Prioritising spending with reduced resources

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Aims of prioritisation
Examples of approaches
So what happened next?
Challenges (discussion)
Council cuts hitting women's contraceptive services, data shows

Advisory Group on Contraception warns that reducing sexual health services could lead to a rise in unintended pregnancies and abortions.

Council funding freeze 'means cuts to many essential services'

Head of local government body issues warning after funding settlement offers no additional money for authorities in 2017/18.

Cuts to public health funding will cost the NHS dear

Juliette Jowit

We should be angry at the chancellor's cynical plans to slash the funding that councils use to tackle problems such as obesity, smoking and drug and alcohol misuse.

Decline in council spending power since 2010

Percentage change at 2012/13 prices

Source: National Audit Office, Dept for Communities and Local Government

*Spending power includes government funding and council tax income.
What is the focus of prioritisation

- Focus on Public Health department priorities
- Focus on Health in all policy
- Focus on commissioned Public Health services
- Focus on Council and NHS services
Principles

• Openness/ transparency
• The whole of the public health grant
• Opportunity costs
• Maximisation health and wellbeing of the population within the cost envelope
• Decommissioning as well as commissioning
• Addressing health and social inequalities
• Cost effectiveness not just evidence base assumption that commissioned services are based on evidence of effectiveness of local services
• Wider determinants of health
• Decision are owned by DLT and adhered to
• Permission to challenge
• Agreed contracts are not set in stone and

• Recommendations and agreed actions are adhered to
• Based on outcomes and best value for money
• **Top slicing of budget to support research/ development/ initiatives / wider determinants to be agreed**
• The assumption that currently commissioned services are based on evidence
• Charging for services should be considered e.g. Leisure services, docspot
• To achieve the maximum health and wellbeing budget within the public health grant envelope
• Need to scope further budget cuts up to 18%
Prevention

Primary Prevention
Health promotion and addressing risk factors, social and genetic factors

Secondary Prevention
Screening of at risk individual, control of risk factors and early intervention.

Tertiary Prevention
Rehabilitation, preventing complications and improving quality of life.

Well Population
People at risk of a health problem
People with a health problem

Spend
Spend
**Overall process**

1. **Overall objectives and strategy**
2. **Principles of approach**
3. **Mandated services**
4. **Review total public health spend rank order**
5. **Apply benchmarking: spend and need, spend and outcomes**
6. **Identify areas for deep dive with a focus on outliers**
7. **Identify areas for investment/disinvestment**
8. **Agree spend/budget**

**Apply prioritisation framework**
How do you save £x million?

You can't salami slice for ever!

How do you spend £x million?
Methods

Between programmes (macro)

Programmes: Tobacco, mental health, obesity etc... (housing, jobs?)
Get a sense of overall priorities

*e.g* Scorecard approach, SPOT tool

Between interventions (micro)

Interventions: Smoking cessation, smokefree campaigns, illicit tobacco
Understand where to invest and shift resources

*e.g* STAR, SPOT tool

Between areas (benchmarking)

How you compare with other similar areas

*e.g* PHE SPOT, CIPFA, PHOF fingertips
# Multi-criteria-decision-analysis (MCDA) - Wakefield

<table>
<thead>
<tr>
<th>Weighting</th>
<th>28</th>
<th>16</th>
<th>20</th>
<th>16</th>
<th>21</th>
<th>Weighted sum score</th>
<th>% of commissioning spend</th>
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<tbody>
<tr>
<td>Programme</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Smoking/tobacco</td>
<td>85</td>
<td>86</td>
<td>93</td>
<td>43</td>
<td>70</td>
<td>77</td>
<td>7%</td>
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<tr>
<td>Obesity</td>
<td>63</td>
<td>83</td>
<td>100</td>
<td>31</td>
<td>79</td>
<td>72</td>
<td>7%</td>
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<tr>
<td>(Public) mental health</td>
<td>85</td>
<td>85</td>
<td>57</td>
<td>35</td>
<td>77</td>
<td>70</td>
<td>5%</td>
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<tr>
<td>Alcohol</td>
<td>85</td>
<td>82</td>
<td>32</td>
<td>56</td>
<td>69</td>
<td>66</td>
<td>4%</td>
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<tr>
<td>Physical activity</td>
<td>70</td>
<td>84</td>
<td>55</td>
<td>38</td>
<td>77</td>
<td>66</td>
<td>4%</td>
</tr>
<tr>
<td>Substance misuse</td>
<td>63</td>
<td>44</td>
<td>11</td>
<td>100</td>
<td>77</td>
<td>58</td>
<td>30%</td>
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<td>Sexual health</td>
<td>70</td>
<td>68</td>
<td>5</td>
<td>75</td>
<td>66</td>
<td>57</td>
<td>24%</td>
</tr>
<tr>
<td>Dental and health</td>
<td>55</td>
<td>66</td>
<td>9</td>
<td>63</td>
<td>66</td>
<td>51</td>
<td>2%</td>
</tr>
<tr>
<td>Domestic abuse</td>
<td>40</td>
<td>77</td>
<td>8</td>
<td>88</td>
<td>58</td>
<td>51</td>
<td>2%</td>
</tr>
<tr>
<td>Health checks</td>
<td>15</td>
<td>53</td>
<td>13</td>
<td>31</td>
<td>55</td>
<td>31</td>
<td>1%</td>
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Socio-technical allocation of resources (STAR) – Wakefield

Detailed focus – within programmes
Technical – needs analyst & health economic skills
Prioritisation scorecard approach - Solihull

- 150 smoking
- 110 weight management adults
- 110 childhood obesity
- 115 drugs and alcohol
- 100 sexual health
- 120 early years
- 120 physical activity
- 105 health checks
SPOT tool – Solihull results
Solihull spend and comparison – 13/14

- Miscellaneous public health services
- Children 5–19 public health programmes
- Smoking and tobacco (all)
- Substance misuse (all)
- Physical activity - children
- Physical activity - adults
- Obesity - children
- Obesity - adults
- Public health advice
- National child measurement programme
- Health protection
- NHS health check programme
- Sexual health services (all)
# Comparison of areas of spend and need with statistical neighbours

<table>
<thead>
<tr>
<th></th>
<th>SOLIHULL</th>
<th>Avg</th>
<th>Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Smoking</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Spend per smoker</td>
<td>£ 26.33</td>
<td>£ 26.33</td>
<td>£ 16.76</td>
</tr>
<tr>
<td><strong>Excess Adults weight</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Spend per obese adult</td>
<td>£ 7.70</td>
<td>£ 7.70</td>
<td>£ 3.41</td>
</tr>
<tr>
<td><strong>Alcohol admission per 100000</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Spend per 'admit'</td>
<td>£ 1,024</td>
<td>£ 1,024</td>
<td>£ 479</td>
</tr>
<tr>
<td><strong>OCU per 1000</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Spend per user</td>
<td>£ 2,266</td>
<td>£ 2,266</td>
<td>£ 929</td>
</tr>
<tr>
<td><strong>Chlamydia diagnoses per 100,000 15-24</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Spend per diagnosis</td>
<td>£ 3,275</td>
<td>£ 3,275</td>
<td>£ 1,370</td>
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</table>
Return on Investment

- Drug and alcohol services for young people: every £ spent brings between £5-£8 benefit
- Every £ spent on adult drug treatment saves £2.50 in society cost
- Sexual health: Every £ spent brings £11 benefit
- CVD: Every £ spent, £11 saved
What happened next?

<table>
<thead>
<tr>
<th>Framework to guide commissioning decisions</th>
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</thead>
<tbody>
<tr>
<td><strong>Priorities</strong></td>
<td><strong>Current needs</strong></td>
</tr>
<tr>
<td>(local/national)</td>
<td>(impact/Ward/District)</td>
</tr>
<tr>
<td><strong>Outcomes</strong></td>
<td><strong>Interdependencies</strong></td>
</tr>
<tr>
<td>(defined/being met/benchmarking)</td>
<td>(LA/NHS/3rd sector)</td>
</tr>
<tr>
<td><strong>Evidence</strong></td>
<td><strong>Service Configuration</strong></td>
</tr>
<tr>
<td>(national/local/value for money)</td>
<td>(informed by consultation)</td>
</tr>
<tr>
<td></td>
<td>(mandatory/discretionary service)</td>
</tr>
<tr>
<td></td>
<td>(alternatives/integration)</td>
</tr>
<tr>
<td><strong>Prevention</strong></td>
<td><strong>Risks</strong></td>
</tr>
<tr>
<td>(primary/secondary/tertiary)</td>
<td>(users/services/financial/political)</td>
</tr>
<tr>
<td><strong>Inequalities</strong></td>
<td><strong>Future considerations</strong></td>
</tr>
<tr>
<td>(target groups/deprived areas)</td>
<td>(contracts/market/demand)</td>
</tr>
</tbody>
</table>

| Re-commission? | De-commission? | or | Re-design? |

Decisions into policy, though council, diluted or scrapped
Challenges

1. Decision making tools – *there are no right answers*

2. The journey (the process) *is as important than as the conclusions*

3. Art v science – interdependencies/impact, politics, *whole system thinking*

4. Who to involve in the process and the decision making (consultation)?

5. Health economics – scale, diminishing returns, timescale, common currency (e.g SROI/ ROI/QALYs)

6. Public health is more than commissioning - *need to embed public health*

7. Is public health spending on the priority areas? How do you prioritise?

8. Top slice wider determinants

9. Blank sheet of paper?
Discussion

**How to best combine the ART and SCIENCE of public health?**

Question of appropriate scale of interventions needs to be addressed and to consider a targeted approach.

There is a natural size of some interventions beyond which marginal returns fall rapidly.

Public Health needs to not forget secondary prevention and linking with NHS screening programmes as well as NHS Healthcheks.

**Who should be involved in prioritisation process and when?**

Application of methods (particularly scorecard approach) wider than public health, i.e. into social care strategy and budgets (this seems feasible) - wider with NHS will be complex.

Need to ensure transparency for the public, and design methods for public consultation that frame the issues clearly and the choices that need to be made.

What is the role of STPs in prioritisation? Public health need to ensure that STP engagement changes from ‘what we (Public Health) can do to support STPs’ to ‘how are you (STP) embedding prevention throughout?’

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