2)

I thought simply giving perhaps one a guide, like a written PDF document, won't necessarily make people read it. I think something like this, when you come into people not used it, they need a softly approach. And sometimes like a visual video representation, it's sometimes very useful. It can very quickly highlight key things to look out for, key considerations, you may want to think of this. And then perhaps giving a step-by-step element of the tool, key things to look out for, this is why we're doing this. Sometimes I think people respond better to perhaps a video, audio, than a document, or even a presentation. The reason I say a video, is I think it might be easier to share around the country, rather than having someone going round, and talking about it. (Senior PH Information Analyst, Site 2)

Part 4: Discussion

While the context for each early adopter local authority site is inevitably specific and distinct and must always be taken into account when adopting the PF or a variant of it, we identified a set of common issues and themes shaping the adoption of the PF tool across the three sites we studied. In this final part, we focus on these as attention to them is likely to be of most assistance to PHE as it seeks to modify and adapt the PF in the light of its application in practice in local settings.

Opportunities and benefits

All three LAs, albeit to varying degrees, completed the process of using the PF and made recommendations to change budget allocations. The majority of recommendations made seemed to be based on evidence and the scoring systems inherent in the PF. Key emerging patterns in most but not all of the recommendations to change budget allocation were based on feasibility, potential and levels of investment. Areas of low potential and low feasibility to improve in the future, and high or neutral investment were often recommended for decreases in budgetary allocations. Similarly, a programme area in one LA with a high potential and feasibility with low investment was recommended for an increase in budgetary allocation.

Across all three sites it was acknowledged that the adoption of the PF tool provided a systematic framework to structure and guide prioritisation decisions. Reflecting the ongoing financial pressures on public health budgets, and on local government spending more generally, our respondents acknowledged that the adoption of the tool could encourage transparency over investment/disinvestment decision-making in public health spending. Moreover, it was felt that the adoption of the tool could help to raise the profile of public health teams and also to contribute to the wider understanding of the prioritisation process across the council. Overall, all three local authorities acknowledged that the adoption of the PF tool provided a platform for greater collaboration between different public health professionals with the potential that this offers to improve investment/disinvestment decisions in public health spending. In particular, emphasis was given to the participatory nature of the tool which it was felt encouraged and enabled collective learning. There was evidence from our first-hand observations of the workshops that the adoption of the PF tool facilitated conversations across different stakeholders which was considered to be essential if public health teams are to overcome the traditional silos in which they operate. Although each site experienced a variety of types of engagement by key stakeholders, there was much praise for the role of the external facilitator as a 'process owner'. Across all sites, PHE played an active role in the organisation and delivery of the workshops and it was considered critical to the adoption of the tool.

Challenges and barriers

Despite these opportunities arising from the PF, our findings demonstrated that significant financial tensions and limited availability of resources, uncertainty around policy, and fundamental questions about the future of the ring-fenced public health budget could hinder the adoption of the PF tool and make decision-makers wary of its purpose and impact. In keeping with government pressures for efficiency savings, respondents stressed the difficulty in setting priorities for allocating a limited pool of resources. From an organisational

perspective, it was acknowledged that the adoption of the PF tool requires a significant investment of time and commitment from public health teams. In particular, concerns were raised over the time required to populate the evidence templates by programme area leads. Moreover, limited capacity among public health teams and challenges in getting the right people together at the same time were thought to be a major barrier to the effective adoption of the PF. For some respondents, uneven attendance at workshops could hinder the wider ownership and therefore successful adoption of the new tool. Some respondents suggested that having pre-populated evidence templates provided by PHE as well as ensuring continuity of participants could improve the adoption of the tool.

The effect of the political environment on prioritisation decision-making was highlighted by many interviewees. In particular, it was felt that the political context in which prioritisation occurs (i.e. local government) could hinder the adoption of the PF tool. Reflecting the political nature of local government it was recognised that any decision-making approach will need to take into account the local political context and organisational agenda, acknowledging that the elected members will take the final decision. In this context, it was acknowledged that ensuring support and committed leadership from senior management was a key enabler to success. In particular, our respondents felt that that elected members' buy-in at an early stage could facilitate the adoption process and avoid problems of ownership at a later stage.

In terms of the prioritisation exercise, our respondents acknowledged difficulties in relation to the different sources and types of evidence that might be used by various stakeholders involved in making decisions. In addition, there was a general perception that limited availability of information and evidence in some areas (such as for mental health services) could hinder the adoption of the tool. Of particular concern among all our respondents was the lack of national indicators in certain areas of public health and an absence of qualitative evidence to inform prioritisation decision-making.

Across all three sites the workshops were favourably received and participants felt they were helpful, informative and well-structured. However, some respondents felt that the PF tool was too linear, mechanistic and deterministic in its design and thus risked failing to address the dynamic, complex and multifaceted nature of the prioritisation process in public health. There were recognised problems around assisting both elected members and staff to understand the underlying principles of the tool. As well as a perception that local government often fails to understand the role of public health, our respondents felt that a lack of understanding of the PF tool's contribution to the prioritisation decision-making process could hinder its adoption.

In addressing these challenges, interviewees recognised that achieving a shared understanding of the benefits of the PF tool through meaningful engagement of all relevant local stakeholders could determine successful adoption. In this regard, respondents suggested that framing the value of PF tool in the context of the prioritisation process is as important as ensuring stakeholders' engagement. Some respondents proposed the provision of supporting documents and an instructional video in order to facilitate this process.

Next steps

The recommendations made for investment and disinvestment decisions arising from the adoption of the tool are a transparent part of a process that is aimed at enhancing allocative

efficiency. However, none of the LAs using the PF specified actual figures in terms of changes in budget. A crucial part of the PF that is deemed optional by PHE is the modelling scenario stage. Furthermore, currently the PF does not explicitly incorporate an assessment of the impact of changes in budget allocation on changes in outcomes separately. However, in regard to capturing the economic impact of the use of the PF in terms of costs and benefits, this stage is the most crucial. It is impossible to assess allocative efficiency if costs and outcomes at the margin are not captured and valued. This does not negate the current value of LAs using the PF.

Looking forward, as the PF becomes more embedded and stakeholders become more comfortable with its use, the next logical stage in the development of the PF would be to include a modelling exercise to assess impact of budgetary allocations on outcomes at the margin as a key element of the process. In particular, an assessment of change in budget allocation and a modelling exercise to estimate the impact on key outcomes and metrics would facilitate the move towards recommendations/decision- making that leads to allocative efficiency gains.

Conclusions

Although our evaluation of PHE's PF was confined to three sites, as they were the most advanced in testing the new tool, it yielded rich insights into the use and value of the PF as well as suggesting modifications to its design in order to strengthen its appeal and impact. The issues the PF seeks to address will not go away and some mechanism which provides a forum for engaged and informed deliberation about priorities and does so in an open, transparent manner will be required. From our research it appears that the PF offers such a mechanism and one that our three sites broadly welcomed. Notwithstanding some weaknesses that may be easily remedied, the tool proved itself to be sufficiently robust to be adopted more widely by local authorities and their public health teams. With a larger number of local authorities using the PF over time, and building on the findings from this modest study which have perhaps inevitably centred on process factors in the PF's uptake, there would be merit in undertaking a larger study to assess the value of the tool more widely across local authorities, especially in respect of its economic impact on outcomes.

Interview Topic Guide

Introduction/Background

1. What is your position/role within your organisation?
2. How long you have you been in your current position?
3. Can you please briefly tell me about your role?
4. How are you involved in the implementation of PHE's new PF tool?
5. What do you know about the new PF tool in which your organisation is involved?

Implementing the new PF tool: Organisational Challenges/Opportunities

1. What do you think are the factors that will either enable or prevent/hinder successful implementation of the new PF tool?
2. What are the main benefits/challenges arising from the PF tool from a commissioning perspective?
3. What do you think are the main organizational barriers to adoption and implementation?
Prompt: managerial/user resistance; difficult to use; specific commissioning issues
4. What do you think are the main policy barriers to adoption and implementation? Prompt:
organizational targets, competing policy objectives, rapid policy reform
5. How important is culture? To what extent is there 'organisational readiness' to accept the adoption of the new PF tool?
6. How important is the political context within the LA when it comes to using the PF tool?
How is it likely to affect its adoption or not?

Building a support network

1. Was there a key individual who championed the adoption of the new PF tool in your authority? If yes, why was this person so crucial and would the tool have been adopted without them?
2. Who are the key individuals in the LA whose support was required for successful adoption of the PF?
3. Who are the key individuals outside of the LA whose support was required for successful adoption of the PF?

User acceptability issues

1. Were there any user acceptability issues in relation to the new PF tool? If yes, what were these and how were they overcome?
2. Were work processes disrupted due to the introduction of the new PF tool? If yes, what form did this disruption take and how was it overcome?
3. Will the benefits of introducing the new PF tool accrue solely within the LA or will there be benefits outside/for other organisations?

User engagement/training

1. Does the effective use of the new PF tool require user training/skills? If yes, what work with users was required to ensure the effective use of the technology?
2. Were users involved in either the adoption or implementation processes? If yes, what form did this involvement take?
3. Has user feedback on the new PF tool been sought? If yes, are you aware of any issues that this feedback raised?

PT tool issues

1. How would you comment on the format and design of new PF tool? Do you find the information presented accessible and easy to understand?
2. Do you think the tool is user friendly and easy to navigate?
3. Were there any user acceptability issues in relation to new PF tool? If yes, what were these and how were these overcome?

4. Are there any specific issues in relation to the content of the tool that would you like to comment?

Engagement with PHE

1. How has your engagement with PHE assisted in the adoption and implementation of the new PF (i.e. workshops)? Was the LA encouraged by PHE to adopt the tool? If yes how was this manifested? What type of support is being offered by the local PHE centre in your area?
2. Do you believe that there would have been adoption of the PF without PHE's support?
3. Is your engagement with PHE still on-going? If, yes, what form does this take?
4. Has PHE produced any guidelines for using the new PF?

Impact

1. Do you consider that the PF tool is likely to have an impact in terms of commissioning intentions or decisions for investment/disinvestment in public health spending? If there's no impact, why not? What is the purpose of the PF tool otherwise? And what sort of impact would you envisage, or wish to see, going forward?

Conclusion

1. Reflecting on the adoption and implementation process for the new PF if you were to undertake this process again what would you do differently and why?
2. Do you have any final comments? Are there any other issues which you think are relevant in the context of this study?

Many thanks for your time