ScotPHN report

Scottish Public Health Network (ScotPHN)

Approaches to Prioritisation for Health and Social Care Integration: Scoping the Involvement of Local Public Health Teams

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1. INTRODUCTION

Health and social care partnerships (HSCP) are required to use appropriate mechanisms to prioritise the investment decisions underpinning their strategic development plans. The Director of Public Health (DPH) and their team has a role to play in supporting the HSCP to set local priorities which best promote the health and wellbeing of their population.

There is no single best way of prioritising complex and varied health and care issues; any such process requires a degree of subjectivity. There is unlikely to be one single ‘tool’ that can make these complicated decisions for us, but there are tools and processes that can help to inform and evidence decision making. ScotPHN was tasked by the SDsPH group with considering whether a ‘once-for-Scotland’ approach could be utilised when providing prioritisation guidance for health and social care integration.

Objectives and approach

The broad objectives of this work are:

- To describe the use of prioritisation tools as they relate to the Public health function within resource allocation in integration of Health and Social Care services in Scotland.
- To signpost relevant research and policy documents and provide an overview of what is being done already in Scotland
- To inform and stimulate further work in this area and highlight research and evaluation needs for the future.

The methods utilised to achieve this include: a systematic review of available published and grey literature and a process of stakeholder engagement to collate and review current practice. Further detail of these processes are included in the relevant sections below.

Prioritisation tools can take many forms and serve a variety of functions; this work focuses on tools which enable identification of both the magnitude of a health problem and methods of intervention which are both feasible and effective. These tools will ideally have a focus on prevention of illness and promotion of health.

Therefore, the work will aim to identify prioritization tools that include a means of quantifying or assessing:

- the size of the health problem;
- the seriousness of the health problem;
- the effectiveness of new or existing practice/intervention; and
- the feasibility of delivering the service/intervention.

Not all tools will do all things: this work will aim to have at least two of these four areas being included in the tool.

Glossary

AHP	Analytic Hierarchy Process
CPP	Community Planning Partnership
CURVE model	Culture, Understanding, Responsibility, Values, Enterprise
DPH	Director of Public Health
HSCI	Health and Social Care Integration
HSCP	Health and Social Care Partnership
IJB	Integrated Joint Board
MCDA	Multi-Criteria Decision Analysis
PBMA	Project Based Marginal Analysis
SDsPH	Scottish Directors of Public Health
SPOT	Spend and Outcomes Tool
STAR	Socio-Technical Allocation of Resources

2. CONTEXT AND EVIDENCE

Policy Context

The way that we plan and deliver adult health and social care services in Scotland has changed. In 2016 the Scottish Government legislated to bring together health and social care into a single, integrated system. Health and Social Care Partnerships (HSCPs) – a partnership of NHS and local authorities, formed under the Public Bodies (Joint Working) (Scotland) Act 2014[1] - are the organisations tasked with delivering this integrated model of care services.

In the context of increasing demand and the ongoing need to improve outcomes, the allocation of resources across health and social care services is a key task of HSCPs. Guidance produced by Scottish Government in September 2016[2] indicates that this requires 'the adoption of a prioritisation process that will support decisions about investment and disinvestment' and which is both practical and proportionate. While the Government advice note outlines the principles of such a process – 'decisions must be made on the basis of clear criteria, a robust process and application of relevant and focused information' – it does not indicate a specific prioritisation tool/process which should be adopted.

There is limited consideration given within the Government guidance note to population health as a factor within prioritisation of health and social care resource. And there is certainly no specific mention, in this document, of the role of NHS Public Health departments in contributing to this process. However, the 2015 Review of Public Health in Scotland[3] clearly describes the Public Health contribution to HSCPs. In summary this includes: providing strategic public health function including 'advice on approaches to prioritisation'; providing health intelligence and data analysis function; and supporting the design and delivery of services. It can therefore be expected that Public Health departments should expect to be approached, if they have not been already, to advise on and contribute to the prioritisation of resource allocation across health and social care services.

Current models of care are not sustainable: a change in approach is required to address the mounting pressures of growing demand and limited finances. Use of an evidence based tool to inform the prioritisation process would need to allow HSCPs to facilitate local review of existing services, consider challenging investment and disinvestment decisions and make recommendations regarding resource allocation. Scottish Government guidance indicates that any prioritisation process must be able to 'facilitate the local review of existing services and existing resource allocation'.[4] The emphasis within the most recent Chief Medical Officers report – Practicing Realistic Medicine[5] - on 'realistic population health' and value based healthcare further strengthens the focus on sustainable resource allocation at local level.

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[1] Scottish Government, Public Bodies (Joint Working) (Scotland) Act 2014.
http://www.legislation.gov.uk/asp/2014/9/pdfs/asp_20140009_en.pdf

[2] Scottish Government, Advice Note: Prioritisation Process; September 2016.
http://www.gov.scot/Resource/0050/00505886.pdf

[3] Scottish Government, 2015 Review of Public Health in Scotland: Strengthening the Function and re-focusing action for a healthier Scotland; 2015. http://www.gov.scot/Resource/0049/00493925.pdf

[4] Scottish Government, Advice Note: Prioritisation Process; September 2016.
http://www.gov.scot/Resource/0050/00505886.pdf

[5] Scottish Government, Chief Medical Officer's Annual Report 2016-17: Practicing Realistic Medicine.
http://www.gov.scot/Resource/0053/00534374.pdf

As part of Public Health Reform in Scotland, the Scottish Government and COSLA have recently developed a set of public health priorities for Scotland which reflect public health challenges that are important to focus on over the next decade to improve the health of the population of Scotland.[6] These priorities will be discussed in more detail in section 3 below. Interventions in line with these high level priorities will still require local discussion and prioritisation.

In summary, Scottish Government policy in relation to allocation of health and social care resource highlights the need for a local focus to prioritisation. The publication of National Public Health Priorities, as part of Public Health reform in Scotland, sets out the broader context around which prioritisation should occur but also reiterates the need for local flexibility. Within the current policy context there is scope to consider whether it would be appropriate to consider aspects of prioritisation using a 'once-for-Scotland- approach, with the aim of creating a coherent public health landscape in Scotland.

Key messages from the evidence base

By definition, to set priorities is to give higher importance to some things over others. Priority setting in health aims to determine what, in the context of limited resources, is most important for the health and wellbeing of the population. In a publically funded health care system decisions need to be made to include both the individual patient perspective and also the 'view of the citizen'[7], considering needs and opinions of those who are not current users of the system but who may use it in the future. The aim should be to produce a 'distribution of healthcare resource which is socially justifiable.

We carried out a rapid review of the literature, both peer-reviewed and grey, in order to gain an appreciation of the current landscape around prioritisation tools. There was a focus on tools which enabled identification of both the magnitude of the health problem and methods of intervention which were both feasible and effective. A rapid review was appropriate given that previous reviews suggest a limited evidence base in this field, and there was a need to prioritise the timeliness of this report.

In this broad view of the literature much of the evidence reviewed did not have a population health focus. There was not a specific focus on the means of identifying the size or seriousness of health problems, nor ways of assessing and comparing the impact of preventative interventions across the breadth of the public health landscape. What evidence was available was more in reference to supporting investment/disinvestment decisions within a particular sector of health service department rather than prioritisation for prevention. Level of evidence was usually weak: taking the form of case studies, evaluations or qualitative review, or broad, high level discussion papers. It largely focused on interventions to tackle existing health problems at an individual rather than population level, and did not allow scope for consideration of possible future challenges.

A range of prioritisation tools were mentioned in the literature; the most commonly references of these are summarised in the table below. As previously mentioned, what evidence there

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[6] Scottish Government, Health and Social Care Delivery Plan. 2016. https://beta.gov.scot/publications/health-social-care-delivery-plan/

[7] Sarah Clark, Albert Weale, (2012) "Social values in health priority setting: a conceptual framework", Journal of Health Organization and Management, Vol. 26 Issue: 3, pp.293-316, https:// doi.org/10.1108/14777261211238954

was for use of these tools was largely biomedical in nature and restricted to use within a single work stream. It is also important to note that there was very limited evaluation of priority setting in the literature, so evidence of actual effect for these tools was limited.

Tool	Summary
Cost Effectiveness Analysis (CEA)	Literature largely focused on broad use of CEA in allocating a fixed health budget between interventions to maximise health in a population. Practical evidence of use of CEA in a UK setting available from NICE.
Programme Budgeting and Marginal Analysis (PBMA)	Programme budgeting is the evaluation of current resources, spend and allocation. Marginal Analysis is the assessment of benefits lost and savings made by disinvesting in a service
Multi-Criteria Decision Analysis (MCDA)	This involves: identifying criteria with which to assess the benefits of an intervention; applying weightings to each of the criteria; scoring the intervention according to the benefit weightings; using cost data to calculate cost/benefit rations for comparison with other interventions
Spend and Outcomes Tool (SPOT)	This tool can be used to give a broad overview of spend and outcomes across a range of public health interventions. Examples in literature largely focused on use within a single healthcare department.
Socio-technical Allocation of Resources (STAR)	An approach to healthcare prioritisation that is based on a concept of decision making as having both a social and technical element

Researchers commented on the acceptability of these prioritisation tools; citing the legitimacy that comes from use of a well-recognised tool as being helpful in creating support for making often unpopular investment/disinvestment decisions. However, it was also noted that the complexity of some of these methods could be a barrier to engagement with the broad range of stakeholders often involved in the decision making process.

Transferring what evidence there is to support the use of these tools in a healthcare setting, to the broader public health environment was not covered by the literature. Creating fair comparison between disparate interventions, using an economic tool as a marker, is challenging: demonstrating value for money within public health interventions where often gains are made many years later makes return on investment calculations very complex. There is a disparity between aspirational priority setting and required resource allocation; maintaining a preventative, upstream focus while facing the operational demands of service provision within health and social care is a constant challenge.

In practice, these tools are often adapted to meet the needs of those using them, often being incorporated into the design of prioritisation frameworks. At a local level, decision makers may use frameworks to ensure a systematic approach to health service prioritisation. Review of the grey literature informs us of a number of prioritisation frameworks in use within the UK.

An example of a prioritisation framework which utilises health economic tools is the one developed by Public Health England (PHE), designed to help local authorities conduct a systematic prioritisation exercise. The principle technique used in this approach is multi-

criteria decision analysis. Updated guidance on the use of this framework was published in June of this year[8]. This guidance states that public health teams are encouraged to 'think about how to get the best value for money' in order to 'make recommendations on whether to increase, decrease or maintain spend' across a variety of programme areas.

NHS Wales, in their 'Prioritisation and Decision Making Framework'[9], suggest that the requirements of a prioritisation framework are to provide 'a robust, transparent and fair process to support decision making and resource allocation. This document has a healthcare focus: it does not specifically reference elements of social care and potential population health impact.

Should it be considered appropriate to have a prioritisation framework for Scotland it may be possible to utilise some of the learning from the documents published in England and Wales, although it should be noted that neither covers the breadth of public health in Scotland following integration of health and social care.

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[8] Public Health England, Prioritisation Framework. 2018. https://www.gov.uk/government/publications/the-prioritisation-framework-making-the-most-of-your-budget

[9] NHS Wales, Prioritisation and Decision Making Framework. 2012. http://www.wales.nhs.uk/sitesplus/documents/861/BCUHB%20Prioritisation%20Framework.pdf

3. EXPERIENCE ACROSS SCOTLAND

Summary of current situation across Scotland

Initial stakeholder engagement was carried out via a set of email requests to Scottish Directors of Public Health (or their nominees). Representatives from all territorial Health Boards across Scotland were asked to respond to the following three questions:

1. Is your health board / local public health department receiving requests from colleagues for support with prioritization of health and social care resource?
   - If so, what does this public health involvement currently look like
   - If your department is not involved directly with prioritisation of health and social care resource, are you aware of how this is being done and by whom?
2. If your public health department were to become involved, do you have an idea of how this would happen and resource would be available?
3. Are there any specific aspects of resource allocation in HSCI which you would like to see addressed within this work? Are there specific outputs which would be beneficial to you?

Detailed responses were received from six Health Boards; these are summarized below:

Question 1	
Health Board	**Response**
A	Request received from HSCPs to develop a prioritization framework to assist the strategic commissioning process. Have been trying to develop above using 'Intermediate Care' as a topic/example
B	Remains difficult to influence resource transfer given the pressures services are facing at present; many of the decisions are primarily about identifying opportunities to reduce spend as vacancies occur.
C	We are getting requests and trying to work with finance colleagues to move towards explicit consideration of health gain etc. We have locally considered some options such as STAR.
D	Public Health has been asked to present a paper on a prioritisation process for disinvestment and investment. The request came from NHS Management Team. This has been led by a Consultant in Public Health with the support of a colleague in Strategic Planning
E	Yes. In the past I have contributed to prioritisation processes for the integration change fund. More recently I have provided input to the strategic needs assessment and strategic plan processes for our 2 health and social care partnerships (which may influence prioritisation). I sit on the working group for Stirling and Clackmannanshire, although we have not done anything on prioritisation directly. In general the method of prioritisation is quite qualitative and led by the relevant managers etc.
F	Local resource allocation and decision making framework subgroup / use of AHP processes

Question 2	
A	There are significant merits to PH being involved in the strategic commissioning process; however there needs to be a national framework with a list of limited tools that should be made available along with health economics input to ensure that a robust evidence based approach is taken. The SG guidance document left it very much to the local partnerships; very variable and not as robust as it could be.
B	This would most likely be coordinated by the local Transformation and Sustainability office (strategic planning) or one of the local Transformation work streams. Unclear what resource would be made available: we would reassign activity as much as possible depending on the requirement of the organization. Suspect we would also want to make use of the skills of the LIST analysts and possibly other national colleagues depending on the topic area.
C	We have limited capacity within the PH department to progress this.
D	Engagement, community involvement and participation skills- we are currently seeking to identify these from, for example, Council partners, health improvement workers and community development health workers. This list is not exclusive as we have just turned our minds to what resource might be available to us.
E	I would like to be more involved. All we could offer in terms of resource would be some of my time and perhaps that of others. I do have an interest in multi-criteria decision making, and programme budgeting / marginal analysis (which I see as a sub-set of the former) – but have not really put these into practice. For me there are links to community planning too – especially community empowerment and deliberative democracy
F	
Question 3	
A	Using appropriate tools would ensure adequate and increasing funding for preventative services. If we could develop an approach drawing on PH principles (i.e. evidenced based, effective, population centred, preventative, reducing inequalities) to prioritization drawing on expertise developed in England where commissioning has been in place for several years this would be helpful.
B	It would be helpful to have a robust evidence base describing models of care (particularly for community care) tried and tested in a real system and shown to work. It would also be helpful to have some clinical champions in key areas to win hearts and minds locally.
C	
D	
E	We need to take account of culture, understanding, responsibility, values etc., and enterprise approaches (CURVE)
F	

This table illustrates that there is currently a variety of experience across Scotland. In a number of Health Boards detailed pieces of work have been undertaken or are ongoing to identify ways of appropriately allocating resource within health and social care. In other areas there appears to be an awareness that this work is taking place but not directly linked to the

public health department. Despite prompting, further responses were not received. It is not possible to say with certainty whether this is an indication that local work relating to resource prioritisation is not currently a focus in these health boards.

The answers to Question 2 appear to identify a limited capacity to support this work locally. The Health Boards where further work has been undertaken in relation to prioritisation it would seem that this has largely been driven by the interests and experience of a single individual.

Examples of specific work being undertaken in Scotland

A number of health board public health departments indicated that specific focused pieces of work had been initiated in relation to resource allocation. Contact was made with named individuals in each department to follow up on this work: in depth interviews were conducted with the Consultant in Public Health leading on the projects in each Health Board.

- Health Board A
    - Using a problem based marginal analysis (PBMA) approach within one topic area (intermediate care)
    - Working collaboratively with academic health economic colleagues and a multi-disciplinary working group
    - Discussions have been positive, however the process has been lengthy and resource intensive in relation to lead consultant time
    - This approach has allowed identification of areas for disinvestment as well as investment
- Health Board D
    - Development of a proposal which aims to set out prioritisation process for investment and disinvestment decisions across the breath of health and social care
    - Based around a multi-criteria decision analysis (MCDA) approach and utilises existing frameworks established for ‘difficult decision making’
    - Designed to be used for large scale changes in service: estimated guide of >£100K cost or saving
    - Broad membership of working group, co-led and public health and local authority representatives. Feeling expressed that a local focus has allowed engagement and buy-in from a range of group members
    - Approach includes time built in for community engagement and as a result is like to be lengthy: estimated to be approximately 18 months from initial planning to final decision making
- Health Board F
    - Work has been undertaken to develop and implement a Resource Allocation and Decision Making Framework (RA&DMF)
    - This utilises an analytic hierarchy process (AHP) decision framework
    - Interest in this field is longstanding with work on the framework having taken place over a number of years. However, to date the framework has not be trialled as part of decision making processes

As outlined above, all of these approaches are in relatively early stages of implementation and therefore it is not possible to evaluate fully the strengths and weaknesses of each approach to prioritisation. It is clear that each method is based on a prioritisation tool for which there is evidence of effectiveness (to varying degrees). As a result of efforts to follow thorough

process and, in some cases, include opportunity for public engagement, each of these examples has taken significant time to develop and implement and has required significant resource input from the lead public health consultant. To what extent it will be possible for this to be sustained is unclear.

In the examples above, working groups have included representatives from across a number of local organisations. This local focus has aided buy-in from stakeholders and supports a community engagement approach to identification of local priorities for investment. It is possible that this local engagement may be lost if a national prioritisation process was undertaken.

Given that each of these examples of local prioritisation are in relatively early stages of development and implementation and considering that the public health involvement in each case relies on specific individuals utilising their individual skills and interest, there is still an opportunity to consider going about this in a more coherent, sustainable way.

Broader stakeholder opinion relating to priority setting

Establishing shared priorities for Public Health in Scotland is one of the public health reforms described in the Scottish Government Health and Social Care Delivery Plan[10]. These priorities have recently been published and are summarised below[11]:

- A Scotland where we live in vibrant, health and safe places and communities
- A Scotland where we flourish in our early years
- A Scotland where we have good mental wellbeing
- A Scotland where we reduce the use of and harm from alcohol, tobacco and other drugs
- A Scotland where we have a sustainable, inclusive economy with equality of outcomes for all
- A Scotland where we eat well, have a healthy weight and are physically active

When creating the national public health priorities, The Public Health Reform Team were keen that they be developed in partnership with stakeholders. To this end, ScotPHN were involved in delivering four engagement events to which participants from across the specialist public health workforce were invited, along with colleagues from local authorities, the third sector, community planning, health and social care partnerships (HSCP) and integrated joint boards (IJB). A full report of these engagement events is available.[12]

[10] Scottish Government, Health and Social Care Delivery Plan. 2016. https://beta.gov.scot/publications/health-social-care-delivery-plan/
[11] Scottish Government, Public Health Reform: Public Health Priorities for Scotland. 2018. https://publichealthreform.scot/the-reform-programme/scotlands-public-health-priorities
[12] Scottish Public Health Network (ScotPHN), Shared Public Health Priorities for Scotland, ScotPHN Engagement Events: Final report. 2018. https://www.scotphn.net/wp-content/uploads/2017/12/2018_05_15-ScotPHN-Report-Engagement-Shared-PH-Priorities-for-Scotland-FINAL.pdf

While the objectives of these engagement events differ slightly from the questions posed in this report – the development of national public health priorities rather than prioritisation in the context of resource allocation – there are nevertheless some themes emerging from the discussions which took place across these four days which I feel are relevant to this work.

There was support for the use of a criteria based approach to generating priorities, although it was agreed that the process of 'weighting' these criteria was challenging. It was also acknowledged that a criteria based approach may present some challenges in fairly representing the breadth of public health: reflecting all domains of public health and ensuring that both transformational priorities and those more likely to result in incremental change are represented.

It was important to the majority of participants that the process of prioritisation should stem from community engagement, with the public being closely involved in decision making. Within this 'bottom-up' approach the requirement for flexibility within the prioritisation process was highlighted, in order that local areas with different public health challenges (e.g. rural vs. urban communities) may allocate priorities relevant to them.

The focus of these engagement events was on generating public health priorities; perhaps because of the nature of the task, there was relatively little conversation relating to the process of disinvestment and what there was tended to focus on avoiding disinvestment. There was an awareness of the need to articulate what public health currently does well and protect against the potential consequences of no longer investing in these areas, however there does not appear to have been any discussion about identification of areas of current resource use which are less efficient and could be changed or stopped

These engagement events were not undertaken for the purpose of considering approaches to local prioritisation. However, the points above highlight some learning from this process which could be utilised should it be considered necessary to develop a single process to support local prioritisation decision making around the national public health priorities.

4. TRANSLATING EVIDENCE, EXPERIENCE AND OPINION INTO EFFECTIVE 'NEXT STEPS'

At a time when there are a growing number of health concerns, scarce resources and differing opinions it is easy to lose sight of the over-arching goals of public health: improving population health outcomes and reducing health inequalities. Often these external influences can appear to dominate the decision making process and make deciding where to focus time and resources challenging.

As outlined above, the use of prioritisation tools can provide a structured approach to analysing health problems and possible solutions. However, the evidence base for their use in anything other than prioritization within a narrow, biomedical topic area is very limited. There are currently colleagues across Scotland utilising a variety of approaches to local prioritization, disinvestment and resource allocation. It would appear that these have, to-date, been lengthy and resource intensive although they are thorough and follow rigid process. It remains open to further discussion how replicable these approaches may be in other health boards and across a broader range of topic area, and how practical their use would be.

Stakeholder opinion would appear to support a 'bottom up' approach to prioritisation, beginning with active community engagement. To what extent such a process could be standardised within a national set of prioritisation criteria, while allowing flexibility required to reflect local need is unclear.

Taking into account the current policy context, evidence base and current experience in relation to use of prioritisation tools, and local resource allocation decision making processes, it seems appropriate to consider what might be the most appropriate way to progress this work. There would appear to be an appetite for a 'once-for-Scotland' approach to local prioritization; however, evidence suggests that there is not an established prioritisation tool suitable for this purpose and therefore an evidence based process would need to be developed. However, such a "top-down" approach might struggle to be consistent with the aspirations for local community involvement, and could limit opportunities for consideration of local circumstances. As such, creating a single local prioritisation tool for use by Public Health teams in Scotland may not be desirable. In this situation an alternative may be to establish a focused expert group in Scotland with the purpose of developing a consistent and coherent framework in which approaches to local prioritisation could be developed, more reflective of the changing public health landscape in Scotland.

On the basis of these considerations, there are four possible options for taking this work forward:

i. maintaining the status quo, collating intelligence from local developments across Scotland;
ii. taking a proactive approach to creating a 'once-for-Scotland' framework to support prioritisation on a 'top-down' basis by adapting existing frameworks;
iii. taking a more 'bottom-up' approach and developing more considered framework that could meet the clear desire for all decision making to be community led; or
iv. a hybrid approach that allow a 'top-down' framework that is supported by guidance on how it can be integrated more fully into local, 'bottom-up' approaches to prioritisation.

Following discussion with the Scottish Directors of Public Health, option iv is the preferred option and will be scoped further by ScotPHN.

report

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