Public Health England

Protecting and improving the nation's health

Place-based approaches to reducing health inequalities

Evaluation report

Contents

Executive summary

There is growing understanding that to tackle many complex public health issues such as the difference in health outcomes between populations and groups (health inequalities), there is a need to intervene at a system level, considering the contribution of, and relationship between, all aspects of place including services, civic organisations and policy makers, and communities themselves. To support this approach Public Health England (PHE) developed a suite of tools and resources known as 'Place Based Approaches to Reducing Health Inequalities' (PBA). The core offer of PBA is an online suite of resources available for all local systems to access, to enable cross-system leadership and action to address health inequalities. The resource was developed by PHE in partnership with Professor Chris Bentley, the Local Government Association (LGA), the Association of Directors of Public Health (ADPH) and through close working with NHS England (NHSE). The PBA suite of resources includes guidance documents and tools to support local areas to implement practical solutions for reducing health inequalities.

In addition to the publication of resources, PHE tested the practical use of the resources at a system or place level through facilitated workshops and support in 4 pilot areas during 2019 and 2020. The support offer included planning with system leaders and delivery of focussed workshops facilitated by Professor Chris Bentley and PHE's National Health Inequalities Team. Workshops gave participants the space and time to apply the PBA tools to their locality and develop place-based plans to reduce health inequalities. The aim of these workshops was to:

- assist organisations to use PBA to identify and agree priority areas and collaborative, systematic action to tackle health inequalities in their areas, at scale
- assess the value of running such directed workshops as an additional resource to the online PBA resources, which are universally available

The University of Manchester was commissioned by PHE's National Health Inequalities Team (HI Team) to undertake an evaluation of the 3 pilot sites (later expanded to 4) receiving the facilitated support offer and the roll out of the universal PBA offer. This document summarises evaluation findings and provides recommendations to inform the development of PBA. As part of this commission, the University of Manchester is also producing an evaluation guide for local areas and for PHE. These will be published separately when completed.

Objectives of the evaluation

The objectives of the evaluation were to:

1. Co-produce a theoretical model of PBA with stakeholders and the Health Inequalities (HI) team.
2. Understand the extent to which the online resource has been accessed, been used and been of benefit to local areas.
3. Understand the challenges and barriers for stakeholders accessing and using the PBA resources and approach.
4. Provide recommendations for development of PBA.
5. Evaluate the effectiveness of PBA workshops.

Methods

A mixed methods approach to the evaluation was used, combining qualitative research methods with quantitative analysis. Realist evaluation methods were selected to deliver an evaluation that could support the ongoing development of the PBA and identify the contextual evidence of what works, for whom, in what circumstances (4).

Researchers from the University of Manchester attended workshops and captured data by interviewing participants about their experience of the workshops and their understanding of PBA. Data on the workshops was analysed thematically and PHE were provided with summaries to inform further workshops. Data collection took place between January 2020 and September 2020. All the collected data was coded into contexts, mechanisms and outcomes. The evaluation team analysed the data to develop an initial programme theory of PBA that could be tested and further refined in future longer-term evaluation. The evaluation team also analysed data on visits to PBA web pages and document downloads using Google Analytics, and observed PHE run workshops to gather feedback from stakeholders.

Universal offer results

Google analytics

Google analytics data was obtained on the number of views of the PBA web pages on the PHE host website and downloads of documents during the period from weeks commencing 30 September 2019 to 19 October 2020. The data was analysed for trends over the period to assess the extent to which the PBA resources were being accessed.

Analysis showed that the most viewed page is the home page, the landing page used to access all pages and downloads related to PBA guidance. Over the 13-month period,

there were 8,966 visits to the home page, an average of 160 views per week. Visitor numbers were highest in the immediate weeks following pre-launch with an average of 294 visits a week during 2019 and reduced during the Christmas holiday period and during national lockdowns. The numbers visiting since the easing of lockdown have been reasonably consistent. Visits to the home page, main report and executive summary were still an average of 102, 62 and 31 per week, respectively, in the period following the lockdown. Downloads of the PBA tools followed a similar pattern.

PHE focus groups

PHE ran focus groups in July 2020 to gather feedback from a range of stakeholders on 3 areas to inform the future development of PBA: Health Equity Assessment Tool (HEAT), PBA Peer to Peer Assessment Tool, and workforce. Members of the evaluation team were able to attend and observe the workshops, which provided data to include in our evaluation report. The HEAT and peer-to-peer assessment tools were considered useful and complemented each other well. Embedding their use within the wider system and not just public health is important, as is ensuring they can be used with a wider range of stakeholders such as the voluntary and community sector.

Pilot results

The evaluation team attended 6 workshops in 4 pilot areas: 2 in North Somerset, 2 in West Yorkshire and Harrogate, one in Lancashire and one virtual workshop in Lincolnshire. The workshops were planned collaboratively between local areas and the Health Inequalities Team. Local areas were responsible for inviting participants and the Health Inequalities Team and Professor Chris Bentley recommended that participants were drawn from the 3 segments of the Population Intervention Triangle (PIT) – services, civic and community sectors. The Population Intervention Triangle is explained in detail in the main PBA report.

Interviews were conducted with 26 participants from North Somerset and West Yorkshire and Harrogate. The coronavirus (COVID-19) pandemic prevented interviews with the other 2 pilot areas. Due to increased workloads no responses to interview requests were received. The results described below therefore only include data from North Somerset and West Yorkshire and Harrogate.

Workshops

The workshops were well received, and participants reported positive experiences. Participants found the PBA toolkit useful to explore local priorities in relation to health inequalities, to assess the existing situation and identify gaps and opportunities for further work. The population intervention triangle, in particular, was identified as a useful tool to both aid understanding of the place-based approach and for service assessment and planning. The characterisation of the 'seams' between

sectors struck a chord with many participants, who considered this a take-away message, which may impact the way they design and evaluate services or interventions.

Participants felt the workshop format added value through the opportunity to network and discuss issues with diverse stakeholders, which fostered common understandings and engagement in the process, and provided them with a ring-fenced block of time to dedicate to the topic of health inequalities. The expertise of Professor Chris Bentley was noted and valued.

From this small pilot, some parts of the self-assessment tools seemed more appropriate to smaller areas such as a local council than a more complex system such as the ICS. There is an appetite to build in the development of an action plan or 'next steps' into the workshop or as a follow up exercise to ensure momentum is maintained. Workshops might have benefited from wider representation, particularly from the community sector.

Understanding and application of PBA

Participants in the pilot workshops had a good understanding of the theory behind the PBA approach and could see opportunities for its application in their roles and local areas. As an addition to previous 'place-based' initiatives, participants felt that this specific programme could provide a 'framework' around which to generate a common set of aims and understandings to tackle health inequalities.

The overarching aim of adopting the approach would be to achieve a reduction in health inequalities and improvement in health outcomes, particularly in the most deprived areas in the pilot sites. However, several shorter-term targets such as the formalisation of priorities and improved recognition of health inequalities were also cited.

Engagement of all stakeholders including communities was seen as the major factor that will influence the success of the programme. Incorporation into formal strategies and the development of infrastructure to support the approach was thought to be key to developing and maintaining engagement across sectors. Resource, capacity, learning from past mistakes and communication were also considered integral to success.

Participants could envisage how PBA might be applied locally although in the main there had not yet been the opportunity to do so. Readiness to adopt the approach varied between the local sites. In North Somerset key factors for success such as political and organisational enthusiasm, and an opportunity to influence policy through the restructure of the Health and Wellbeing Board provided fertile context for PBA, as did recognition of a specific geographical area in need of a targeted approach. In West Yorkshire and Harrogate, there was less clarity on how PBA might fit into the organisational strategy, and where in the system initiatives would be applied. Follow up work to see how the implementation of PBA has progressed following the workshops is recommended in both sites.

A theory of PBA

An initial programme theory of PBA was developed throughout the evaluation (the full details of which are described in the following report). In line with the realist methodology, this theory should be further tested and refined as part of a long-term evaluation. The PBA programme theory will help stakeholders to understand how PBA might work in their context and what factors they may need to consider to help the mechanisms to operate effectively.

Conclusion and recommendations

Whilst the COVID-19 pandemic has had a detrimental impact on both the pilot activities and on the methods proposed to evaluate the universal offer of PHE's Place Based Approaches to Health Inequalities, it has also highlighted the potential utility of the approach. Health inequalities have widened during the pandemic (7) and PBA has the potential to generate a common set of aims and understandings around health inequalities and to provide a framework for action. PBA pilot areas were clear that the PBA resources are valuable but had not had the opportunity to implement them fully during the time of the evaluation. There was some consensus that the facilitated workshop approach with support from PHE may be necessary to support implementation and maximise the impact of PBA. It was evident that pilot areas were motivated to use PBA but lacked a shared understanding on how to implement the approach to inform next steps and action planning.

A summary of recommendations from the evaluation is provided below:

1. The aims, objectives and expected outcomes of the priority setting exercises could be made clearer.
2. Some parts of the PBA self-assessment tools may be more appropriate to smaller areas such as a local council than a more complex system such as the ICS. PHE could consider refining or adapting tools or exercises to meet the needs of the target audience.
3. PHE could consider incorporating the development of an action plan or 'next steps' into the workshop agenda or as a follow up exercise to ensure momentum is maintained.
4. Consideration could be given to encourage local areas to strive for more balanced sector representation at workshops, which may benefit from a wider range of participants, particularly from the community sector.
5. Follow up work to see how the implementation of PBA has progressed following the workshops is recommended in both pilot sites – North Somerset and West Yorkshire and Harrogate.

6. The PBA website could be updated:
   a. Simplify the home page and make it easier to navigate to the main report.
   b. Provide a summary description next to each link describing the contents to allow for easier navigation.
   c. Consider combining Tools A to D into a single document to reduce duplication of content within them.
   d. Create a separate section for case studies and use the same format as the other documents.
7. Consider hosting the HEAT and peer-to-peer assessment tools in one place on a web platform, with all associated documents available. To maximise stakeholder benefit, tools should be modified to incorporate existing data where possible.
8. Ensure all tools are accessible for those without public health expertise. Consider provision of training, and securing senior leadership buy-in to maximise the likelihood of their use.
9. Provide a recorded webinar by Professor Bentley and the Health Inequalities Team on PBA as part of the universal offer. This will allow those areas not involved in the pilot to benefit from their expertise and will offer a useful introduction to inform understanding of the approach and how to implement it.
10. Build evaluation practice into PBA using the toolkits to be provided by the University of Manchester evaluation team:
    a. PBA guidance for PHE evaluation of activities
    b. PBA evaluation toolkit for local areas
11. The programme theory of PBA could be tested through an evaluation of PBA implementation over the long term. Opportunities to access funding to do so can be investigated with the University of Manchester.

Introduction

There is growing understanding that to tackle complexities such as health inequalities, there is a need to intervene at a system level with the community. Public Health England (PHE) developed the Place Based Approaches to Reducing Health Inequalities (PBA) resource to help guide place-based approaches to health. Core to this is Population Intervention Triangle (6) which provides a framework for place-based action to reduce health inequalities. Actions at civic, community and service levels are delivered from a core of place-based systems such as system leadership, partnership working and vision and strategy about the desired change.

To support organisations who want to use PBA, PHE provided a suite of open access online resources. These included self-assessment guides to support place-based action to improve health, a guide to using local health inequalities data to prioritise action on health inequalities and a repository of case studies. In addition, PHE offered facilitated support to use the resources and develop place-based approaches locally in 3 pilot areas during 2019 and 2020. The COVID-19 pandemic stalled the pilots, but also highlighted the importance of health inequalities and how pre-existing inequalities in health have been exacerbated during this testing time. This has emphasised the value that the PBA may be able to have to local systems.

The University of Manchester was commissioned by PHE's National Health Inequalities Team to undertake the evaluation of the 3 pilot sites (later expanded to 4) receiving the facilitated support offer and the roll out of the universal PBA offer. This document provides an evaluation of the PBA. The evaluation period being reported on here is from the commissioning of the project at the start of October 2019 to the end of November 2020.

Place-based approaches to reducing health inequalities (PBA)

PHE exists to protect and improve the nation's health and wellbeing and reduce health inequalities. The PBA was developed as part of PHE's remit to support local systems to reduce health inequalities.

Universal offer

The core offer of the PBA is an online resource available for all local systems to access to address health inequalities. The resource was developed by PHE in partnership with the Local Government Association (LGA), Association of Directors of Public Health (ADPH) and through close working with NHS England (NHSE). The PBA resource includes guidance documents and tools. The toolkit aims to support local areas to

implement practical solutions for reducing health inequalities. Published in July 2019, the toolkit includes:

- a report and executive summary on place-based approaches for reducing health inequalities
- a guide to using national and local data to address health inequalities
- Tool A: guide to place-based action for health inequalities
- Tool B: civic support to communities
- Tool C: service to community
- Tool D: civic to service integration
- a slide set: summary and examples of how to use a place-based approach to reduce health inequalities
- case studies

Pilot offer

As part of the PBA pilot, PHE trialled a facilitated workshop programme delivered by PHE and Professor Chris Bentley to give participants the space and time to apply the PBA tools to their locality and develop place-based plans to reduce health inequalities. The PHE health inequalities team worked with local co-ordinators (Directors of Public Health in the pilot areas) to produce bespoke sessions tailored to meet the needs of the local area.

The aim of these workshops was to assist organisations to use PBA to tackle health inequalities in their areas, and to assess the value of running targeted workshops as an additional resource to the online PBA resource toolkits, which are universally available.

Objectives of the evaluation

The objectives for this evaluation report are:

1. Co-produce a theoretical model of PBA with stakeholders and the Health Inequalities (HI) team.
2. Review of the quantitative data available.
3. Understand the extent to which the online resource has been accessed, been used and been beneficial to local areas.
4. Understand the challenges and barriers for stakeholders accessing the PBA resources and approach.
5. Provide recommendations for development of PBA.
6. Evaluate the effectiveness of PBA workshops.

The following sections cover the evaluation methods and evaluation activity carried out by the University of Manchester team. Following this, we present the results from the

pilot areas and the universal offer. We then present the programme theory of PBA. The final section contains our conclusions and recommendations for the future of PBA

Evaluation methods

Evaluation approach – overview

We used a mixed methods approach to the evaluation, combining qualitative research methods with quantitative analysis. Realist evaluation methods were selected to deliver an evaluation that could support the ongoing development of the PBA and identify the contextual evidence of what works, for whom, in what circumstances (4).

Realist evaluation

Realist evaluation recognises that the observed effects of interventions in complex or variable systems will be contextually contingent. This provides policy-makers and the practice community with a rich, detailed and practical understanding of complex interventions that will be of particular use for the planning and implementation of local, regional or national programmes (3).

Realist evaluation objectives are:

- to assess the theory behind the intervention
- to use qualitative and quantitative methods to capture the intervention, identifying:
    - o a description of the actual intervention
    - o context condition(s) (C)
    - o underlying mechanism(s) (M)
    - o observed outcome(s) (O)
- to identify patterns within a Context-Mechanism-Outcome (CMO) configuration
- to evaluate the robustness and plausibility of the observed patterns
- to compare the findings with the programme theory of change and modify the programme for a future iteration

Central to the realist methodology is the context, mechanisms and outcomes (CMO) approach to the evaluation of interventions. This provides a useful framework which can be used to make sense of complex situations where multiple factors are simultaneously at play (8).

Methods

For the purposes of this evaluation, we defined 2 stakeholder groups:

1. On the ground stakeholders are the practitioners who access and make use of the PBA approach and tools and take part in the pilots.
2. Senior stakeholders are the PHE Health Inequalities team and the commissioners of the evaluation, plus other stakeholders involved in the design of the PBA.

We reported findings and maintained regular communication through project management meetings and email with the senior stakeholders. We provided rapid feedback to ensure timely updates to inform the ongoing delivery of the pilots and maximise their impact. Figure 1 outlines the realist evaluation process and highlights how we collected, analysed and validated the data. The methods are described in detail below.

A project plan was developed and signed off by the senior stakeholders in February 2020. However, many of the methods were rendered impossible by the emerging pandemic and the subsequent lockdown. In consultation with the PHE Health Inequalities team, the methods were adapted to meet the new realities of project delivery and evaluation under COVID. The following sections summarise the methods that were used during the evaluation and are shown in Figure 1.

Figure 1: Realist method for PBA evaluation
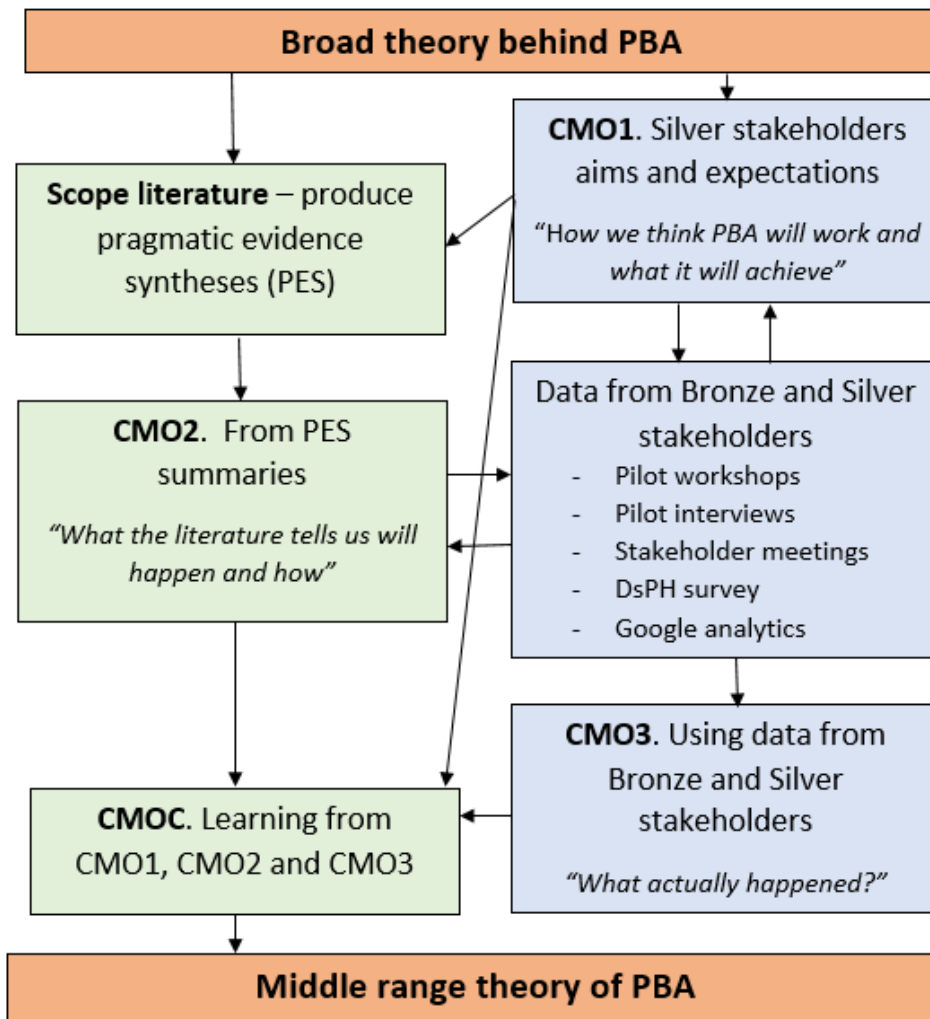
The above flowchart demonstrates:

Starting point: Broad theory behind PBA.

Stage 1a: Scope the available literature to produce a pragmatic evidence synthesis (PES). PES to also be informed by stage 1b.

Stage 1b: Context-Mechanism-Outcome 1 (CMO1), informed by senior stakeholders' aims and expectations, by asking 'How we think PBA will work and what it will achieve'. Informed by stage 2b.

Stage 2a: Context-Mechanism-Outcome 2 (CMO2), informed by pragmatic evidence synthesis (stage 1a), 'what the literature tells us will happen and how'. CMO2 also informed by stage 2b.

Stage 2b: Data collected from all stakeholders. These data may be collected from: pilot workshops; pilot interviews; senior stakeholder meetings; Directors of Public Health survey; Google analytics. These data inform stages 1b, 2a, and 3b.

Stage 3a: Context-Mechanism-Outcome Configurations (CMOC). The combined learning and conclusions for CMO1 (stage 1b), CMO2 (stage 2a) and CMO3 (stage 3b). These configurations lead to the result.

Stage 3b: Context-Mechanism-Outcome 3 (CMO3), informed by data from all stakeholders, asking 'what actually happened?' These insights inform stage 3a.
Result: Middle range theory of PBA developed (also referred to as an initial programme theory of PBA).

Stakeholder aspirations and expectations

As a first step, we set out to identify an initial programme theory. We reviewed documents related to the PBA and coded the data as context, mechanism or outcome, according to the definitions within realist methodology (4) (5). We used thematic analysis (1) to identify common themes and to specify initial context-mechanism-outcome configurations, reflecting the initial theories behind the programme. This was presented to the senior stakeholders in a workshop in November 2019 for their feedback and together we generated an initial CMO matrix, CMO1, which identified key contexts, mechanisms and outcomes of the PBA and highlighted some initial underlying hypotheses to test.

Rapid literature reviews

Following the November 2019 workshop, the evaluation team conducted rapid reviews of the literature to identify evidence to support or refute the underlying hypotheses of the PBA approach. We reviewed literature on community co-production, place-based approaches and systems leadership. The reviews of the literature populated an additional CMO matrix (CMO2). These are available on request from heatlh.equity@phe.gov.uk. Senior stakeholders validated CMO2 in February 2020.

Pilot areas: workshops and interviews

The evaluators attended the workshops in each pilot area and then contacted attendees to conduct telephone interviews to consider the following:

1. Their reflections on the workshops; and
2. Their reflections on their understanding and the potential application of PBA.

The aim of the interviews was to explore the complexities of an intervention that is designed to support local areas to implement practical solutions for reducing health inequalities in what are likely to be widely varying contexts. Semi-structured interviews were recorded, transcribed and analysed. Ethical approval was not needed, as this was an evaluation project that was not collecting personal data. Short summaries of the first workshop in each area were provided to the PHE health inequalities team to inform the delivery of the second workshops.

The transcripts were coded to identify themes, which were then allocated to the context, mechanism, outcome framework through group discussions. The data was collected and analysed to be used along with the data collected for CMO2 and CMO1.

Universal evaluation

In addition to the pilots with their targeted support, the evaluation considered the universal offer available through the PHE website.

DPH survey and interviews

To evaluate the uptake and usefulness of the PBA tools and resources, we planned to conduct an online survey of Directors of Public Health. Our intention was to include a section that would allow public health teams to indicate whether they would be willing to be interviewed. Telephone interviews would then be conducted, recorded, transcribed and analysed. Unfortunately, this survey was timed for early April 2020 and as Directors of Public Health are at the forefront of the management of the outbreak, it was not feasible to conduct it due to the pandemic.

Google analytics

A final strand to the evaluation of the universal PBA offer was the analysis of Google analytics data.

We obtained page view data by week between September 2019 and October 2020 for 5 HTML pages:

1. PBA main page
2. PBA main report
3. PBA annexes
4. PBA foreword and executive summary

We also collected the download numbers for the PBA resources:

1. A guide to using national and local data to address health inequalities
2. Tool A: a guide to place-based action for health inequalities
3. Tool B: civic support to communities
4. Tool C: service to community
5. Tool D: civic to service integration

We analysed this data to assess the use and utility of the web pages and the analytics data to support future evaluation activities.

A theory of PBA

All the collected data were coded into contexts, mechanisms and outcomes. The evaluation team identified the context-mechanism-outcome configurations (CMOC) that led to each outcome. We used these CMOCs to develop an initial programme theory of PBA (referred to as a middle range theory in realist evaluation) which can be tested and further refined in future longer term evaluation (2).

Evaluation activity summary and project management

Project management

Two meetings were held with the senior stakeholders of the evaluation:

1. November 2019 to develop the initial CMO1 framework (initial programme theory).
2. February 2020 to validate the CMO2 framework and proposed success indicators.

Additional meetings did not take place because of the impact of the pandemic. Monthly project management meetings took place throughout the project from November 2019 to November 2020 between the HI Team and the evaluation team. Monthly meetings paused between April and August 2020 with 2 separate review meetings in May and July 2020.

Evaluation activity

Below is a summary of the key areas of the evaluation activity.

North Somerset pilot

Two researchers attended the 2 workshops in North Somerset on 18th November 2019 and 16th January 2020. We were able to conduct 19 interviews with workshop participants. We had planned to conduct follow up interviews 3 months after the second workshop to evaluate progress, but this was not possible due to the pandemic.

West Yorkshire and Harrogate pilot

Three researchers attended both workshops for the West Yorkshire and Harrogate pilot. The first took place on 16th December 2020 and we were able to interview 9 participants. The second workshop took place on 28th February 2020. COVID-19 measures coincided with data collection post-workshop 2 and meant we were only able to interview 3 participants.

Lancashire pilot

Two researchers observed the first Lancashire workshop on 10th March 2020. COVID-19 measures prevented any further pilot activity. We were able to conduct one interview, but it was not included in the final analysis due to the lack of data collection.

Lincolnshire pilot

Lincolnshire was added as an additional pilot area. Three members of the research team observed the first workshop, held through videoconferencing software Microsoft Teams, on 24th September 2020. We were not able to conduct any interviews with participants and therefore the pilot was not included in the final analysis.

Universal offer

We intended to survey Directors of Public Health (DsPH) across the country to test the knowledge of PBA within the public health teams, including whether they had made use of the resources. We would then have conducted semi-structured interviews with DsPH to identify how the PBA resources had been used, how useful they were, challenges or barriers experienced, and any recommended improvements. COVID-19 measures prevented this strand of the evaluation.

In July 2020, PHE conducted 3 online workshops with stakeholders to obtain feedback on PBA and associated tools. Members of the evaluation team were able to attend and observe the workshops, which provided data to include in our evaluation report.

Universal offer results

Google analytics

Google analytics data allows us to see the number of times a web page has been viewed and documents downloaded. For this analysis, page view and download data were obtained from Google analytics between weeks commencing 30th September 2019 and 19th October 2020.

Page views

The page view data looks at the visits to the following and is shown is Figure 2:

- home page – Guidance on health inequalities: placed-based approaches to reduce inequalities
- main report – Placed-based approaches for reducing health inequalities: main report
- foreword and executive summary – Place-based approaches for reducing health inequalities: foreword and executive summary
- annexes – Place-based approaches for reducing health inequalities: annexes

As seen in Figure 2 the most commonly viewed page is the home page, the landing page used to access all pages and downloads related to PBA guidance. Over the 13-month period between September 2019 and October 2020, there were 8,966 visits to the

home page, with a weekly average of 160 views. Visitor numbers were highest in the immediate weeks following pre-launch with an average of 294 visits a week during 2019. As well as being the most commonly viewed page, the home page experiences the most fluctuation in weekly page visits. The number of page views declined steadily over 2019, a decline that was possibly expected following the initial launch.

A sharp decline in views occurred in the week beginning 23 December 2019, which was a shared experience on all pages. The visits to the home page reduced from 242 in week commencing 16 December 2019 to 21 in week commencing 23 December 2019. This is likely due to 2 reasons: the Christmas period, and the change in cookie consent process for GOV.UK on 20 December 2019 to an opt-in model in line with the Information Commissioner's Office guidelines. Since then, the website can only gather data from people who explicitly have allowed it to do so, whereas previously it would assume consent. Based on previous traffic to GOV.UK, the government digital service estimate approximately 30 to 40% of users provide consent. This may account for some of the reduction in average weekly visits from 294 in 2019 to 154 in early 2020.

There was a sharp decline seen in March coinciding with the COVID-19 pandemic and national lockdown on 23rd March 2020, which saw public health professionals redeployed across the country. The average weekly views reduced by a third from 154 in early 2020 to 102 visits per week from lockdown until the end of the period of analysis. Visits to the home page have exceeded 100 per week since the relaxation of lockdown in early May (except during July and August where lower visit numbers would be expected).

Figure 2: PBA page views from weeks commencing 30 September 2019 to 19 October 2020
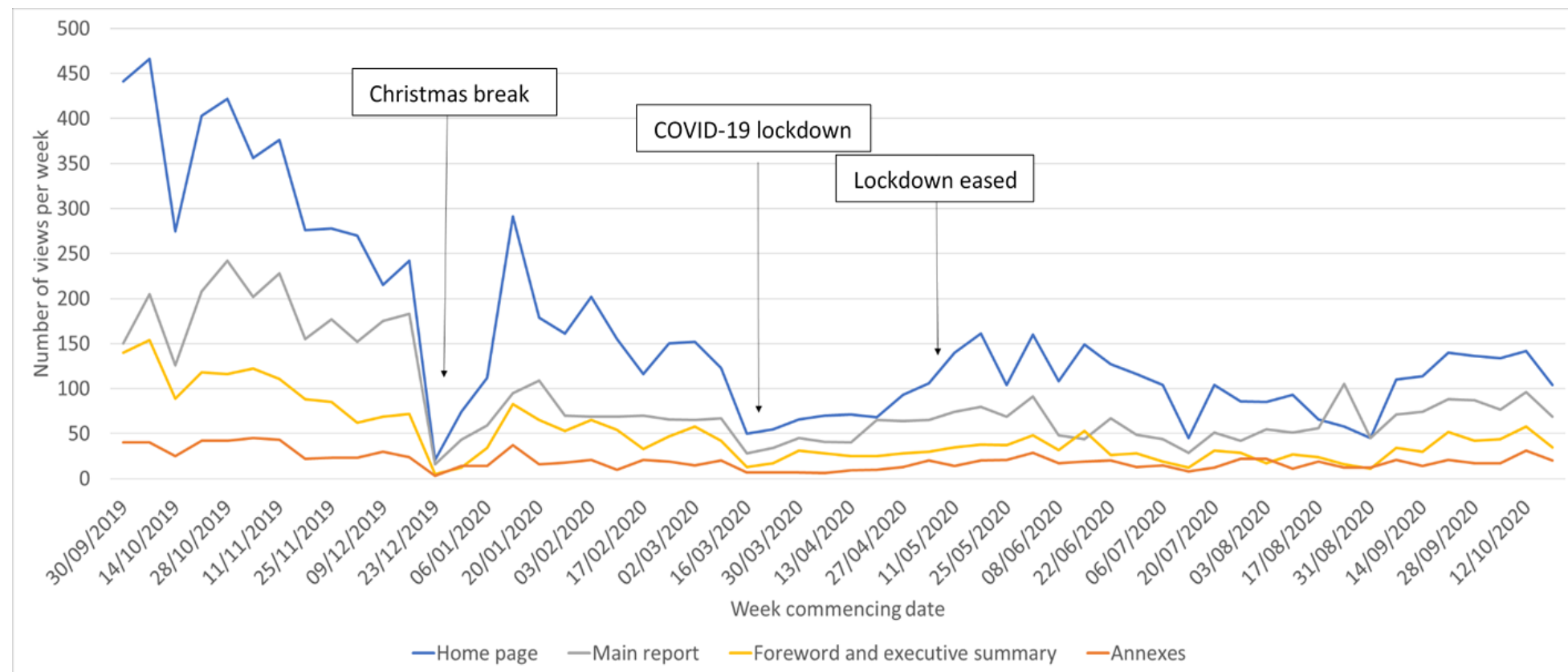
Over the 13 month period under review, there were 4,945 visits to the main report, with 88 average weekly views. Similar to the main page, there was a drop off in views from a weekly average of 162 in 2019 to 70 in the early part of 2020, prior to the March lockdown. The average views reduced slightly to 62 per week between lockdown and the end of the reporting period in October 2020. There were between 29 and 62 weekly views of the main report since the relaxation of the first lockdown in May 2020.

The foreword and executive summary page was visited 2,752 between September 2019 and October 2020, with a weekly average of 49 views. The average weekly views over the period follow the same declining pattern from 89 views per week in the 2019 period, reducing to 50 in the pre-lockdown period of 2020 and 31 per week in the post lockdown period of 2020.

The annexes had the lowest viewing figures of the 4 pages and were visited 1,113 times over the period under evaluation, a weekly average of 20 views. This equates to 30 views per week in 2019, 18 views per week in the 2020 pre-lockdown period and 16 views per week in the post-lockdown period.

Looking across the pages, there is a consistent gap between the visits to the home page and those that click to go on to the main report. On average, just over half (55.2%) of home page views led to views of the main report page. Increasing the numbers of people who click through from the home page to the main report or executive summary should be a priority. This could potentially double the number of people reading the report or its executive summary. However, it is worth noting that despite the turbulence experienced during this period, the main report was viewed between 28 and 70 times each week during 2020.

Download data

The download data looks at the visits to the following:

- Tool A: Place-based working towards population-level change in health inequalities
- Tool B: Civic support to communities
- Tool C: Service to the community
- Tool D: Civic to service integration
- A guide to using national and local data to address health inequalities

Figure 3: PBA downloads from weeks commencing 30 September 2019 to 19 October 2020
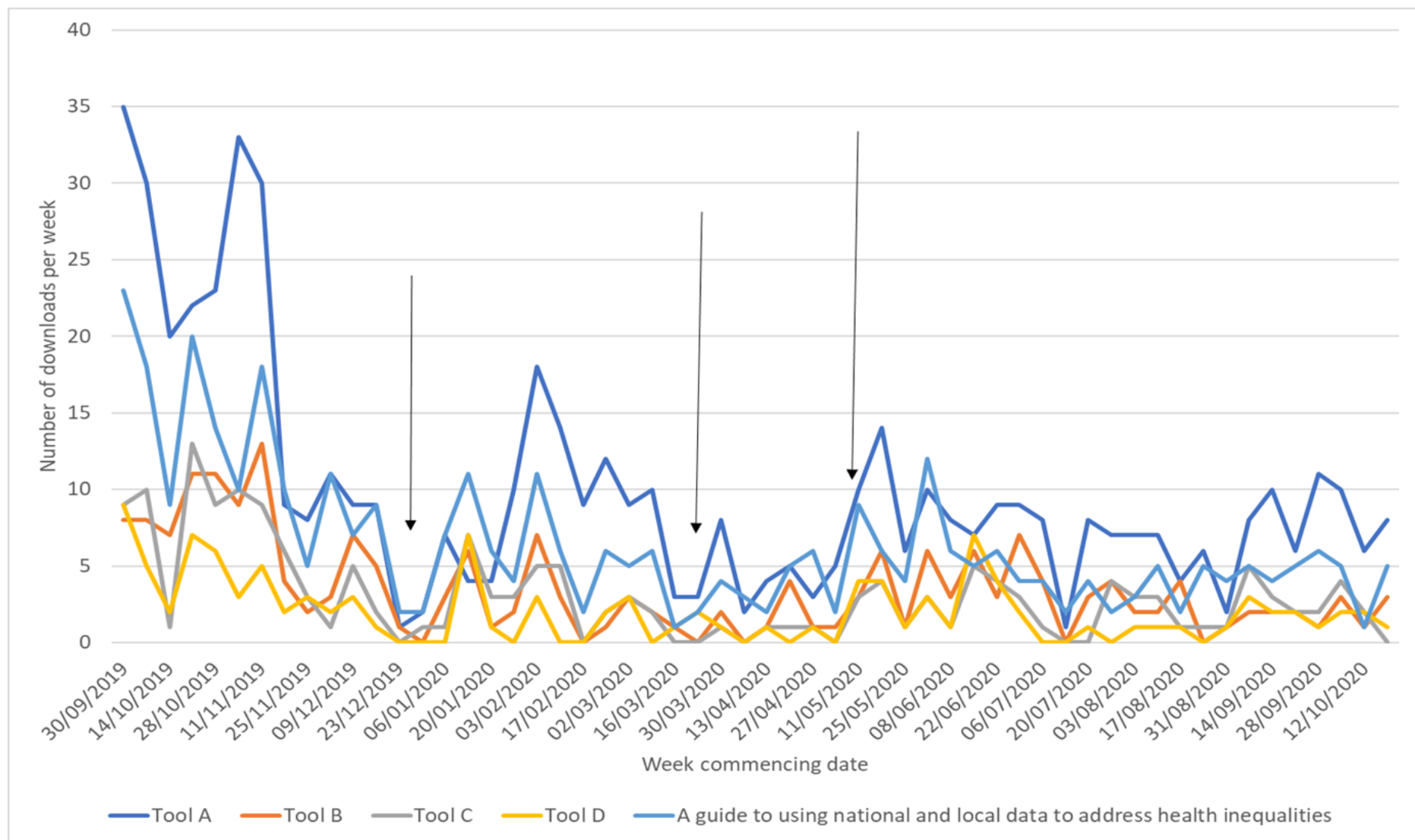
The pattern of downloads is very similar to that of the page views with large drops over Christmas of 2019 and when the lockdown was implemented in response to the COVID-19 pandemic in March 2020. Download figures after Christmas 2019 have to be treated with similar caution due to the change in consent processes.

As seen in Figure 3, Tool A is the most downloaded document, followed by the guide to using national and local data to address health inequalities. The tools were downloaded 554 and 361 times over the period, an average of 10 and 6 downloads per week, respectively. Both experienced reductions in the weekly downloads between September 2019 and October 2020. Weekly downloads of Tool A reduced from a weekly average of 17 in 2019 to 7 in the post-lockdown period of 2020. Downloads of the guide to using data to address health inequalities reduced from 11 per week to 4 per week between the same periods.

Tool B was downloaded 196 times over the period, an average of 4 times per week. The average weekly downloads reduced from 6 to 2 per week after the lockdown was announced. Tool C was downloaded 170 times over the period, 3 times per week. On average, the weekly downloads reduced from 6 in 2019 to 2 following the start of the COVID-19 lockdown. The least downloaded document is tool D, which was downloaded 114 times over the period of evaluation. This is an average of 2 downloads per week, which did not change significantly over the period.

A brief description of each tool and/or combining tools A to D into a single PDF would make it simpler for people to navigate and find the required tool. There is a clear drop in download activity for each tool, A to D, as each subsequent tool is less frequently downloaded than the previous. It may be useful to understand the reasons for this drop off, including whether it indicates further support is needed to work through the later tools.

There were only 106 views of the case studies throughout the period. This is likely because the link is not as obvious as others are and is at the bottom of the page under the "details" section as part of normal text. Creating a separate section with a description and a link similar to the main report could make this more obvious to find and access.

Conclusions

Several recommendations stem from the analysis:

- simplify the home page and make it easier to navigate to the main report
- add in a summary next to each link describing the contents to allow for easier navigation
- consider combining Tools A-D into a single PDF document to reduce duplication of content within them

- have a separate section for case studies and use a similar format as to other documents

PHE focus groups

PHE ran focus groups in July 2020 to gather feedback from a range of stakeholders on 3 areas to inform the future development of PBA: Health Equity Assessment Tool (HEAT), PBA Peer to Peer Assessment Tool, and workforce. This section summarises the discussions that took place.

HEAT tool

The HEAT tool is a framework for assessing health inequalities and equities. A summary version and e-learning module is also available to support different users. Feedback in the section included:

1. It is useful for informing service redesign and business planning, communication in services and driving quality improvement. The tool is practical and simple to use. The simplified version of the tool may be better for working with wider colleagues.
2. It needs embedding into the wider system, and not just regarded as a 'public health' tool.
3. The language was not too public health centric and good for using with wider stakeholders.
4. Consideration should be given to including it in the commissioning cycle.
5. Limited availability of data is a challenge. A tool that utilises already available data is preferable.

Peer to peer self-assessment tool

The peer-to-peer self-assessment tool offers extended questioning for PBA. It can be used in a more interactive way to form an evidence-based response. Key comments were:

- the tool is quite timely given the impact of COVID-19 currently on emphasising certain health inequalities
- the structure of the framework was liked and considered useful, particularly the inclusion of evaluation from the very beginning
- all documents should be linked in one place with a user guide. Clarify whether sections of the tool could be used in isolation, rather than full completion, which may increase flexibility of the tool
- as the tool complimented the HEAT tool, hosting it on a web platform supporting collaboration would be beneficial

- this tool's unique selling point is engaging to understand communities. It is important to understand the community perspective on what 'good' looks like Elective member buy in is important, along with Health and Wellbeing Boards and Local Government Association endorsement and a link into Primary Care Networks. As this can be bureaucratic and slow, this needs consideration
- due to workload pressures, the tool needs to be easy and quick to use. The tool needs preferably to pull data into it automatically. Marmot indicators for local authorities data should be embedded

Workforce requirements

A third discussion was about the workforce requirements to enable organisations to make use of the tools. A summary of the key points is given below:

1. When asked what skills and competence requirements were needed, some felt this was difficult to answer due to current service pressures and lack of resources. There was a feeling that there was a lack of resources to do this.
2. There are few public health professionals in some organisations, so it can be difficult to secure the required expertise.
3. The tools need to be useable for anybody involved in the PBA work, to instil confidence and competence in using them. This is important as skills and competence can vary widely.
4. Cultural competence is important and a requirement for reaching hard to engage and underserved communities.
5. The voluntary and community sector are an excellent source of intelligence and a responsive resource. They should be trained to use the tools. However, train the trainer models should be avoided due to capacity issues.
6. Specific training for 'how to work with community groups' is required.
7. Although sometimes a challenge, senior level buy-in is required to support implementation.

Conclusions

The HEAT and peer-to-peer assessment tools were considered useful and complemented each other well. Embedding their use within the wider system and not just public health is important as is ensuring they can be used with a wider range of stakeholders such as the voluntary and community sector.

1. Hosting the tools in one place on a web platform, with all associated documents available and developing the tools to draw in already available data would be most beneficial to stakeholders.
2. Ensuring the tools are easy to use for those without public health expertise, provision of training and senior leadership buy-in will prevent additional pressure on resources and time and maximise the likelihood of their use.

Pilot areas results

The evaluation team attended 6 workshops in 4 pilot areas: 2 in North Somerset, 2 in West Yorkshire and Harrogate, one in Lancashire and one virtual workshop in Lincolnshire. The workshops were planned collaboratively between local areas and the Health Inequalities Team. Local areas were responsible for inviting participants and the Health Inequalities Team and Professor Chris Bentley recommended that participants were drawn from the 3 sides of the population intervention triangle (services, civic and community sectors).

Interviews were carried out with attendees at PBA workshops with North Somerset (NS) Council and West Yorkshire and Harrogate (WYH) Integrated Care System (ICS) between November 2019 and February 2020. A total of 26 participants were interviewed, some of whom attended both workshops and 2 interviews.

Evaluation of the workshops

Participants were asked about their expectations of the workshops and whether these were met, use of the PBA toolkit and for general feedback. Below we provide a summary of the themes that emerged from the interviews.

Workshop expectations

Most people attended the workshops after a conversation with or invite from the DPH or local organiser. Participants felt the workshops were relevant to their role, or institutional priorities to reduce health inequalities, and saw it as an opportunity to 'initiate discussions' with colleagues and other relevant stakeholders. Whilst most respondents did not have specific expectations or 'preconceived notions' of the workshops, they had an interest in the approach, and expected the session to be interesting and that they would come away with new information.

> "If I'm honest, I didn't know what to expect, didn't have time to think about it. But I thoroughly enjoyed it and found it fascinating and very relevant and could obviously make connections between the workshop and the work I do."

Several participants commented that provision of the toolkit in advance to allow for pre-reading might have been helpful, although there was also an acceptance that many would not have time for this.

> "The agenda did have a link to all of the tools online but looking at that fresh was quite overwhelming. And that's why I feel like there needs to be a middle ground

where you can realistically expect people to spend 10 minutes to read it, get a feel for it and then come to the workshop prepared."

For those that attended both workshops, there was an expectation that the second would progress to a more concrete application of the toolkit in the local area. There was a feeling from some that this expectation was not fully met. In WYH, some participants expected to gain further clarity about how health inequalities would be tackled at an ICS level and that although these discussions took place, participants felt this was still to be determined.

Structure and format of workshops

As part of the PBA pilot, PHE trialled a facilitated workshop programme bespoke to each area. This was delivered by PHE and Professor Chris Bentley to give participants the space and time to apply the PBA tools to their locality and develop place-based plans to reduce health inequalities. The PHE health inequalities team worked with local co-ordinators (Directors of Public Health in the pilot areas) to produce bespoke sessions tailored to meet the needs of the local area.

General Feedback

General feedback for the sessions was positive, and participants felt that overall, the sessions were well pitched with plenty of 'opportunities for participation' and discussion. For some specific sessions, participants felt that a clearer idea of the desired outcomes or 'learning objectives' would have been helpful to guide the activities.

All day sessions were a large chunk of time to take out of people's diaries, but feedback indicated that the opportunity to block out this time to discuss health inequalities with others was appreciated, and time well spent.

It was suggested that earlier communication of the event and the timings might have allowed others to attend. There was good coherence between the workshops, and the recap provided a good briefing for those who had only attended workshop 2 and a useful reminder for those who attended workshop 1.

Examples and case studies of where the approach has worked elsewhere were appreciated and helped participants to envisage how PBA might work in their own areas.

> "I can't overemphasise how helpful it is to have people come and talk about things that have been done in other areas. Sometimes it's really difficult to find examples of things that have been done elsewhere. It's that real proactive sharing. Sometimes when you contact regional colleagues, it can be quite hard to access and find, there would be loads of googling etc. so it's really helpful to have examples of similar work that has been done in other areas."

Suggestions for improvements included a formal introduction section for participants and mixing up tables between activities to allow for further networking and a mix of perspectives.

On a practical level, several participants mentioned that they had not received the slides from the sessions, or asked how to access them, suggesting they may not be aware that the resources are available via the PHE website.

External facilitation

External facilitation was considered 'helpful' ('critical' by some) for an outside perspective and to encourage openness and honesty, enabling attendees to be 'more willing to talk' where previously internal discussions may have stalled. Walk-through of the tools from the facilitators was considered helpful, as opposed to exploring the tools from the website without further explanation.

> "I would put a lot of value on any area that wants to use it being able to have the workshop, even if it's just one workshop just to explain the concept behind it."

In particular, the expertise brought by Chris Bentley was warmly welcomed and felt to benefit the process, both in terms of proof of concept from previous application of the approach and for highlighting local issues.

An expert in the field added weight to discussions around local area prioritisation, which may have been acknowledged but the importance not fully recognised. For example, the extent of the disparity between outcomes in Weston-Super-Mare and elsewhere in NS.

> "Now if I had just looked at that graph I would have just said oh yeah there's that bottom decile and same thing we know, but having someone that experienced who had seen so much of different systems, it was actually very powerful for him to make that point."

Conversely, some participants felt that local facilitation might have aided discussions in some cases, particularly during activities designed to apply the toolkit to a local context, where some existing local knowledge may have been beneficial.

> "I think because they were external facilitators some things got lost in translation, I think. Perhaps having facilitators from our local area would have a bit more ownership of that work that we did on that as well."

A combination of the 2 approaches might be considered for future workshops.

Sector representation

Participants welcomed the opportunity to discuss issues with colleagues from other sectors, and networking was one of the main stated benefits of the sessions. However,

concerns were raised that some important stakeholders or sectors were underrepresented. Participation from the community sector was felt to be lacking, especially in the sessions that specifically addressed the community aspects of PBA.

> "The people who were in the room were the health professionals and commissioners who already work in the sector. So clearly not having the community voice at the right level and having the numbers of organisations around the room could mean that it's a process going in a certain direction without actually having effective consultation."

In North Somerset, the NHS and primary care were specifically cited as underrepresented, and from within the council itself, it was suggested that the information about the event may have been 'better understood by people with a health service background' perhaps limiting attendance from other departments. In West Yorkshire and Harrogate, it was felt there was need to expand participation to the wider local authority workforce.

It was recognised that stakeholders from a wide range of sectors were included in the invitation list, and in some cases, non-attendance was a result of competing work schedules. However, consideration of scheduling and earlier communication were suggested as potential solutions.

> "I think that one of my disappointments was when I saw the invite list, that didn't really match with those of us that did attend, so for me there was some big gaps around primary care, some of the GPs, and I can't remember but there was no mental health representation in the room that I was aware of, and I felt that was significant really, I felt that was a shame."

Use of the PBA tools

Both workshops followed a similar format, with self-assessment tools from the PBA toolkit used in the morning sessions, followed by area-specific priority setting exercises in the afternoon, designed with more input from local area leads.

For most participants, the workshop was their first exposure to the PBA toolkit. The tools employed in the sessions were considered useful and sparked relevant discussions, to the extent that it was commonly felt there had not been enough time to complete the exercises in enough depth.

> "A personal reflection on that, I don't know if we had enough time to sufficiently go through the tool in the depth that it required because there was an awful lot of information and discussions that were being had on our table that we just didn't have the time to follow-up because we were very mindful that we had to get through every element of the tool in that session."

Self-assessment was found to be a good conversation starter and facilitated 'honest' discussions about different understandings of progress, and the situation in different areas of the system. Participants welcomed the opportunity to hear opinions of other stakeholders.

> "I think it was quite an interesting conversation, because we were trying to see the effects as a healthy economy and what is happening across the whole of North Somerset. We had five or six people from different organisations with different perspectives. There was quite a debate when trying to decide where people felt they were in terms of the assessment."

As the self-assessment tool related to different aspects of the Population Intervention Triangle, an exercise was carried out at each session and there was a suggestion from some participants that this was 'repetitive', where moving on to practical application may have been more productive.

Particularly in West Yorkshire and Harrogate (but also arising to some extent in North Somerset), there was a feeling that some of the self-assessment tools were harder to apply when participants were from different levels in the system. Some felt this was a good way to highlight the issues and start discussions, others felt it made the tools difficult or perhaps 'impossible' to use practically.

> "I mean what we're talking about and what we were trying to evaluate using that tool was so big – it's the West Yorkshire and Harrogate system, which is every health organisation, every community sector organisation, every local authority across West Yorkshire and Harrogate and each of those individual components are already really big in themselves. So maybe it's just impossible really… I thought some of the points on the list were useful elements of it. I was thinking, if I was leading a similar piece of work, it might be helpful to have that list almost as a checklist. You know, have we thought through these things. I can see it might be useful in that way."

In both settings, the initial self-assessment tools were well received, but participants were less clear on the aims and purpose of afternoon priority setting sessions. There was a feeling that although discussions were useful and stimulating, it had not been possible to 'get to the priority or outcome needed'.

> "I think for the afternoon one, the ask definitely needed to be clearer. I think even though we had kind of been told what to do, I think the facilitators, they couldn't really explain it back to us, and there was also a lot of data on the tables to be able to digest in that sort of time and use it in a meaningful way."

The Population Intervention Triangle was considered clear and easy to apply (a 'very succinct and elegant way of describing how the different interventions fit together'). Many felt that this would be the tool they would be most likely to take back into their roles, as a 'visualisation tool,' and a method of checking that all elements of a service or intervention had been considered.

> "I think it's the easiest one to engage with. With any kind of simple graphical representation, you can kind of get your head around it quite quickly, and then after that it is about choosing the different tools that deal with the different points of the triangle, and the seams between them, to think about can we look at that in a slightly more systematic way or what is going on there, do we think we are working well or are there areas where we can be doing better."

For many, this was the tool that 'sticks in the mind' and discussion around the seams gave participants a new way of framing their service delivery.

> "And I think the seams – I had not seen that described before – we often talk about the gaps, but it was a much more proactive way which showed that you actually can target the seams."

Whilst the tools were thought to be a good mechanism for fostering common understandings, some felt there might be a need to ensure the language used is transferrable across disciplines, particularly where the aim is to achieve a cross-organisational approach. The workshop approach to introducing the tools was welcomed by participants, many of whom felt accessing them through the website alone without further direction might have been overwhelming.

> "I think there's a lot of value in the workshops. I think that yes, you could in theory just use the tools, but I think due to the level of detail in the tools that they offer – which is needed for them to be successful but still, there is a lot of reading and understanding that needs to be placed in order to achieve the maximum benefit – and I think because of that, without the workshop, I don't think we would've had a positive reaction."

Value of the workshops

Several key themes emerged where participants felt that the workshops added value: engaging people in the process, improved knowledge and understanding, networking opportunities and providing time and space to focus on health inequalities.

Engaging people in the process

In both sites, workshops were seen as a good 'kick-start' to get people together and 'on the same page', facilitating thinking about:

- current ways of working and gaps in service provision
- health inequalities as a priority
- understanding how PBA might link to their work or role
- building engagement and momentum

> "I think bringing that group of individuals, the attendees together shares understanding, improves understanding of why the ICS is doing what it's doing. It enables and facilitates conversations in the room as well; I think it drives a degree of connectivity between partners across the system, across the different places so that's all good. Shared understanding has improved so it's good to bring people together and it's good to talk about that kind of stuff in a room."

In North Somerset in particular, local organisers felt that the workshops fostered a sense of ownership and engagement with the approach, which was one of their main aims.

> "It was a sense of collective ownership, and expectation I suppose is what I wanted to create, an expectation that we were going to work together effectively and that there was a possibility to do things a bit differently, and to use a framework that would last in North Somerset for a long period of time and be relevant and I think we did get some of that build in the first workshop."

The participants also observed enthusiasm.

> "I think people just opened up. People…there is a desire to change. And a need for change."

Improved knowledge and understanding

Participants left with a greater understanding of PBA and more specifically the tools and how to use them in practice, and PBA as a 'framework' on which to structure interventions to tackle health inequalities.

> "There hasn't been any difference in my understanding of place-based approaches since the last workshop, but it's more about understanding how that works on a practical level. I have a better idea of how that might be put into practice in a particular setting."

However, for some, there was still work to do before they felt the tools could be applied in their own roles or settings.

> "But in terms of taking techniques and tools away, and gone, ah, I can apply that specifically in my bit of the world…that is a different question and a lot less obvious."

Participants also reported a better understanding of the issues in their area because of discussions with others and from the presentations prepared by Chris Bentley.

> "I suppose my takeaway was about actually, if you really did prioritise everything around those wards that would have the biggest impact. So for me, it wasn't new information but when it was presented was very impactful about just how much outliers those wards were, and that's where you would focus."

Some in West Yorkshire and Harrogate reported the workshops increased their understanding of the ICS structure and priorities, including where health inequalities fit in.

> "I am new to this role, and I wanted to understand what systems are doing in terms of health inequalities and how they approach that. It gave me new tools and insight into a new approach to take our programme forward."

Networking

A commonly cited expectation of the workshops was to meet others from across sectors, and this aim appears to have been met and appreciated. Participants valued the opportunity to broaden their perspectives, 'strengthen relationships' and 'reflect' on the opinions of others.

> "The added value is the connections that happen with the people I met on the day during the workshop. Because the partnership is so big, people don't always get the opportunity to connect with other people. And I've often said "I don't know what I don't know until someone tells you."

Some participants reported having continued these conversations and followed up new links outside of the workshops.

> "And one of the participants I met and spoke to, we've since connected with someone in my team for a project that we're working on that we thought we might be able to work together. So that's always helpful as well."

Time and space

With busy schedules, participants valued the provision of a specified block of time to focus exclusively, with sufficient time and space to think and discuss in depth.

> "It's partly about having it in a more structured way but it's also about having that time to think about it a bit more rather than it being conversations on the fly always being tacked on to some other set of priorities. Having space to think it through a bit is important, I think."

Workshop outcomes

Whilst the value of the workshops was recognised by all participants, a significant number expressed disappointment that the sessions ended without 'concrete actions' and next steps being set and would have liked to have seen greater focus on 'practical applications'.

> "I guess really we have identified some of those key themes and now I think it is about fleshing out what it means – what are the longer term aims, are there immediate opportunities and actions to get things happening, and from (our) perspective, what do we need to do to position ourselves to be able to support this agenda."

In North Somerset, the leadership team felt the outcome of the workshop was positive and had a clear idea about how this would feed into the organisational strategy moving forward, but this appears not to have been clear to other participants at the time of interview.

> "Taking that a step further and getting towards an action plan. Just getting some clear actions, even if that meant that it all went to the health and wellbeing board and that's the place to do those next steps. That might be the answer, but it wasn't clear."

In West Yorkshire and Harrogate, most participants remained unclear on specifically how PBA might be incorporated into the ICS strategy.

> "Again, this comes back to the practicality bit about West Yorkshire and Harrogate. If that was an opening workshop to explain the tools and approach and that kind of stuff and to get people on the same page. I'm not convinced it 100% did that but it certainly provided some clarity. Like any workshop I think the next step is how we take that and make it real and useful for people in the room."

Conclusions

1. The workshops were well received, and participants reported positive experiences.
2. Participants found the PBA toolkit useful to explore local priorities in relation to health inequalities, assess the existing situation and identify gaps and opportunities for further work.
3. The population intervention triangle was identified as a useful tool to both aid understanding of the place-based approach and for service assessment and planning. The characterisation of the 'seams' between sectors struck a chord with many participants, who considered this a take-away message, which may impact the way they design and evaluate services or interventions.

4. The aims, objectives and expected outcomes of the priority setting exercises could be made clearer.
5. External facilitation was helpful both in the explanation of the toolkit, and in fostering discussion. The expertise of Chris Bentley was well noted.
6. Participants came away with improved knowledge about PBA and how it might apply in their roles.
7. Participants felt the workshop format added value through the opportunity to network and discuss issues with diverse stakeholders, which fostered common understandings and engagement in the process, and provided them with a ring-fenced block of time to dedicate to the topic of health inequalities.
8. From this small pilot, some tools seemed more appropriate to smaller areas such as a local council than a more complex system such as the ICS. It may be possible to refine or adapt tools or exercises to meet the needs of the target audience.
9. Whilst some participants would have liked a more concrete action plan as an outcome of the workshop, motivation to put the approach into practice seemed strong in the responses. Follow-up will be necessary to determine how this develops post-workshop.
10. There is an appetite to build in the development of an action plan or 'next steps' into the workshop or as a follow up exercise to ensure momentum is maintained.
11. Workshops might have benefited from wider representation, particularly from the community sector.

Evaluation of understandings and application of PBA

In addition to providing feedback on the workshop experience, interview participants were asked about their understandings of PBA as an approach to reducing health inequalities including how it might be applied in their own roles. These results fed into the development of the CMOC and the programme theory of PBA, which is central to this evaluation (see A theory of PBA). To supplement this, a summary of the interview findings is presented below.

It should be noted that data collection took place before the impact of COVID-19.

Understandings of PBA and its value in tackling health inequalities

Participants were asked what they understood by PBA, and across the 2 sites, understandings fell broadly into the following 3 categories:

1. Systems perspective – PBA as a facilitator to bring together sectors as part of a strategic approach. Some participants drew on resources from the toolkit to elaborate here, with mention of the population intervention triangle and the relationships between service, civic and community sectors.

   > "From our perspective as a voluntary sector infrastructure organisation, PBA is bringing together health, wellbeing, public sector and third sector to ensure we have a joined up strategic approach to reducing health inequalities."

2. Focusing on the needs of smaller local areas or neighbourhoods and designing appropriate responses, often incorporating increased community involvement.

   > "It is about the needs of a population in a particular place. What services exist, how are they delivering, how might they be improved or work in a more collaborative way to improve outcomes for the people that live in a certain place."

3. An approach to public health that is wider than a medical or clinical approach and incorporates wider determinants.

   > "I think I understand it to be fairly broadly drawn and probably about trying to understand the various kinds of inputs that would affect health and wellbeing, so rather than being what you might describe as a purely clinical approach to all of this, what are the various inputs that might affect health and wellbeing."

There was a mix of previous experience, with some participants having used similar approaches before, and others drawing solely from their learning in the workshop sessions.

Many participants felt they were familiar with the approach as a principle, although sometimes under a different guise. However, most were not familiar with the specific toolkit and PHE suite of resources before the workshops.

> "I probably have come across it before, I have worked across public sector and NHS for over 30 years. It may not have been called PBA. But there have been lots of similar approaches looking at demographics in certain areas in terms of services being provided or commissioned."

Some felt that this package of resources added value (see below) whilst for others there was a suggestion that this was not innovative.

> "It's good. I think probably when I've spoken to other people in the team they are like 'oh no, not another framework'. So I think some people might wonder what is new or different about this approach, but I personally think it's a good simple one."

Those who felt the approach added value identified several ways in which it did so. These included a recognition that hitherto service level approaches had not been sufficiently effective, with PBA as an alternative option incorporating a broader range of stakeholders, providing an opportunity for increased community involvement.

> "There's a way into, from my perspective, to climb across the top of the organisation and be involved in activities going on in different places, in different parts of the organisation, bring able to stich some of that together through a health and wellbeing strategy sounds eminently sensible and actually quite a good way of trying to build a coalition around place."

This, it was felt, would add opportunities to 'influence service provision', whilst incorporating existing community assets.

> "It's about how we can understand and mobilise our community assets to help support people that maybe in a way historically when there was more funding, were supported by statutory organisations or more formal services which are no longer in place."

The PBA approach could offer a framework or 'methodology' upon which to build a strategic approach or 'common narrative' to address health inequalities, considered a complex issue.

> "For me it was about having a clear methodology – an approach that we could apply to our local place, given that we have some distinct challenges around health inequalities…I suppose this felt like a good way of bringing together a range of stakeholders, getting a common understanding, and then getting some agreement about what we are going to do."

> "So I think it offers a degree of clarity and a vision that local areas can buy into without too much ambiguity…I think it removes that question of what level is this work best done at, to the extent that it enables them to see that this is a reasonable approach across a particular footprint and that's going to be a beneficial thing going forward."

Expected outcomes

Participants identified a range of desired outcomes from adopting a PBA approach to health inequalities. Most felt that the overall goal was a reduction in health inequalities and improvement in health or quality of life, demonstrable either through metrics and data or through the perceptions of residents.

> "For me it would be about reducing inequality, but it would be much more broad in terms of our aims. Either about reducing health inequalities or raising standards

of housing and improving access to employment, education, improving outcomes as a result of that and having more people succeed through their educational journey. All those wider determinants."

"The first one would be inequality indicators, narrowed inequalities between the better and more disadvantaged areas. But then I guess the other option would be what do the people who actually live (in the area) think – do they see a difference in their lives and health, do they have more employment opportunities and so forth."

Where specific geographical areas had already been identified as priority targets, demonstrable improvements in these areas was a main aim.

"It was outlined that there were some primary areas of concern and they've targeted specific wards. Looking at the data over the longer term, if we start to see that things are changing, we'd start to see that what we've done is having an impact. In the shorter term I guess it's having some clear steps to get there."

Shorter-term outcomes on the way to achieving this overarching aim were also cited:

- achieving a better understanding of health inequalities
- forming a collaborative approach, including communities
- identification of priorities to inform the organisational strategy
- establishing commitment to approach at organisational leadership level
- developing clarity of strategy and level of intervention
- development of appropriate initiatives (for place, for community), which can be flexibly applied according to local criteria

It was also hoped that PBA would become a standard way of working, sustainable into the future.

"I would hope it just becomes normal practice and that we start using it in all the work that we do, which I think it has already started, but maintaining that in the long-term."

Factors influencing success and failure of the approach

In the context of their own localities and roles, participants were asked to consider what factors might influence the success of PBA and to identify factors they thought might lead to a risk of failure.

Engagement

The key issue raised was 'engagement', whether this be related to 'buy-in' within the organisation, working in partnership with other organisations, sectors or departments, or

with communities. Failure to achieve this was considered a key risk to the success of the approach. Quickly establishing the 'credibility of the approach' with some 'quick wins' was one way suggested to help foster engagement.

> "You've got to have strong leadership and all the relevant and key stakeholders are all on the same page. And I suppose it's ensuring that you always have that community engagement from the start, and it's not left too late to engage with the community and the voluntary sector."

> "So I guess the skill is in picking a reasonably small number of priority areas so people have clarity over what we should be working on, and working our way through those areas to be able to build credibility for the approach. So we are going to have to show how we can use it to make short medium and long term gains."

Strongly linked to this was the need bring together stakeholders and to develop trust and 'strong relationships', moving away from siloed approaches to working and service design and delivery and reconciling top down versus bottom-up approaches.

> "I would say some relationships have historically been strong, others were strengthening, others I think were strong but we're being clearer about what we're trying to achieve together if that makes sense. It's not just about strong partnerships, it's also about how we want to utilise that partnership and how to maximise that effort in the right direction."

To do this, developing a common understanding around health inequalities and the PBA approach was felt to be vital. Particularly those working outside public health considered a common language and set of priorities that could be understood across sectors and disciplines necessary, to ensure that everyone was 'pulling in the right direction'.

Participants felt that strong leadership and communication, through infrastructure and strategy such as a Health and Wellbeing Board, could aid this. A sense of ownership and clarity around roles and responsibilities would help to ensure success. Collaborative decision-making would be necessary for this. This sense of ownership and common direction needed to filter through all sectors and levels, and extend to the sharing of resources, learning and data.

> "Understanding and emphasising that it is not a standalone work stream. The only way we are going to really reduce health inequalities is if everybody owns this agenda. It is not an agenda to just be owned by people who are passionate about health inequalities; it is an agenda to be owned by everyone."

A specific element of engagement addressed extensively by participants was a recognition that community involvement from early stages of any programme or

intervention had been missing in many cases and would need to be incorporated for PBA to be a successful approach. It was also raised that as part of these conversations, that to meet these criteria, representation from the community at workshops should also be increased (see Structure and format of workshops).

> "I feel at this early stage there should be more community representation. Sometimes it's having those organisations who are the delivery partners who deliver pivotal services in the community and having them around the table to actually help co-design the approach and have a bit more of a say in it would probably have more impact."

It was also noted that in order to engage effectively with the community, additional resources would be necessary, and that further work would need to be done to form the necessary infrastructure and links to facilitate the approach.

> "For example, we've got nine primary care networks. Which is great and its moving things into those communities and we'll have better results, but where previously I only had to attend one CCG, now there are nine. So we need to recognise that this will take time and it is a much more resource intensive way of working and it is very dependent on relationships and people developing those relationships, which also takes time as well."

Action planning and strategy

A key issue emerging from the workshop-specific feedback was the need for the outcomes of the workshop session to be fed into more formalised organisational strategies. In North Somerset, the success of PBA was considered to be closely linked to its incorporation into the Health and Wellbeing Strategy, which is simultaneously under development, and participants recognised that embedding the approach here would facilitate a co-ordinated approach towards common priorities.

> "So if we can set it at Health and Wellbeing Board level, it is the best chance to get the civic leadership right, it's the best chance to get some common understanding, and agree about some of the approaches we might take, and then if we can embed it into the health and wellbeing strategy which we will be writing in the next financial year then it becomes sort of hard wired into the way in which we should be doing things."

Capacity and Resources

Concerns were expressed that the approach will require capacity, time and money (in a context of reduced funding and staff levels). Participants questioned whether other services or programmes might lose out as a result. There was an emphasis from participants that appropriate initiatives must be developed so that public funds were not wasted, but that in some cases developing such initiatives will cost more money.

"But I think it does go back to capacity, because we're making it sound like a series of actions… but to be really frank is that a lot of those actions will rely on partnership working, which will may require more facilitated sessions with partners."

Complexity

There were concerns from those in West Yorkshire and Harrogate ICS that the level of complexity across the large area, with competing priorities and varying levels of need, may render PBA ineffective.

"We need to recognise that the commissioning of services cannot always be commissioned at that bigger level and footprint. If you commission services at big regional level, it won't meet the requirements of a PBA when the demographics are very different. I think the ICS level is too wide and big to apply the PBA. The demographic requirements are very different across the city. It's even more different across that footprint."

Flexibility

On a related note, flexibility to apply the approach appropriately in a local setting was considered necessary.

"What's really clear is that the local areas need enough flexibility to adapt it to individual circumstances. Anything that is too rigid gets a lot of pushback. It's that kind of thing that one size does not fit all, even if the approach is a universal one and thought of as a good idea."

Identifying the right issues

Workshops centred on identifying priority areas to which PBA might be applied, and participants were keen that these priorities were clarified and fed forward into policy and strategy.

"In a practical way, we would be able to focus in on some priorities for how we can achieve that and who we want to focus on, whether that's geographic place or particular communities, to try and close that gap."

Leadership and accountability

Related to the incorporation of PBA into strategy and policy through instruments such as a Health and Wellbeing Board, participants expected senior leadership to support the approach and steer other parts of the system towards achieving the common aims.

"This has got to be the approach from senior leadership all the way down and the whole system needs to be engineered to make this approach happen."

Learning from past initiatives

A number of participants spoke of the importance of analysing the reasons for previous failures before entering into a new approach, to avoid 'falling into the same trap', and adopting an 'iterative' attitude towards PBA with scope for making improvements as the programme develops.

Long-term approaches

Several participants expressed concern that the approach would not be given the necessary time to demonstrate impact, particularly as changes in health outcomes may take many years to observe.

> "We need to give it time – we are always a little bit guilty of going 'oh we tried that, there's new shiny thing, let's try something else'. And we need to stop doing that and commit to a thing and give it time."

Momentum

However, they also felt it was important to maintain a sense of momentum and 'harness the motivation' achieved through the workshops, perhaps through a series of shorter-term targets of performance goals leading towards a longer-term outcome. Contrasting voices, mainly from the ICS, suggested that moving ahead too quickly before common understandings had been established might be detrimental.

> "If we push to try and progress before it is at the stage where it is ready to, then it will be more of a burden than a help."

Utility of PBA in practice

PBA as an approach

Participants supported the application of PBA as an approach to tackle health inequalities but at the time of interview had not had the opportunity to apply it in practice, and most could not provide specific examples of how it might work in their roles (see also below in Next Steps).

> "So thinking around how we structure the work, particularly that myself and my team does, to provide data and tools that are useful and usable, clearly it would have been focused around Primary Care Networks and places etc. anyway but I'm sure it will influence it. Am I capable of telling you now how that is going to happen? I don't think so. But it will influence it, once it's deployed."

It was clear that there were differences in the way participants felt that PBA could be applied depending on the local context. In North Somerset, the pilot was based in a local authority in the process of restructuring its Health and Wellbeing Board. The importance of policy and strategy were highlighted, and most participants felt that PBA should be

formalised through this infrastructure, and would therefore filter through into other departments, organisations and sectors.

> "I think with the changes that have been going on in the health and wellbeing board, probably in the last 12 months there hasn't been as much opportunity in my view. I think prior to that, yes, there was, but there's been significant changes in the way public health is structured and run in NS in the last probably 12 to 18 months and I think this gives us the chance to reset and relaunch a little bit in terms of what we want to do with our budget and resources."

This approach would facilitate the involvement of colleagues from areas other than public health such as regeneration and housing.

> "And some of that will be around health inequalities, but some will be access to jobs or employment, poor housing etc. And so the challenge for the chief exec is how on a place-based approach, we can focus more efforts and target more of our resources ultimately."

In North Somerset, there was an outlying ward in terms of deprivation, and all participants felt a renewed emphasis on the need to direct of resources to this area to tackle inequalities.

> "…And therefore crystallising a 10-year Health and Wellbeing Strategy, which could be broad and loose, crystallising that around the very specific issue that everyone knows is there but no one has wanted to necessarily engage with, that opportunity strikes me as quite powerful really."

At ICS level in West Yorkshire and Harrogate, it was less clear where PBA might fit into the organisational strategy, although the principles were widely considered helpful.

> "From a West Yorkshire point of view, it will help us in the health inequalities work stream to focus on those areas a bit. Could we have done that without it? Possibly, but I think it will help and we could and should use that to build on our work."

It was suggested that whilst 'place-based' interventions may still take place at a local level, there might be a role for the ICS in using PBA. It could focus on complex issues, such as legislation or broader economic considerations, or provide an overview of where variation exists across the ICS footprint and whether this can be addressed.

> "Coming into that meeting, I had 2 hats on; mainly I am considering place, but also thinking about it from a system point of view and how we can borrow ideas from other areas. PBA needs to be at all 3 levels – retaining some 'place' footprint

is really important because there are such differences across the area, so there might be some things we might want to focus at a specific area."

Further detail on how participants responded to the tools in the workshop setting can be found in the Workshop Evaluation (see Use of the PBA tools).

Most participants had no experience of the toolkit before the workshops, and at the point of interview had not had the opportunity to use the toolkit in their roles. Nevertheless, most participants thought the tools could be a useful resource and noted ways in which they might be applied in practice. The population intervention triangle was seen as easy to understand and apply and was the tool participants could most immediately envisage using.

> "I think this tool would be really beneficial because it would enable us to focus down on those three specific points in the triangle really. I think previous tools or previous approaches to inequalities have been very broad and have looked at a larger geography that might not actually be suitable or as relevant for our demographic. So I hope that trying a more focused approach can be successful."

For some, further thought or training might be necessary before the tools can be applied.

Participants felt they might be able to use the toolkit in the following ways:

1. As a diagnostic tool to generate and assess priorities.

> "To use that as almost like a diagnostic tool for what is going on and what are the areas that the board might want to concentrate on, particularly in the priority areas that it agrees on, you probably want to do a level of analysis underneath that once you have decided your priorities, a level of analysis that uses the element of the toolkit to really flesh out what we think the added value of the Health and Wellbeing Board is and try to achieve some of those goals."

2. As a 'checklist' to ensure all sectors had been adequately considered.

> "We are thinking of using the triangle to do a bit of analysis for all of our work programmes, so we can think more or be more reflective on, yes fine we commission certain types of services but what are the other things going on around that issue that might be able to improve outcomes for a larger number of people or a particular group who might be suffering the poorest outcomes."

3. As a self-assessment exercise to identify gaps.

> "We would do the self-assessment with key partners. We would amend these tools – foundations and framework is useful and we amend to cover broader inequalities."

4. In partnership meetings to explain the approach.

> "I think we didn't really have a framework to explain it to everyone else, but this is easy to talk about so we have done a poster using the triangle, like a poster to explain to other people."

Participants felt that the tools could and should be applied in a flexible manner to account for the local situation and aim of the exercise.

> "It needs to be something that evolves with the journey that the partnership is on already, and as long as it has the flexibility to do that, it could become something that is quite helpful."

Next Steps

In terms of taking PBA forward, there was an enthusiasm and 'motivation' to do so, but exactly how this would take place was not clear to all participants. For those involved in the leadership and restructure of the Health and Wellbeing Board in North Somerset there was a commitment to formally integrating PBA into the strategy.

> "So we'll get some agreement about next steps in the development of the strategy, the topics and the way in which the JSNA will be developed – so provide some of the evidence and intelligence to support decision making. And then we will have some agreement on the priorities for 2021 as the strategy is being developed, which will require public engagement and much more bottom-up approaches as well as the leadership figures in the room."

Others in North Somerset recognised that this would be the case but awaited further detail on how this would affect their own practice.

> "I have a sense about the direction of travel, but I'm not very clear how that can happen in practice. So there's quite a lot of ambition there. But obviously that's something for the new Health and Wellbeing Board to discuss and decide what to do."

Some concern was expressed that it was necessary to 'harness the momentum' in the direct aftermath of the workshops. Some participants from outside the council and not

involved in the Health and Wellbeing Board were uncertain how to remain involved but were keen to be 'part of the conversations going forward'. For the voluntary sector, the establishment of further infrastructure to support their full contribution was the next step.

> "In terms of the wider community discussion, there's a lot to be decided around how it will be set up and what infrastructure will be in the background to support voluntary sector organisations and charities…"

How the approach might fit with wider strategy set by the Sustainability and Transformation Partnership or ICS, whilst keeping the local focus was also raised.

> "I suppose one of the big challenges we have is how you can keep a specific focus on North Somerset within a strategic transformation partnership, the ICS that is covering a bigger geographic footprint. How do you get a specific focus on the needs of our population?"

In West Yorkshire and Harrogate there was less certainty about the potential to apply the approach effectively in the ICS (as above) and the mechanism by which that might be achieved.

> "Potentially yes. I mean the place based approach is already happening where I work, but I don't feel like the rest of the system is necessarily aligned to make it work everywhere or make our lives particularly easy in terms of making it work in our place."

This may be linked to the stage of development of the ICS where some participants felt that the ICS role still needed to be 'defined' before further initiatives are added to the mix.

> "It is interesting to test at ICS scale. We have six places which make up our ICS and are doing their own place based systems, so I would be interested to see if it helps to connect some of the tensions between what's happening in there and what you're trying to do at the next level up. People felt they were further ahead on their more local areas than we were at the partnership and I think part of that is that we do have very strategic senior sign ups, but it takes a while to filter down, so I think people who would then have the responsibility for making some of that happen haven't quite got the same place, so maybe this will be something that helps facilitate that."

Conclusions

1. Participants in the pilot workshops had a good understanding of the theory behind the PBA approach and could see opportunities for its application in their roles and local areas.
2. As an addition to previous 'place-based' initiatives, participants felt that this this specific programme could provide a 'framework' around which to generate a common set of aims and understandings to tackle health inequalities.
3. The overarching aim of adopting the approach would be to achieve a reduction in health inequalities and improvement in health outcomes, particularly in the most deprived areas in the pilot sites. However, a number of shorter-term targets such as the formalisation of priorities and improved recognition of health inequalities were also cited.
4. Engagement of all stakeholders including communities was identified as the major factor that will influence the success of the programme. Incorporation into formal strategies and the development of infrastructure to support the approach was thought to be key to developing and maintaining engagement across sectors.
5. Resource, capacity, learning from past mistakes and communication were also considered integral to success.
6. Participants could envisage how PBA might be applied locally although in the main there had not yet been the opportunity to do so.
7. Readiness to adopt the approach varied between the local sites. In North Somerset key factors for success such as political and organisational enthusiasm, and an opportunity to influence policy through the restructure of the Health and Wellbeing Board appeared to provide a fertile context in which to introduce PBA as a formalised approach. This is combined with recognition of a specific geographical area in need of a targeted approach where attention can be directed.
8. In West Yorkshire and Harrogate, how PBA may fit into the organisational strategy, and where in the system initiatives would be applied is less clear and this was reflected in the responses of participants about how PBA can be applied in practice.
9. The toolkit could be used as a diagnostic tool for priority setting, a checklist for service design and delivery, a self-assessment tool, and to increase understanding of the approach with partners.
10. Follow up work to see how the implementation of PBA has progressed following the workshops is recommended in both sites.

A theory of PBA

The data collected from the interviews with workshop participants was aligned with CMO1 and CMO2 to develop a broader theory of PBA, which is explained in this section. The CMOC is presented in the appendix of this report (Appendix: CMOC). Abbreviations are C for context, M for mechanism and O for outcomes. Each is numbered in the order in which they appear.

Using PBA in practice

Applied in a specified local context (C1), PBA provides a flexible and adaptable approach (M4) which allows for the identification of geographical and priority areas (M1). The PBA toolkits support the engagement of others in PBA by helping to communicate the concepts (M2) and act as diagnostic tools to identify priorities, reflect on existing organisational structures and aid service design (M3). Such mechanisms of action lead to improvement in priority health metrics of quality of life, morbidity and mortality in targeted geographies (O2). Ultimately, this will enable appropriate implementation of PBA to improve services and reduce health inequalities (O1).

Engagement of community and stakeholders

PBA can act as a vehicle to bring people together to develop a common understanding of health inequalities and potential solutions (M5). This can achieve integration through partnership working (O3) where there is siloed or disjointed working (C2), resulting in better services and a reduction in health inequalities (O1). Devolved leadership and trust (M8) can develop where there is community engagement and partnership working (C3) which will enable co-designed and delivered interventions and services (O6 and O7) with improved community uptake (O8) and ultimately reduced health inequalities (O1).

In a context where engagement and partnerships exist (C3), a common understanding of health inequalities and solutions to tackle them (M5) should foster community involvement in the development of local plans, policies and priorities (O4). Increasing community and public involvement will create a sense of ownership and empowerment, including greater understanding of their role and responsibilities (M6), which will increase community involvement in decision-making processes (O4) and in the planning and delivery of services (O6). Greater ownership of the decision-making processes will enable identification of community needs and co-production of solutions to meet those needs (O7) which should support an uptake in services and reduction in health inequalities stemming from inequitable access (O1). Strengthening community engagement may allow for the recruitment of community researchers who can collect data, identify priorities and propose solutions (M7) leading to co-design and delivery of

solutions (O6 and O7), improved uptake of services and interventions (O8) and a reduction in health inequalities (O1).

Local area infrastructure and opportunities

There may be opportunities to influence local policy or planning decisions, for example, Integrated Care System (ICS) or Health and Wellbeing Board (HWB) strategies. In these contexts, community engagement in those decision-making processes (M9) and training stakeholders to operate in complex systems with resilience and sustainability (M10), will support improved, co-designed, integrated and culturally relevant services that meet the needs of the population (O6, O7, O8 and O11).

Using PBA to inform organisational or partnership strategies (M11) or to develop partnership or cross-departmental working (M12) will increase collaboration and partnership working (O16) where there are opportunities to influence decision-making processes (C4). In these contexts, PBA may lead to the development of specific action plans (M13), building ownership and influencing policy (O9), thereby leading to improved services and reduced health inequalities (O1).

PBA is likely to become a standard way of working (O13) where it informs organisational or partnership strategies and working (M11 and M12) in contexts where there are opportunities to influence policies and planning processes (C4) or where local leaders, for example the directors of public health, take a proactive approach to PBA (C5). In complex contexts, including large infrastructures like an ICS (C6), the use of PBA to inform strategies and partnership working (M11 and M12) can empower or strengthen community participation in decision making (O6) leading to improved intervention and reduced health inequalities (O1). The shared learning and shared information (M14) within complex infrastructures (C6) can, in itself, impact on services and health inequalities (O1). However, the operation of PBA in complex infrastructures (C6) with the sharing of learning and information (M14) and developing partnership working and strategies (M11 and M12) may lead to a focus that is too strategic and risks losing sight of local priorities (O12) which may reduce the potential impact on health inequalities (O1).

Capacity and resources

The greatest impact on health inequalities (O1) is likely to be achieved where capacity and resources are made available to support PBA (C7). Changes in capacity and resource planning (M15) enabled in this context will allow for realignment of resources to support place-based work at scale (O14) and will signal the importance of health inequalities, recognition of the need to tackle the wider determinants of health and whole system approaches, and prompt a shift from individualist to structural interventions (O15). The availability of capacity and resources (C7) makes it possible for

commissioners to involve community partners (M16) which helps empower or strengthen community participation in priority setting, intervention design and delivery (O6).

Focus on health inequalities

In contexts where there is a common understanding of, and focus on, health inequalities (C8), PBA can facilitate shared governance and systems-based approaches (M17), increasing collaboration and partnership working (O16), and recognition of the importance of whole system, long term and structural interventions (O15) to reducing health inequalities (O1). A common focus on health equalities (C8) can also ensure high-level buy in (M19) and dedicated resource (M18) allowing capacity and resources to be aligned to support placed-based work (O14). Dedicated resource, including worker capacity and funding (M18), may also operate as a mechanism where health inequalities are a national priority (C10) leading to increased partnership working (O16), strengthened community engagement in decision-making and delivery (O6) and shifts towards whole system and structural interventions to tackle the wider determinants of health (O15) and reduce health inequalities (O1).

Within areas that face disadvantage, such as socio-economic disadvantage or a population with higher than average proportions of protected characteristics (C9), PBA supports targeted approaches (M20) to strengthen community involvement in decision making, planning and service delivery processes (O6) which can lead to improvement in health inequality outcome metrics (O1 and O2). PBA can enable high-level buy-in in areas with the potential and capacity to change (M19). In contexts of disadvantaged areas (C9) or where health inequalities is a priority policy nationally (C10), PBA can increase collaboration and partnership working (O16), empower communities to participate (O6) and shift the focus from individual and downstream interventions towards upstream, whole-system and structural approaches (O15) to reducing health inequalities.

Previous experiences

Previous experiences of engagement coupled with an incentivised workforce or community (C11) can allow for learning about what is currently happening in the area and what happened before (M21) which can lead to strengthened community engagement in decision-making processes (O6) and the perception that PBA is a viable method to create change (O17) leading to reduced health inequalities (O1). The consideration of PBA as an appropriate framework to generate change (O17) can also be generated by managing expectations, especially in relation to timescales, in an area with previous experiences of engagement and an incentivised workforce or community (C11).

However, where previous experiences of scheme failures have left the community or workforce fatigued (C12) learning about what is happening currently and what went before (M21) will determine the outcome of PBA. Where the learning takes place, PBA may be considered a viable framework leading to change (O17). Where the learning does not take place, PBA may be viewed as a new name for existing or previous unsuccessful ways of working (O18) which will hinder the ability to take action to reduce health inequalities (O1).

Assets

PBA is flexible, with the potential to work with existing service delivery or organisational boundaries, and to incorporate existing assets (M23). This flexibility means it can be adapted to meet the needs of partners and the community and should support integrated working (O3) and strengthened community participation in the planning and delivery of interventions (O6) to tackle health inequalities (O1). The presence of existing community assets (C13) provides the opportunity to build new or strengthen existing partnerships with non-traditional health settings (M24). This can strengthen community participation in priority setting, design and delivery activities (O6) but can also support integration (O3), collaboration and partnership working (O16), all of which ultimately should lead to reduced health inequalities (O1).

Conclusions

This theory of PBA should help others to understand how PBA might work in their context and what they may need to consider to help the mechanisms to operate effectively.

Conclusions and recommendations

Whilst the COVID-19 pandemic has had a detrimental impact on both the planned pilot activities and on the proposed methods to evaluate the universal offer of PHE's Place Based Approaches to Health Inequalities, it has also highlighted the potential utility of the approach. Health inequalities have widened during the pandemic (Public Health England, 2020) and PBA has the potential to generate a common set of aims and understandings around health inequalities and to provide a framework for action. PBA pilot areas were clear that the PBA resources are valuable but had not had the opportunity to implement them during the time of the evaluation. There was some consensus that the facilitated workshop approach with support from PHE may be necessary to support implementation and maximise the impact of PBA. It was evident that pilot areas were motivated to use PBA but lacked a shared understanding on how to

implement the approach to inform next steps and action planning. A summary of recommendations from the evaluation is provided below.

1. The aims, objectives and expected outcomes of the priority setting exercises could be made clearer.
2. Some PBA tools may be more appropriate to smaller areas such as a local council than a more complex system such as the ICS. PHE could consider refining or adapting tools or exercises to meet the needs of the target audience.
3. PHE could consider incorporating the development of an action plan or 'next steps' into the workshop agenda or as a follow up exercise to ensure momentum is maintained.
4. Consideration could be given to sector representation at workshops, which may benefit from a wider range of participants, particularly from the community sector. Further advance notice would also increase participation from primary care and the NHS.
5. Follow up work to see how the implementation of PBA has progressed following the workshops is recommended in both pilot sites – North Somerset and West Yorkshire and Harrogate.
6. The PBA website could be updated:
    a. Simplify the home page and make it easier to navigate to the main report.
    b. Provide a summary description next to each link.
    c. Consider combining the tools into a single document to reduce duplication of content within them.
    d. Create a separate section for case studies, using the same format as the other documents.
7. Consider hosting the HEAT and peer-to-peer assessment tools in one place on a web platform, with all associated documents available. To maximise stakeholder benefit, tools could be modified to incorporate existing data where possible.
8. Ensure all tools are accessible for those without public health expertise. Consider provision of training, and securing senior leadership buy-in to maximise the likelihood of their use.
9. Provide a recorded webinar by Professor Chris Bentley and the Health Inequalities Team on PBA as part of the universal offer. This will allow those areas not involved in the pilot to benefit from their expertise to increase understanding of the approach including how to implement it.
10. Build evaluation practice into PBA using the toolkits to be provided by the University of Manchester evaluation team:
    a. PBA guidance for PHE evaluation of activities b. PBA evaluation toolkit for local areas
11. The programme theory of PBA could be tested through an evaluation of PBA implementation over the long term. Opportunities to access funding to do so can be investigated with the University of Manchester.

References

1. Braun, V and Clarke, V, 'Using thematic analysis in psychology' Qualitative Research in Psychology 2006, Volume 3, pages 77–101

2. Hedström, P, and Udehn, L, 'Analytical sociology and theories of the middle range' The Oxford handbook of analytical sociology 2009, pages 25–47, Oxford University Press

3. Pawson, R and others. 'Realist review: A new method of systematic review designed for complex policy interventions' Journal of Health Services Research and Policy 2005, Volume 10, pages 21–34. (viewed on 19 May 2021)

4. Pawson, R, and Tilley, N, 'Realistic evaluation' SAGE Publications, 1997

5. Pawson, R, and Tilley, N, 'Realist Evaluation' 2004, pages 1–36 (viewed on 19 May 2021)

6. Public Health England, 'Reducing health inequalities: system, scale and sustainability' 2017 (viewed on 21 May 2021)

7. Public Health England, 'Disparities in the risk and outcomes of COVID-19' 2020 (viewed on 21 May 2021)

8. Rycroft-Malone, J and others. 'A realist evaluation: the case of protocol-based care' Implementation Science 2010, Volume 5, pages 1–14 (viewed on 21 May 2021)

Bibliography

A range of literature that was accessed to support this evaluation but not referenced directly are referenced below.

Background literature

Arksey, H, and O'Malley, L, 'Scoping studies: Towards a methodological framework' International Journal of Socal Research Methodology: Theory and Practice 2005, Volume 8, pages 19-32

Asaria, M, and others. 'The costs of inequality: Whole-population modelling study of lifetime inpatient hospital costs in the English National Health Service by level of neighbourhood deprivation' Journal of Epidemiology and Community Health 2016, Volume 70, pages 990-996 (viewed on 19 May 2021)

Booth, A, 'Unpacking your literature search toolbox: On search styles and tactics' Health Information and Libraries Journal 2008, volume 25, pages 313–317 (viewed on 19 May 2021)

Boudon, R, 'What Middle-Range Theories Are' Contemporary Sociology 1991, Volume 20, pages 519–522

Boulkedid, R, and others. 'Using and reporting the Delphi method for selecting healthcare quality indicators: A systematic review' PLoS One 2011, volume 6 (viewed on 19 May 2021)

Braun, V, and Clarke V. Using thematic analysis in psychology' Qualitative Research in Psychology 2006, Volume 3, pages 77–101 (viewed on 19 May 2021)

Dahlgren, G and Whitehead, M, 'Policies and strategies to promote social equity in health' Background document to WHO: Strategy paper for Europe 1991, Insititute for Future Studies, Stockholm (viewed on 19 May 2021)

Davis, K, and others. 'What are scoping studies? A review of the nursing literature' International Journal of Nursing Studies 2009, Volume 46, pages 1386–1400

Drummond, M, and others. 'Methods for the Economic Evaluation of Health Care Programmes' 2005, Oxford University Press, 3rd edition

Guest, G, and others. 'Collecting Qualitative Data: A Field Manual for Applied Research' 2013, SAGE Publications

Hedström, P, and Udehn L, 'Analytical sociology and theories of the middle range' The Oxford handbook of analytical sociology 2009, pages 25–47. Oxford University Press

Hsu, C-C, and Sandford, BA, 'The Delphi technique: Making sense of consensus' Practical Assessment Research and Evaluation 2007, volume 12, pages 80–89

Khangura, S, and others. 'Evidence summaries: the evolution of a rapid review approach' Systematic Reviews 2012 (viewed on 19 May 2021)

Marmot, M, and Bell, R, 'Fair society, healthy lives' Public Health 2012, pages s4–s10 (viewed on 19 May 2021)

Office for National Statistics 'Health state life expectancies by national deprivation deciles, England and Wales: 2015 to 2017' 2019 (viewed on 19 May 2021)

Palinkas, LA, and others. 'Purposeful sampling for qualitative data collection and analysis in mixed method implementation research' Administration and Policy in Mental Health 2015, Volume 42, pages 533–544 (viewed on 20 May 2021)

Pawson, R and others. 'Realist review: A new method of systematic review designed for complex policy interventions' Journal of Health Services Research and Policy 2005, Volume 10, pages 21–34. (viewed on 19 May 2021)

Pawson, R, and Tilley, N, 'Realistic evaluation' SAGE Publications, 1997

Pawson, R, and Tilley, N, 'Realist Evaluation' 2004, pages 1–36. (viewed on 19 May 2021)

Pope C, Ziebland S, and Mays N, 'Qualitative research in health care. Analysing qualitative data' BMJ 2000, pages 114–116 (viewed on 20 May 2021)

Public Health England, 'Reducing health inequalities : system, scale and sustainability' 2017 (viewed on 21 May 2021)

Rycroft-Malone, J and others. 'A realist evaluation: the case of protocol-based care' Implementation Science 2010, Volume 5, pages 1–14 (viewed on 21 May 2021)

Studdert, J, and Stopforth, S, 'Place-based health: a position paper' New Local Government Network 2015 (viewed on 20 May 2021)

Sutton, AJ, Cooper, NJ, and Jones, DR, 'Evidence synthesis as the key to more coherent and efficient research' BMC Medical Research Methodology 2009, Volume 9 (viewed on 20 May 2021)

The King's Fund 'Making the case for public health interventions' 2014 (viewed on 20 May 2021)

Social Value UK 'A Guide to Social Return on Investment' 2012 (viewed on 20 May 2021)

Community co-production rapid literature review

Alakeson, V, Miller, C, and Bunnin, A, 'Coproduction of health and wellbeing outcomes: the new paradigm for effective health and social care' 2013 Office for Public Management, London (viewed on 20 May 2021)

Coulter, A, 'Engaging communities for health improvement A scoping study for the Health Foundation' The Health Foundation 2009, (viewed on 20 May 2021)

De Andrade, M, 'Tackling health inequalities through asset-based approaches, co-production and empowerment: ticking consultation boxes or meaningful engagement with diverse, disadvantaged communities?' Journal of Poverty and Social Justice 2016, Voluem 24, Issue 2, pages 127-141

NHS England, 'Good practice – Turning Point' 2019 (viewed on 20 May 2021)

Foot, J, 'What makes us healthy? The asset approach in practice: evidence, action, evaluation' Asset Based Consulting 2012 (viewed on 20 May 2021)

Public Health England, 'Health inequalities: place-based approaches to reduce inequalities' 2019 (viewed on 20 May 2021)

Horne, M, Corrigan, P, and Khan, H, 'People Powered Health: Health For People, By People and With People' 2013 (viewed on 20 May 2021)

Lam, B, and others. (2017), 'Unearth Hidden Assets through Community Co-design and Co-production' The Design Journal 2017, Volume 20, pages 3601-3610 (viewed on 20 May 2021)

Moore, T, and Fry, R, 'Place-based Approaches To Child and Family Services: A Literature Review' 2011 Murdoch Childrens Research Institute and The Royal Children's Hospital's Centre for Community Child Health, (viewed on 20 May 2021)

NHS Health Scotland 'Asset-based approaches to health improvement' 2011 (viewed on 20 May 2021)

O'Dwyer, L, and others. 'Do area-based interventions to reduce health inequalities work? a systematic review of evidence' Critical Public Health 2007, Volume 17, pages 317-335

Pennington, A, and others. 'Scoping review of review-level evidence on co-production in local decision-making and its relationship to community wellbeing' 2017, What Works Wellbeing (viewed on 20 May 2021)

Public Health England 'A guide to community-centred approaches for health and wellbeing' 2015 (viewed on 20 May 2021)

South, J, and others, 'An evidence-based framework on community-centred approahces for health: England, UK' Health Promotion International 2019, Volume 34, Issue 2, pages 356-366

Winterton, R, and others. 'Considering the implications of place-based approaches for improving rural community wellbeing: The value of a relational lens' Rural Society 2014, Volume 23, pages 283-295

Place based approaches rapid literature review

Catt, H, and Senior, S, 'Making the urban environment around schools healthier, developing an initial programme theory: an early realist process evaluation of the London superzones pilot' medRxiv 2020 (viewed on 21 May 2021)

Dannefer, R, and others. 'The Neighborhood as a Unit of Change for Health: Early Findings from the East Harlem Neighborhood Health Action Center' Journal of Community Health 2019, Volume 45, pages 161-169 (viewed on 21 May 2021)

Lewis, S, and others. 'Reframing 'participation' and 'inclusion' in public health policy and practice to address health inequalities: evidence from a major resident-led neighbourhood improvement initiative' Health and Social Care in the Community 2019, Volume 27, pages 199–206

Patychuk, DL, 'Bridging Place-Based Research and Action for Health' Canadian Journal of Public Health 2007, Volume 98, pages s70–s73

Putland, C, Baum, FE, and Ziersch, AM, 'From causes to solutions - Insights from lay knowledge about health inequalities' BMC Public Health 2011 (viewed on 21 May 2021)

Steer, M, and Machin, AI, 'A qualitative exploration of stakeholder perceptions of the implementation of place-based working and its potential to reduce health inequality' Journal of Public Health (Bangkok) 2018, Volume 40, pages 813–819

Storey-Kuyl, M, Bekemeier, B, and Conley, E, 'Focusing 'upstream' to Address Maternal and Child Health Inequities: Two Local Health Departments in Washington State Make the Transition' Maternal and Child Health Journal 2015, Volume 19, pages 2329–2335 (viewed on 21 May 2021)

Systems leadership rapid literature review

Brown, M, and others. 'Implementing potentially better practices for multidisciplinary team building: Creating a neonatal intensive care unit culture of collaboration' Pediatrics 2003, Volume 111, pages e482-488 (viewed on 21 May 2021)

Davis, PD, and Marshall, DR, 'Teamwork: an essential for leading and launching innovation'. Nursing Administration Quarterly 2014, Volume 38, pages 221–229 (viewed on 21 May 2021)

Goodman, B, 'Leadership and Management in Nursing - A Critical Approach' 2018 (viewed on 21 May 2021)

Harkins, P, '10 Leadership Techniques for Building High-Performing Teams' Linkage 2011 (viewed on 21 May 2021)

Horak, BJ, 'Dealing with human factors and managing change in knowledge management: a phased approach' Topics in Health Information Management 2001, Volume 21, pages 8–17

Kotter, JP, 'Leading Change' 2012, Harvard Business Review Press

Kotter JP, and Schlesinger, LA, 'Choosing Strategies for Change' Harvard Business Review 2008 (viewed on 21 May 2021)

Ng GKB, and others. 'Factors affecting implementation of accreditation programmes and the impact of the accreditation process on quality improvement in hospitals: a SWOT analysis' Hong Kong Medical Journal 2013, Volume 19, pages 434–446 (viewed on 21 May 2021)

Ryerson University Human Resources Department 'Change Management Leadership Guide' 2011 (viewed on 21 May 2021)

Selbie, D, 'Evaluating the first place-based programmes for systems leadership' Health Service Journal blog 2015 (viewed on 21 May 2021)

Senge, P, Hamilton, H, and Kania, J, 'The Dawn of System Leadership' Standford Social Innovation Review 2015 (viewed on 21 May 2021)

Storey, J, and Holti, R, 'Towards a New Model of Leadership for the NHS' NHS Leadership Academcy 2013 (viewed on 21 May 2021)

Timmins, N, 'The practice of system leadership' The King's Fund 2015 (viewed on 21 May 2021)

Tahara, DC, and Green, RP, 'Strategic re-design of team-based patient-focused health care services' Advances in Health Care Management 2014, Volume 16, pages 3–22 (viewed on 21 May 2021)

Appendix: CMOC

Block 1 – Using PBA in practice

Context	Mechanism	Intermediate outcome	Final outcome
When delivered in a specified local context (C1)	the PBA approach allows for the identification of geographical and priority areas (M1)	leading to improvement in metrics measuring health outcomes - QoL, life expectancy etc. (O2)	(potentially) resulting in) improved services and reduced health inequalities (O1)
When delivered in a specified local context (C1)	the toolkit can be used to communicate PBA concepts and engage others in PBA (M2)		resulting in (appropriate implementation of PBA to) improved services and reduced health inequalities (O1)
When delivered in a specified local context (C1)	the toolkit can be used as a diagnostic tool to identify priorities, aid service design and reflect on existing organisational structures (M3)	leading to improvement in metrics measuring health outcomes - QoL, life expectancy etc. (O2)	Resultingin (appropriate implementation of PBA to) improved services and reduced health inequalities (O1)
When delivered in a specified local context (C1)	Where there is a flexible approach to adapt to local context (M4)	this can lead to improvement in metrics measuring health outcomes - QoL, life expectancy etc. (O2)	resulting in (appropriate implementation of PBA to) improved services and reduced health inequalities (O1)

Block 2 – Community and/or stakeholder engagement

Context	Mechanism	Intermediate outcome	Final outcome
Where there is existing siloed or disjointed working (C2)	PBA can be used as a vehicle to bring people together to develop a common understanding (M5)	to achieve integration (O3)	resulting in (appropriate implementation of PBA to) improved services and reduced health inequalities (O1)
When engagement and partnerships (vertical and horizontal) exist (C3)	PBA can be used to as a vehicle to bring people together to develop a common understanding (M5)	and this will result in community involvement being incorporated into local plans and policy documents (O4).	
Engagement and partnerships (vertical and horizontal) (C3)	will increase community and public involvement and increase a sense of ownership (including knowing their role and taking responsibility) (M6)	and this will result in community involvement being incorporated into local plans and policy documents (O4).	
Engagement and partnerships (vertical and horizontal) (C3)	will increase community and public involvement and increase a sense of ownership (including knowing their role and taking responsibility) (M6)	and this will result in case studies demonstrating success of the PBA approach (O5)	And improved services and reduced health inequalities (O1)
Engagement and partnerships (vertical and horizontal) (C3)	will increase community and public involvement and increase a sense of ownership (including knowing their role and taking responsibility) (M6)	and this will result in Strengthened/ Empowered community participating in planning and delivery of services (O6)	and improved services and reduced health inequalities (O1)

Context	Mechanism	Intermediate outcome	Final outcome
Engagement and partnerships (vertical and horizontal) (C3)	will increase community and public involvement and increase a sense of ownership (including knowing their role and taking responsibility) (M6)	and this will result in the identification of community needs and co-produced interventions (O7) leading to increased uptake of services (O8)	and improved services and reduced health inequalities (O1)
Engagement and partnerships (vertical and horizontal) (C3)	will allow community researchers to be recruited and trained to collect data, identify priorities and propose solutions (M7)	and this will result in planning and delivery of services (O6), the identification of community needs and co-produced interventions (O7) leading to increased uptake of services (O8)	and improved services and reduced health inequalities (O1)
Engagement and partnerships (vertical and horizontal) (C3)	leads to devolved leadership and building of trust (M8)	and this will result in Strengthened/ Empowered community participating in planning and delivery of services (O6), the identification of community needs and co-produced interventions (O7) leading to increased uptake of services (O8)	and improved services and reduced health inequalities (O1)

Block 3 – Local area infrastructure

Context	Mechanism	Intermediate outcome	Final outcome
Where there is an opportunity to influence institutional policy or planning (for example ICS strategy or LA HWB) (C4)	community engagement in planning – co-production (M9) will lead to	and this will result in Strengthened/Empowered community participating in planning and delivery of services (O6), the identification of community needs and co-produced interventions (O7) leading to increased uptake of services (O8) and improved access to integrated health care services that are culturally relevant (O11)	and improved services and reduced health inequalities (O1)
Where there is an opportunity to influence institutional policy or planning (for example ICS strategy or LA HWB) (C4)	training to develop new ways of working allowing stakeholders to be comfortable with chaos to build resilience and sustainability (M10)	will result in Strengthened/ Empowered community participating in planning and delivery of services (O6), the identification of community needs and co-produced interventions (O7) leading to increased uptake of services (O8) and improved access to integrated health care services that are culturally relevant (O11)	and improved services and reduced health inequalities (O1)

Context	Mechanism	Intermediate outcome	Final outcome
Where there is an opportunity to influence institutional policy or planning (for example ICS strategy or LA HWB) (C4)	There can be Incorporation of PBA approach into organisational/cross-organisational strategy (Formalisation of approach) (M11) and Opportunities for interdepartmental/cross-organisational working (M12)	Influencing policy and ownership – PBA captured in ICS plans, Health and Wellbeing strategies, etc. (O9) increased collaboration and partnership working (O16)	leading to improved services and reduced health inequalities (O1)
Where there is an opportunity to influence institutional policy or planning (for example ICS strategy or LA HWB) (C4)	This can lead to development of specific action plans (M13)	Influencing policy and ownership – PBA captured in ICS plans, Health and Wellbeing strategies, etc. (O9)	leading to improved services and reduced health inequalities (O1)
Where there is an opportunity to influence institutional policy or planning (for example ICS strategy or LA HWB) (C4)	There can be Incorporation of PBA approach into organisational/cross-organisational strategy (Formalisation of approach) (M11) and Opportunities for interdepartmental/cross-organisational working (M12). This can lead to development of specific action plans (M13)	PBA becomes a standard way of working (O13)	leading to improved services and reduced health inequalities (O1)
When there is a proactive approach to PBA from local leaders (DPH etc.) (C5)	There can be Incorporation of PBA approach into organisational/cross-organisational strategy (Formalisation of approach) (M11) and Opportunities for interdepartmental/cross-organisational working (M12).	PBA becomes a standard way of working (O13)	leading to improved services and reduced health inequalities (O1)

Context	Mechanism	Intermediate outcome	Final outcome
Complexity - In a large organisational infrastructure (such as the ICS) (C6)	Incorporation of PBA approach into organisational/cross-organisational strategy (Formalisation of approach) (M11) and opportunities for interdepartmental/cross-organisational working (M12)	Strengthened/Empowered community participating in planning and delivery of services (O6)	Can lead to improved services and reduced health inequalities (O1)
Complexity - In a large organisational infrastructure (such as the ICS) (C6)	Shared learning and shared information (M14)		Can lead to improved services and reduced health inequalities (O1)
Complexity – In a large organisational infrastructure (such as the ICS) (C6)	Incorporation of PBA approach into organisational/cross-organisational strategy (Formalisation of approach) (M11) and opportunities for interdepartmental/cross-organisational working (M12) and Shared learning and shared information (M14)	may risk losing sight of local priorities (O12)	

Block 4 – Capacity and Resources

Context	Mechanism	Intermediate outcome	Final outcome
Where capacity and resources made available for PBA (C7)	Changes in capacity and resource planning (M15) can lead to	Shift or alignment of resources to support place-based work at scale to reduce health inequalities (O14) and a Recognition of the importance of HI; wider determinants and whole systems; and shift from individual to structural interventions (O15)	Can lead to improved services and reduced health inequalities (O1)
Where capacity and resources made available for PBA (C7)	Commissioners can involve community partners (M16)	Leading to Strengthened/Empowered community participating in planning and delivery of services (O6)	Can lead to improved services and reduced health inequalities (O1)

Block 4 – Focus on Health Inequalities

Context	Mechanism	Intermediate outcome	Final outcome
Common understanding and a focus on Health Inequalities (C8)	can facilitate agreed shared governance processes/ systems-based approaches (M17)	which can lead to increased collaboration and partnership working (O16)	Can lead to improved services and reduced health inequalities (O1)
Common understanding and a focus on Health Inequalities (C8)	can facilitate agreed shared governance processes/ systems-based approaches (M17)	which can lead to recognition of the importance of wider determinants of health, whole systems approaches, long-term approaches and a shift from individual to structural interventions (O15)	Can lead to improved services and reduced health inequalities (O1)
Common understanding and a focus on Health Inequalities (C8)	Dedicated resource (money, people etc.) (M18)	Shift or alignment of resources to support place-based work to reduce health inequalities (O14)	
Common understanding and a focus on Health Inequalities (C8)	Potential + capacity for change (area) and high-level buy-in (M19)	this can lead to improvement in metrics measuring health outcomes - QoL, life expectancy etc. (O2)	Can lead to improved services and reduced health inequalities (O1)
Disadvantaged areas (socio-economic; protected characteristics; vulnerable groups; geography) (C9)	Targeted approaches to community involvement (M20)	this can lead to improvement in metrics measuring health outcomes - QoL, life expectancy etc. (O2) and Strengthened/Empowered community participating in planning and delivery of services (O6)	Can lead to improved services and reduced health inequalities (O1)

Context	Mechanism	Intermediate outcome	Final outcome
Disadvantaged areas (socio-economic; protected characteristics; vulnerable groups; geography) (C9)	Potential + capacity for change (area) and high-level buy-in (M19)	which can lead to increased collaboration and partnership working (O16), Strengthened/Empowered community participating in planning and delivery of services (O6) and recognition of the importance of wider determinants of health, whole systems approaches, long-term approaches and a shift from individual to structural interventions (O15)	Can lead to improved services and reduced health inequalities (O1)
Health inequalities as policy priority nationally (C10)	Potential + capacity for change (area) and high-level buy-in (M19)	which can lead to increased collaboration and partnership working (O16), Strengthened/Empowered community participating in planning and delivery of services (O6) and recognition of the importance of wider determinants of health, whole systems approaches, long-term approaches and a shift from individual to structural interventions (O15)	Can lead to improved services and reduced health inequalities (O1)

Context	Mechanism	Intermediate outcome	Final outcome
Health inequalities as policy priority nationally (C10)	Dedicated resource (money, people etc.) (M18)	which can lead to increased collaboration and partnership working (O16), Strengthened/Empowered community participating in planning and delivery of services (O6) and recognition of the importance of wider determinants of health, whole systems approaches, long-term approaches and a shift from individual to structural interventions (O15)	Can lead to improved services and reduced health inequalities (O1)

Block 5 – Previous experiences

Context	Mechanism	Intermediate outcome	Final outcome
With an incentivised workforce/ community with experience of engagement (C11)	Learning about what is happening currently and what has happened before (M21)	Can lead to Strengthened/ Empowered community participating in planning and delivery of services (O6)	Can lead to improved services and reduced health inequalities (O1)
With an incentivised workforce/ community with experience of engagement (C11)	Learning about what is happening currently and what has happened before (M21)	PBA can be considered a viable methodology/framework to make a change (O17)	
With an incentivised workforce/ community with experience of engagement (C11)	By managing expectations: timescales (M22)	PBA can be considered a viable methodology/framework to make a change (017)	
Where the workforce/ community is fatigued by previous failure (C12)	Without (?) Learning about what is happening currently and what has happened before (M21)	PBA may be considered as new name for existing ways of working or a new initiative without learning from past experiences (O18)	
Where the workforce/ community is fatigued by previous failure (C12)	Learning about what is happening currently and what has happened before (M21)	PBA can be considered a viable methodology/framework to make a change (O17)	

Block 6 – Assets

Context	Mechanism	Intermediate outcome	Final outcome
Where there are existing community assets (C13)	Boundaries that flex to include assets or work with existing service delivery boundaries (M23)	Can result in Integration (O3) and Strengthened/ Empowered community participating in planning and delivery of services (O6)	Can lead to improved services and reduced health inequalities (O1)
Where there are existing community assets (C13)	Opportunity to build new partnerships or strengthen existing partnerships with non-traditional health settings (M24)	Can result in Integration (O3) and Strengthened/ Empowered community participating in planning and delivery of services (O6), increased collaboration and partnership working (O16)	Can lead to improved services and reduced health inequalities (O1)

About Public Health England

Public Health England exists to protect and improve the nation's health and wellbeing, and reduce health inequalities. We do this through world-leading science, research, knowledge and intelligence, advocacy, partnerships and the delivery of specialist public health services. We are an executive agency of the Department of Health and Social Care, and a distinct delivery organisation with operational autonomy. We provide government, local government, the NHS, Parliament, industry and the public with evidence-based professional, scientific and delivery expertise and support.

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339

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