JOINT HEALTH AND WELLBEING STRATEGY FOR DORSET 2013 - 2016

A strategy to improve the health and wellbeing of people in Dorset and to reduce the inequalities in health outcomes that exist between different parts of the population.

Contents

Introduction

The **Dorset Health and Wellbeing Board** (HWB) is a strategic partnership board consisting of local organisations that share a collective vision to drive improvements in people's health and wellbeing. The board is a statutory body, established within the terms set out by Health and Social Care Act (2012). It relates to the population of Dorset, defined as those people living within the administrative boundaries of Dorset County Council. The Dorset Board includes councillors and officers from county and district/borough councils, GPs from the Dorset Clinical Commissioning Group, the National Commissioning Board, HealthWatch, and representation from voluntary and community organisations.

The **Joint Health and Wellbeing Strategy** (JHWS) is the key document by which the HWB sets out its strategic intentions. The strategy was developed during the course of 2012, following consultation and engagement with multiple stakeholders. A summary of the responses to the consultation is detailed in Appendix 1. The JHWS is based on the assessment of the needs of the local population and on evidence of what is effective in improving health and wellbeing; and this information is presented separately via the **Joint Strategic Needs Assessment** (JSNA) for Dorset. The strategy does not seek to take on everything at once, but instead sets priorities for joint action that will have a real impact on people's lives in Dorset.

The strategy for Dorset sets out the following:

- A brief overview of the key issues affecting people's health and wellbeing in Dorset (taken from the Dorset JSNA).
- Agreed principles, and the ways of working that will be adopted to implement the strategy
- The vision and aims of the Health and Wellbeing Board.
- Five priorities for action in 2013-14.
- Plans for monitoring progress.

The strategy will initiate the development of more detailed multi-agency plans in line with the priorities that have been agreed, and these in turn will affect the commissioning and delivery plans of individual constituent organisations and partnership plans for specific localities/districts.

Health and Wellbeing in Dorset: a brief overview

Health and wellbeing is influenced by many aspects of how and where we live, work and what we enjoy doing in our spare time. This section provides an overview of the factors that can affect health and wellbeing for people living in Dorset. It uses information gathered as part of the ongoing Joint Strategic Needs Assessment process about:

- The health and wellbeing of people living in Dorset across the life-course, from children and families to older people, and what this tells us about their needs;
- Dorset as a place to live and work and differences in social determinants of health that can lead to inequalities in health in Dorset.
- Information on particular health issues as well as health and social service use in Dorset

Our local population

The 2011 Census population figures show that Dorset's population has grown over the past decade by around 5%, to 412,900. This compares with a GP registered population of 402,947 for the 59 general practices serving the Dorset population. A quarter of the population are at or over retirement age, a greater proportion than that seen in England (16%) or the South West (20%).

The proportion of the population in Dorset describing themselves as belonging to an ethnic group other than White British has risen from around 3.2% in the 2001 Census to 7.2%, based on experimental statistics from ONS. This is still much lower than England at 17.2%. The minority ethnic population on average appears to be younger than the White British population. A particular population group that is not well represented by available data but that tends to suffer from a higher mortality rate, including maternal and infant mortality is the Gypsies and Travellers population. Within Dorset there are four designated sites for Gypsies and Travellers (near Wareham, Piddlehinton, Shaftesbury and Blandford) with a combined capacity of 46 pitches.

The county is divided into 6 districts and there are 7 GP localities. Population figures for Dorset and each locality are shown below:

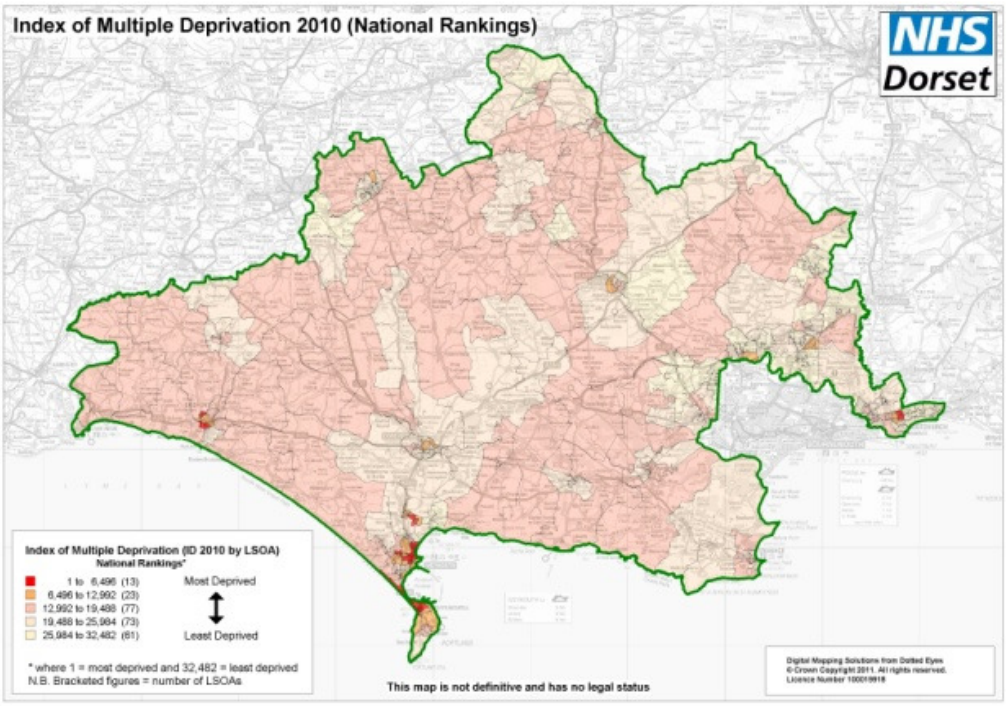
GP Locality	Population
Christchurch	53,703
Dorset West	40,897
East Dorset	69,777
Mid Dorset	41,814
North Dorset	89,848
Purbeck	33,403
Weymouth & Portland	73,505
Total	**402,947**

The ageing population of Dorset will present a number of challenges for the future; in particular potential increases in demand for social care (community and residential based services), supported housing need and the need to take account of the increasing impact of chronic disease. The impact of population ageing will depend on whether older people are enabled to remain independent and remain in good health for longer.

Health and wellbeing and inequality

The population of Dorset is generally healthy, with average life expectancy at birth for both men and women ranked inside the top ten in the country, at 84 years for women and 80 years for men. There are however inequalities in health outcome seen between districts across the county. Average life expectancy is 4 years lower for men living in Weymouth and Portland compared to East Dorset, with a gap of 3 years for women. There has been very little change in the gap in deaths from all causes between the most deprived areas compared with the least deprived area and this remains at about 185 deaths per 100,000 persons. By comparison the gap nationally is about 320 deaths per 100,000.

Dorset is an affluent area. We do have some small pockets of deprivation, mainly in Weymouth and Portland, which has 10 of the 13 Dorset small areas (lower super output areas) in the fifth most deprived of areas nationally, with two in West Dorset and one in Christchurch (shown in red in the map below). At the district level, even Weymouth and Portland, where we have the most deprivation, is no more deprived than the England average.



Although heart disease and cancer remain the largest cause of death, accounting for 63% of all deaths in Dorset, rates are low compared to England and continue to fall, part of which can be attributed to reductions in smoking prevalence. Similarly all cause mortality rates for both males and females in Dorset have been lower than the England average since 1999 and have fallen since then at a similar rate to the England averages (Local Health profiles 2011). Across Dorset mortality rates are highest in Weymouth and Portland.

Despite there being generally lower mortality rates in Dorset than in England, we have a higher burden of disease, with prevalence rates for heart disease, stroke, respiratory disease cancer higher than those in England and predicted increases in prevalence by 2020 estimated to result in potentially 9,278 additional patients with these long-term conditions. This higher prevalence is also reflected in higher admission rates for some of these problems, with admissions for circulatory problems, particularly heart disease, consistently higher than in England and rising over the last few years. This reflects our older population structure, and increasing expectations on health services. Despite this, overall admission rates have stabilised in Dorset and are similar to rates for England as a whole, although rates for England continue to increase. Emergency admission rates continue to increase both for Dorset and for England.

Another increasing problem is alcohol, with a 60% increase in hospital admissions rate for alcohol related harm between 2002/03 and 2008/9. This increase is not spread evenly across districts, with the lowest rates in East Dorset and the highest in Weymouth & Portland. Admissions are predominantly amongst the younger age groups, with under 18s in Weymouth and Portland having significantly more admissions for

alcohol related harm than the England average. Prevalence of binge drinking is also highest in Weymouth and Portland. Alcohol-attributable mortality is higher in men than women, but is no different from the England average.
Drug misuse is generally low in Dorset, at 6 per 1,000 adults (that is 16 – 65 year olds), however, in Weymouth & Portland rates are significantly higher (11.2 per 1,000 adults) than the England average of 9.4 per 1,000 adults.
Use of illegal drugs is predominantly an issue for young people (aged 16 – 24), particularly those living in more deprived area. Patterns of drug use are different in different groups and opiate use in Dorset peaks at 24-35 years (at 16 per 1,000); although this is relatively low and falling, numbers of people requiring hospital treatment for opiate use have remained fairly constant, with most patients coming from Weymouth & Portland.

The prevalence of people with complex mental health problems (not including more common mental health problems such as depression) in the Dorset population is 0.67%, is similar to the England average, 0.77% (SWPHO 2011) but varies across Dorset. In 2009/10 there were 695 completed mental health assessments for new patients which represents a reduction of just over 800 from 2004/05. The prevalence of dementia is higher than in England.

Sexual health in Dorset appears better than many other areas, with low rates of sexually transmitted infections. Teenage conception rates are also below the national average, however, there are six wards with a teenage conception rate that is either in the highest 20% in England or higher than 60 per 1,000 females. Five of these wards are amongst the most deprived wards in Dorset. This demonstrates a potential need to refocus the level and type of delivery of sexual health information and services to suit these particular communities. Also higher than the England average is the proportion of under-16 conceptions that lead to abortion (67%).

Preventing ill health in Dorset

Dorset performs well on most important measures of prevention affecting children and families, such as initiation and continuation of breast feeding. Smoking in pregnancy however remains a challenge, with rates higher than the national average and relatively static.
Local data shows that child obesity and physical activity are significantly better than their England averages, whilst child tooth decay is similar to the England average. As with many health issues there is variation in rates within Dorset, with the highest rates of childhood obesity seen in the more deprived areas.

Physical inactivity in adults is an important issue that can affect health in the longer term – Nationally, 21% of the adult population (aged 16+) achieve three 30 minute sessions of physical activity a week (Sport England 2008), whilst 23% of the population in Dorset participates in 30 minutes of moderate intensity activity at least 3 times a

week. Overall, males are more active than females with 58% of males engaging in five sessions of 30 minutes of physical activity each week compared to 42% for females. The most active groups of adults are aged 18 – 24 and 45 – 64. After the age of 64 there is a sharp decline in the number of active adults.

Adult smoking is low (14%), except for smoking in pregnancy (18%), with highest rates seen in Weymouth and Portland. Hospital admissions attributable to smoking are also low (919 per 100,000), with the highest rates in Christchurch (1,362 per 100,000). Death rates due to smoking in Dorset (141 per 100,000) are significantly better than England, with the highest rate in Weymouth & Portland (195 per 100,000). Lung cancer is the single biggest cause of cancer deaths in Dorset, accounting for 18% of all cancer deaths and is almost entirely preventable.

Health and wellbeing across the life course: children and families

Many children and families living in Dorset are thriving and enjoy similar health to children and families elsewhere in England. Infant mortality rates are lower (although not significantly) than those of England. Measures of child obesity and physical activity are significantly better than their England averages, whilst child tooth decay is similar to the England average.

However, this generally healthy picture is not true in all areas, with small pockets of deprivation, particularly in Weymouth & Portland. Poverty and inequalities in housing and education needs can all contribute to poorer outcomes for some children and families.
Despite this generally healthy picture in 2010/11 nearly 4,000 0-4 year olds in Dorset were admitted to hospital; 450 of these were emergency admissions. Most were due to actual or suspected infections, problems relating to low birth weight and/or short gestation period and respiratory problems.

Most children feel safe in Dorset but safeguarding remains a continued focus, with considerable effort in recent years to ensure a lead “Named” GP for safeguarding (adults and children) in every practice and improvements to safeguarding children training. A recent joint Ofsted/CQC inspection of safeguarding and children in care services found all services to be adequate or good and the management of safeguarding in Dorset was graded as outstanding.

Older people

With 26% of the population at or over retirement age the health and wellbeing of older people is a key priority. For all mortality indicators Dorset is lower than England, however, for health and well being indicators only “limiting long term illness” shows a better value, the others are either similar or marginally worse than the England values. This is indicative of a generally healthily but longer lived older population.
The number of older people living in Dorset is expected to increase further, and with continuing gains in life expectancy there will be a growing number of people living to an advanced old age. In 2033, it is projected that the number of all adults aged over 85 years will have more than doubled since 2008. This will have a major impact on the future provision of care services in Dorset due to the increased vulnerability associated with this older age group.
In 2009/10 older age people (65 years and over) accounted for nearly half of the total hospital admissions in Dorset, increasing by 14.4% and 28.8% in the 65 – 84 and 85+ age groups respectively between 2006/07 and 2009/10. Re-admission rates (within 30 days of discharge) for people aged 75+ have also been steadily increasing.

The two most common causes for admission in the 65 – 84 year old are cancer and circulatory conditions, with an increased proportion for circulatory conditions in the most recent year. However, in the 85+ population the commonest causes of admission are circulatory, injury & poisoning and respiratory conditions. A lower proportion of cancer admission in this age group may be due to people with cancer not surviving until this later age. Admissions due to injury & poisoning group are mainly emergency admissions, suggesting that more robust falls prevention strategy could be required.
Co-morbidity is an important issue in older people. Often, especially in the older population, a person will need treating for more than one acute/chronic condition. We define the number of co-morbidities a person has to be the number of times a person was admitted into secondary care for different conditions. Looking at the types of conditions that form these co-morbidities we find that Injury & Poisonings are more common as co-morbidities in the 85+ age group, whilst conditions relating to the digestive and musculoskeletal systems are more common as co – morbidities in the 65 – 84 year olds. This serves to highlight the different and complex care needs in the old and very old.

Isolation is known to be a risk factor for depression and those in isolated areas with poor access to transport (public or private) may require emotional and practical support to fully access health care services. Dorset pensioners have better access to transport than found nationally (POPPI 2011).
In 2001 7.5% of all Dorset persons aged over 65 were estimated to have some form of Dementia, which is similar to the levels seen in England, 7.2% (POPPI 2011). This equates to 8,017 people and is expected to rise to 14,052 people by 2030 (POPPI 2011). Due to differences in the population structure within Dorset, West Dorset is expected to

see the largest increase in people with Dementia. However, diagnosis of dementia remains a problem in Dorset (and England) as a whole, with only 37% of those with dementia expected to be diagnosed (Dorset Health Scrutiny Committee 2010).
The adult safe guarding service focus is on prevention rather than prosecution, with the emphasis on understanding how issues arose and putting in procedures to prevent them from happening again. There is currently a comprehensive review of adult safe guarding services in Dorset looking at how these services could be restructured to meet future service level demands and to ensure best practice is implemented.

Wider determinants of health

Many aspects of health and wellbeing over our lifetimes can be affected by income, education, housing and the quality of our local environments. This section sets the context around some of these social determinants of health outcome and health status.

Environment

With 55% of its geography designated as areas of outstanding natural beauty and 114Km of coast line designated as a world heritage site, the local environment is of particular importance to Dorset, and around 70 % of the Dorset population live in rural settlements or market towns rather than urban areas.
Dorset is one of the top ten counties for recycling waste with 48% household waste recycled in 2008/09, which is only 4% less than the number one county council. As a result of this, from 2005 to 2010, Dorset reduced waste its landfill capacity and deposits by 38% and 44% respectively, whilst keeping its waste treatment and transfer more-or-less constant.
Although there is no data available to directly measure the Dorset air quality, according to the Department for Environment, Food & Rural affairs, from 2000-2011 there have been no instances where CO has been measured as high or very high in the South West and only 35 days where Ozone has been measured as High over the same time period (DEFRA 2011).

Housing needs in Dorset

The average household size in Dorset is 2.15 people, less than the England average, due, in part, to the large retirement population in Dorset. Over the last ten years, 16,123 new dwellings have been built in Dorset, of which 15% have been affordable housing. The average house price in 2009 was around £242,103, 10% more than the England average and over 9 times higher than the median Dorset wage, so affordable housing is an important issue in Dorset.
Future housing and support options will have to be able to respond to the higher than average increases in older people expected in Dorset over the next twenty years,

including a doubling in the number of people over 85; changing housing aspirations of people with a learning disability, with a move to greater independent living and supported accommodation and increasing numbers moving into adulthood; and increasing numbers with physical and mental illness who have particular housing needs.

Our economy

Although 5.6% of young people are classed as NEET (Not in Education, Employment or Training, 1% less than the National average), education attainment is generally good, with 59% of children attaining 5 GCSEs at grade A* – C including Maths and English. This is significantly higher than the national average of 55% (Local Health profiles 2011). One percent of the children enrolled in schools are in a Community or Foundation Special school (Dorset Data Book 2011).

These good educational attainment levels are also seen in the working age population where 50% have the equivalent of an NVQ level 3 or higher and 30% have NVQ level 4 or higher. As a result of this skilled and educated work force only 1.9% of the adult population are long term unemployed, a third of the national average (Local Health Profiles 2011).

Half of the work force is employed in either Business services or the Public sector and the median gross weekly wage is 89% of the England median (£490). However, as a result of low unemployment leading to multiple-income households and small family size, the gross disposable household income per head is about 5% greater than the England average (Dorset Data Book 2011).

How safe is Dorset?

Dorset is a relatively safe place to live with crime rates of 53 per 1,000 persons. This is substantially lower than the England average (87 per 1,000). However, there is variation within Dorset with the highest crime rates found in Weymouth & Portland which, at 93 per 1,000, which is higher than the England average. Although the majority of crimes committed in Dorset are theft (non-motor vehicle), violent crimes committed in Weymouth & Portland are significantly higher than the England average (Local Health Profiles 2011). As with crime, the incidence of anti-social behaviour is relatively low in the Dorset Local Authorities, except Weymouth & Portland where there are 98.7 incidents per 1,000 persons (compared with the Dorset average of 55.1).

How strong and cohesive are local communities?

Indicators that attempted to measure “strong communities” – in the Citizenship Survey – are no longer collected. However the last publication, the Citizenship Survey: Community Spirit Topic (2011), showed that 89% of people in the least deprived deciles agreed with the statement that “people of different background get on well together” which is a similar proportion to the South west average, 88%, of people who agree with that statement. Additionally 90% of those aged 65+ in the South West also agreed with the statement. 67% of South West respondents also said they were not worried about becoming a victim of crime, which is greater than the England average (62%).
Whist these indicators imply the Dorset population is a strong an cohesive one, an important caveat to this is that the Dorset population is also relatively homogenous, so there are not a wide range of people from social/economic/ethnic backgrounds to mix with.

Principles

The following principles have been adopted by the Dorset Health and Wellbeing Board and have informed the development of the strategy and prioritisation process.

A. We will fully engage local people and organisations to influence the development of the Joint Health and Wellbeing Strategy and make its delivery accountable to local people through the Health and Wellbeing Board.

The development and implementation of the strategy will be undertaken in collaboration with communities as well as voluntary, public and private sector organisations. Citizen involvement is integral to the Health and Wellbeing Board, which will foster accountability to local people through the membership of county and district councillors and local Healthwatch. Board meetings will be open for members of the public to attend and the board will act transparently in relation to all key decisions.

B. We will commission and provide services and interventions that are cost effective and are built on the best evidence of what works

This is particularly important in service redesign, where a very high degree of certainty is required before disinvesting in, or reorganising an existing service in order to invest in a new service model.

C. We will continue to assess the health and social needs of the Dorset population to inform our decision-making

Our plans are only as good as our understanding of the issues affecting people's health and wellbeing. The causes of health and illness are highly complex and far-reaching, spanning personal, social, and environmental factors. Our Joint Strategic Needs Assessment will summarise the breadth of population needs at a county and locality level, and reference more detailed work on particular priority outcomes.

D. We will work on a whole system basis

No service or intervention exists within a vacuum, or as an end in itself. We need to understand the interrelationships across services and with communities, families and people. The better the alignment of the whole system, the better the improvement in outcomes will be. The emphasis will be on sustainability, operating within environmental limits, and we will not seek short-term gains at

the expense of improving outcomes in the long-term. The Board is committed to working in partnership at every level, influencing plans in localities as well working with other county-wide strategic partnerships (for example the Local Enterprise Partnership; cultural, nature and community safety partnerships).

E. We will prioritise those who have, or who are likely to develop the worst health outcomes

Those with the greatest health and wellbeing needs often require more time and support than others if their outcomes are going to improve. Our efforts and resources will therefore be more concentrated on those with greater needs in line with our vision of reducing inequalities.

F. We will take a life-course perspective to improving the health and wellbeing of the population

There are measurable inequalities in health and wellbeing outcomes very early on in life with patterns of inequality often remaining throughout adulthood and into old age. Even in a population with an older demographic, it is important to intervene appropriately across the life-course, and maintain an emphasis on the early years that will accrue long-term benefits in population health and wellbeing.

G. We will seek to develop a sustainable health and social care system through early intervention and prevention

The increasing demands on health and social care services cannot continue to be met simply by increasing the supply of services. Effective preventative community action will be essential in building sustainable health and social care services of the future.

H. We will adopt an objective and transparent approach to measuring progress across priority outcomes

It is only through evaluation and by measuring changes in outcomes that we can learn about whether we have made a difference and about what works. But in order to assess our progress in reducing inequalities, we also need to understand who is benefiting the most: whether in those within a particular income bracket, living in a certain area, or of a particular social group.

I. We will co-ordinate our actions with those of neighbouring local authority areas, particularly Bournemouth and Poole, whilst remaining focused on delivering services in localities based on local needs

The work of several key organisations transcend local authority boundaries as do the daily movements of many local people; so where appropriate, planning needs to be considered across a wider geographical area. In particular, we will work closely with the Health and Wellbeing Board for Bournemouth and Poole.

Vision

To improve the health and wellbeing of people in Dorset and to reduce the inequalities in health outcomes that exist between different parts of the population.

The vision of the HWB has two distinct elements, yet they are fundamentally connected. The primary means of improving the population's health and wellbeing overall should be through reducing inequalities, or in other words in seeking to improve the health and wellbeing of those with poorest outcomes even more rapidly than those with better health and wellbeing status. Sir Michael Marmot, who has conducted a national independent review into health inequalities, calls this approach '**proportionate universalism**', and it is consistent with expectations set out in the Health and Social Care Act. More importantly however, it is the fairest way to improve health and wellbeing in Dorset, which in general terms is already one of the healthiest local authority areas in the country.

Aims

1. **People live in environments that support their health and wellbeing.**

2. **People, families and communities are enabled to live healthy and fulfilling lives.**

3. **People with increased risk of poor health are identified early on and are supported to prevent premature problems developing.**

4. **People living with long-term health problems avoid complications and maintain a good quality of life.**

Through these aims, the Board is keen to emphasise a continuum of preventive action that includes the fundamental determinants of health and wellbeing at an early stage, as well as later actions to prevent the onset of particular illness or complications from a given long-term condition. In many circumstances, this continuum will be linked to stages across the life-course (childhood, adulthood and old age), but clearly this will not always be the case, for example where illness or disability is experienced in childhood.

The aims of the strategy are quite generic and are unlikely to change over the three-year course of the strategy, but the specific priorities that the Board chooses to work on will be subject to review on an annual basis. It is when the aims are applied to a specific outcome or priority, that they become a driver of programme plans across the partnership. The aims seek to assist individual organisations or groups in identifying the contribution they can make to improve an agreed outcome. The programme outlines on pages 25 to 29

demonstrate this approach as it relates to the priorities for 2013-14.

Aim 1:

People live in environments that support their health and wellbeing.

Our health and wellbeing is affected by the environment in which we live. Both the wider physical environment and the more immediate home or work environment can act as a risk to health or alternatively promote health and wellbeing. Environmental factors can influence health in obvious ways; for example a large volume of fast moving traffic moving through a village increases the likelihood of serious road traffic collisions with potential for injury or death. More subtly however, evidence shows that the same high speed traffic is also likely to make it more difficult for people to get around their neighbourhood and meet with friends and neighbours, adversely affecting their mental health and reducing levels of physical activity in the community.

In Dorset, the natural environment is considered a major asset, promoting the health and wellbeing of local people. But are the benefits associated with natural environment realised by those with the poorest health outcomes?

The availability of good quality, flexible and affordable housing that promotes the health and wellbeing of the occupant is of ongoing importance in Dorset, particularly in light of changing demographics and in areas where there are low incomes.

There are 'costs and benefits' associated with all policy decisions about the environment and housing – we will promote decision making based on a clear understanding of the impact of these decisions on health and wellbeing. Furthermore we will work to ensure the adverse impact of any decision does not unfairly fall upon one group in society or widen health inequalities.

Aim 2:

People, families and communities are enabled to live healthy and fulfilling lives.

Our daily habits and behaviours are inextricably linked to our experience of health and wellbeing throughout life. It's clear that people take personal responsibility for their actions, but it is also important to recognise that health related behaviours are to some degree predictable and dependent on external factors. Many behavioural norms are established very early on in life, either through direct experience or through learning from significant others. By focusing on healthy development in the early years, and through supporting families to develop healthy patterns of behaviour, health and wellbeing can be improved across the life-course.

Health education is important in informing people about the best course of action to take to prevent the occurrence of premature health problems, but for education to be effective, it requires wider reinforcement. Public policy needs to support people in making healthier decisions by making the healthier choice the easier or more rewarding choice to make. Similarly, reinforcement comes through our daily experience of the people and communities that surround us.

If for example a family moves into a community where they find the majority of children walk or cycle to school, their understanding of the benefits of physical activity is reinforced, and it is more likely that they themselves will do the same. On the other hand, health education which aims to reduce excessive alcohol consumption amongst teenagers will be unlikely to succeed if it is within a social context where parents or peers are binge drinking and misusing alcohol on a daily basis.

Promoting healthy behaviours in local communities is not as straightforward as it might first appear. We will support families and carers to give children the very best start in life. We will also invest in health education and health promotion services assisting people in making healthier choices; and we will seek to reinforce this with supportive policies and through collaboration with local communities.

Aim 3:

People with increased risk of poor health are identified early on and are supported to prevent premature problems developing.

Risks to health and wellbeing are not evenly distributed across populations, but instead conspire to form patterns of inequality. If inequalities are to be reduced, it is critical that risks are identified early on in their development and, where possible, action is taken to mitigate their impact on health and wellbeing. This requires services to actively seek out groups of people known to be at heightened risk, as they may be the ones least likely to seek help from services or participate in universal screening programmes. The earlier that modifiable risks can be identified and preventative measures put in place, the better the outcomes for health and wellbeing. So, for example, smoking cessation or a reduction in excess weight at a younger age will confer greater benefits in terms of avoiding disease later on.

The 'NHS Healthcheck' programme is designed to be proactive in identifying modifiable risks as they relate to cardiovascular disease; however the programme is limited in that it only becomes open to people when they turn 40 years of age.

Key risk factors that are possible to modify include: smoking, high blood pressure, over-weight and obesity, inactivity, high levels of cholesterol, pre-diabetes, drinking alcohol to harmful levels, drug misuse, work related stress, anxiety and depression.

We are committed to identifying risks as early as possible, including during childhood and will work in a targeted way to bring about reductions in inequalities in health and wellbeing outcomes.

Aim 4:

People living with long-term health problems avoid complications and maintain a good quality of life

Over the last century long-term (or chronic) health problems have increased in tandem with improved life expectancy and a reduction in infectious disease. Managing long-term health problems and disability in an effective and efficient way has therefore become a central strategic challenge in the planning of public services.

Preventing the further exacerbation of health problems, or slowing the progression of ill-health, remains a central theme of the strategy; helping people to remain as independent as possible, and maintaining purposeful and meaningful lives. Where appropriate, models of care should encourage recovery and functional reablement, giving individuals the skills and confidence to take control of, and manage their own health problems. Importantly, this involves working with, and supporting families, carers and local community groups that are the providers of so much informal care. Health and social care services need to work in unison to provide the right levels of care when it is needed. With increasing demand for care services and no additional resource, it is critical to minimise the use of high-dependency, high-cost care provision.

Dorset already has a demographic profile that is older than most other parts of England, and the trend of an ageing population is set to continue for at least a further twenty years. The demand for care is therefore likely to increase over that time. Furthermore, it can be more costly to provide care across rural areas.

Maintaining a sustainable health and social care system which meets the needs of local people in Dorset is of central importance to improving population health and wellbeing. We are committed to working together in facing these challenges, accepting the need for systemic change and innovative new ways of working.

Priorities for action 2013-14

The Health and Wellbeing Board is committed to working in a focused way on a limited number of priorities at any one time. It is not expected that the very wide ranging work on health and wellbeing that is already established across Dorset will somehow cease as a result, nor will it be the case that all other performance requirements (some of which may be externally driven) can be ignored. The Board does however want to work proactively to lead improvements in relation to the top local priorities. Whilst it takes some time for new programmes of work to be properly established and effective actions implemented, the board will review its priorities on an annual basis and priorities may change or be added to according to capacity or progress made.

Based on the principles that have been established, the board developed a decision making tool to assist with the process of prioritisation. Information from the JSNA, along with wider sources of evidence was used to score competing priorities against set criteria. For good reasons, no prioritisation process should ever be considered to be completely objective, but with the use of this type of prioritisation tool, decision making becomes more consistent and definitely more transparent. The tool sets out ten prioritisation criteria which allow for scoring as follows:

a) Is the priority expressed as a health and wellbeing outcome? If not, the issue is excluded from the prioritisation process.	Yes	The priority is expressed as a 'state' or an 'end point' that is clearly descriptive of population health and wellbeing.
	No	The priority is expressed as an intervention or a process indicator. It may be thought of as an outcome, but is not in itself descriptive of the health and wellbeing of a population.
b) Over what time period can improvement in the outcome be expected? (During 2013/14 it is expected that at least 2 priority outcomes identified are amenable to short/medium term change)	Short term	within 2 years (quick win)
	Medium term	within 5 years
	Long term	6 years or longer
1. Is there evidence that Dorset residents see the outcome as a priority?	**	Public consultation exercise documents expressed need
	*	Unknown – no evidence of expressed need found
	Not rated	Public consultation exercise has determined - not a priority
2. Is there much difference/variation between localities or districts in Dorset?	***	Statistically significant differences in outcome have been recorded between localities /districts
	**	Marked but not statistically significant differences recorded
	*	Unknown – differences have not been measured

	Not rated	Outcome is distributed equally across localities/districts

3. Is there evidence that the outcome adversely affects those identified as being particularly vulnerable?	***	Statistically significant differences in outcomes have been recorded between social groups (i.e. groups with 'protected characteristics' includes indicators of socio-economic position)
	**	Marked but not statistically significant differences recorded between social groups
	*	Unknown – differences have not been measured
	Not rated	Outcome is equally distributed across social groups
4. In measuring the outcome, does Dorset compare poorly when compared with England as a whole?	***	Indicators demonstrate that performance is significantly worse than England average
	*	Unknown – there is no comparable data with England
	Not rated	Indicators show performance is comparable or better than England average
5. What is the current size of the problem, in terms of how the outcome affects the population as a whole? *a. Affect on premature mortality (<75 years)?*	***	High impact on population death rate (>200 deaths per annum in Dorset)
	**	Moderate impact on population death rate (100-199 deaths)
	*	Low impact on population death rate (<99 deaths)
	Not rated	No related deaths in the population
b. Affect on morbidity?	***	High impact of prevalence of ill health in the population
	**	Moderate impact of prevalence of ill health
	*	Low impact of prevalence of ill health
	Not rated	No impact of prevalence of ill health in the population
c. How big is financial cost to local public sector organisations in seeking to manage the problem?	***	High cost (>£10m per annum)
	**	Medium cost (£2-£9.9m)
	*	Low cost (<£1.9m)
	Not rated	There is no cost to the public sector in seeking to manage the outcome.
6. Is the outcome clearly measurable?	***	Reliable population data is collated that is highly relevant to the outcome and can aggregated to various levels to allow for inequalities to be identified in the population
	**	Population data is collated that is broadly descriptive of the outcome
	*	Good proxy indicators can be measured
	Not rated	Outcome is not measurable locally

7. Is there good evidence that the outcome is amenable to change? *a. Are there interventions that are effective in bringing about improvements to the outcome?*	****	There is reliable evidence of a large effect
	***	There is uncertain evidence of a large effect or reliable evidence of a moderate effect
	**	There is uncertain evidence of a moderate effect or reliable evidence of a small effect
	*	There is uncertain evidence of a small effect
	Not rated	There is insufficient or no evidence
b. Is there evidence that the interventions are cost effective?	****	There is reliable evidence that interventions are very cost-effective
	***	There is uncertain evidence that interventions are very cost-effective or reliable evidence that the intervention is cost-effective
	**	There is uncertain evidence that interventions are cost-effective
	*	There is insufficient or contradictory evidence
	Not rated	No economic evidence could be identified
8. Do the interventions relevant to this particular outcome also have positive impact on other important outcomes, thereby providing opportunity to improve overall resource utilisation in relation to multiple outcome areas?	***	Reliable evidence of positive impact on several other key health and wellbeing outcomes
	**	Reliable evidence of positive impact on one other outcome, or uncertain evidence of positive impact on several other outcomes
	*	Uncertain evidence of positive impact on one other outcome
	Not rated	No evidence of positive impact on other outcomes
9. Will improvements to the outcome require widespread inter-professional, inter-agency working?	**	Widespread inter-professional/inter-agency working required
	*	Some limited inter-professional/inter-agency working
	Not rated	Outcome can be improved significantly by just one professional group or agency
10. Are there any external imperatives associated with the outcome?	***	Outcome is directly related to a statutory requirement or mandated programme of the local authorities or other public sector bodies
	*	Outcome is prioritised through government policy/guidance or is included in the NHS, Adult Social Care or Public Health Outcome Frameworks
	Not rated	No mention of the outcome in current national policy documents

At a workshop in December 2012, the board selected a long-list of outcomes to be put through the prioritisation process. A panel subsequently met to review the evidence and completed the matrix. The results of this process are detailed in appendix 2.

For 2013-14 the following priorities have been identified:

- Reducing the harms caused by smoking
- Reducing circulatory disease
- Reducing the harms caused by road traffic collisions
- Reducing the harms caused by diabetes
- Reducing anxiety and depression

'Reducing the harms caused by inequalities in GCSE attainment' also scored highly through the prioritisation process. The Health and Wellbeing Board need to decide whether to include this issue as a priority for the Board, or whilst acknowledging the importance of the issue, seek to devolve responsibility for this outcome to the Dorset Children's Trust Board.

It should be noted that the panel was not able to obtain enough evidence in relation to the first criteria to enable any form of objective scoring to take place (Is there evidence that Dorset residents see the outcome as a priority?) Whilst there has been a large amount of public consultation locally over many years, there was concern that information sources were not directly comparable, and results depended on the right questions being asked, as opposed to whether there were real differences in expressed need.

The following few pages, provide an overview of each priority and sets out a high-level programme outline corresponding to each one. Their purpose is to summarise the main interventions and to prompt the development of more detailed partnership plans.

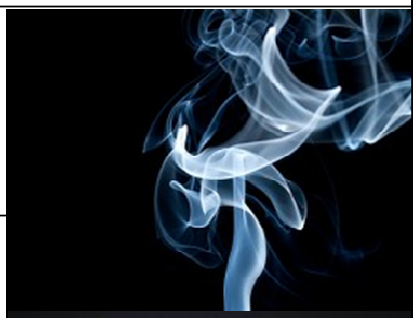
Priority: Reducing the harms caused by smoking

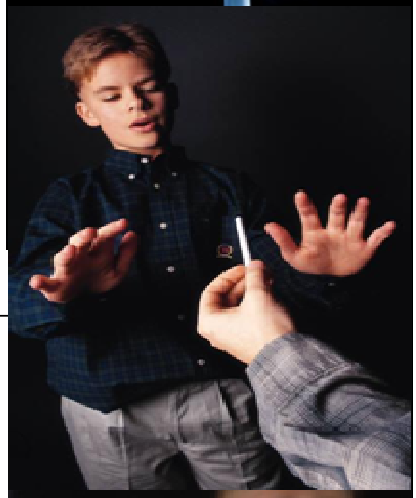
Smoking tobacco is one of the greatest risk factors associated with premature mortality , and it remains the single most preventable cause of death. Tobacco use, has a strong causal relationship with diseases such as ischaemic heart disease and stoke, lung, trachea and bronchus cancers. Patterns of smoking behaviour are strongly associated with a social gradient, with higher rates of smoking amongst the least well off. It is therefore a significant driver of health inequalities at a population level. Smoking tobacco not only harms the smoker, but can also impact the health of others through exposure to environmental tobacco smoke.

The smoking rate for Dorset is lower than that of England, yet significant inequalities exist between local communities. Maternal smoking, is particularly high and associated with more deprived communities. More needs to be done to prevent young people from starting to smoke, as well as providing support for those who want to quit.

Vision: To improve the health and wellbeing of people in Dorset and to reduce the inequalities in health outcomes that exist between different parts of the population.

1. People live in environments that support their health and wellbeing	• Effective implementation of legislation that prevents people from smoking in public places. • Policies that discourage exposure to ETS in confined spaces e.g. cars, particular focus on children.
2. People, families and communities are enabled to live healthy and fulfilling lives	• Health promotion programmes in schools and other educational settings. • Targeted approaches through the use of social marketing and peer to peer support/education. • Support for better regulation of market forces, includes the positioning and packaging of tobacco products, preventing under-age sales and illegal importation and supply.
3. People with increased risk of poor health are identified early on and are supported to prevent premature problems developing	• Promote NHS Health Checks to target audiences • Smoking cessation services target communities and social groups with higher prevalence. • Support and advice for pregnant smokers , with a focus on sustained cessation amongst younger parents. • Establish holistic preventative services that offer support relating to other risk factors e.g. alcohol misuse, mental ill-health.
4. People living with long-term health problems avoid complications and maintain a good quality of life.	• Support smoking cessation, even once health problem is established. • Effective management of symptoms • Care for people in community or hospital.





Priority: Reducing circulatory disease

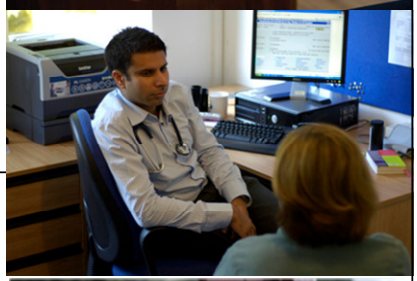
The term circulatory (or cardiovascular) disease is inclusive of a number of diagnosis, all of which affect the cardiovascular system, principally cardiac disease, vascular diseases of the brain and kidney, and peripheral arterial disease. Collectively these diseases remain the biggest cause of premature death in England, though over the past thirty years cardiovascular mortality rates have decreased significantly. Although these diseases usually affect older adults, antecendents of circulatory disease begin early on in life, so preventative actions are effective from childhood. Factors that modify the risk of disease include healthy eating, physical activity and avoidance of smoking.

Overall, rates of disease in Dorset compare well with England as a whole, but circulatory disease remains the most significant cause of premature mortality in the population. It is also subject to significant inequalities between areas (Weymouth and Portland has the highest premature mortality rate from circulatory disease) and strongly correlates with socio-economic status.

Vision: To improve the health and wellbeing of people in Dorset and to reduce the inequalities in health outcomes that exist between different parts of the population.

1. People live in environments that support their health and wellbeing	• Planning a built environment that encourages physical activity. • Healthy workplaces • Sustainable healthy food production and supply • Transport systems that encourage physical activity • Reductions in air pollution
2. People, families and communities are enabled to live healthy and fulfilling lives	• Programmes to improve early life experiences through support to families and carers i.e. developing healthy norms • Programmes to increase levels of physical activity in target communities. • Health education programmes and supportive policies to promote: good nutrition, safer drinking etc
3. People with increased risk of poor health are identified early on and are supported to prevent premature problems developing	• Promote NHS Health Checks to target audiences • Early identification and treatment/management of modifiable risk factors: hypertension, cholesterol, smoking, alcohol misuse, obesity. • Good management of diabetes.
4. People living with long-term health problems avoid complications and maintain a good quality of life.	• Effective treatment / revascularisation • Cardiac rehabilitation • Ongoing management of risk: blood lipids, blood pressure • Anti-thrombotic therapy • Reablement • Care for people in community or hospital: assistance with independent living.



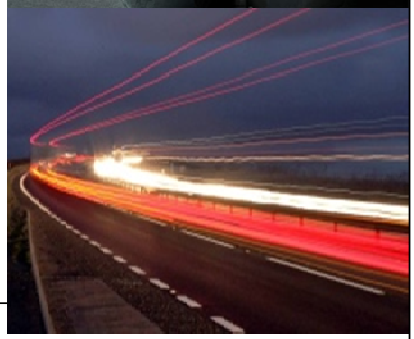




Priority: Reducing harms caused by road traffic collisions

Absolute numbers of road traffic collisions that result in serious injury or death are few when compared with the data that relates to other outcome priorities for Dorset. However, the impact of road traffic collisions on people's health and wellbeing can be considerable, not only for the people directly involved, but for their family and friends as well. The likelihood of collision is highest in younger drivers, so the consequences of injury or disability can sometimes be experienced over a whole life-time, and in themselves may ultimately lead to the emergence of other health problems. There is evidence that rates of road traffic accidents can be reduced over time, and this is particularly associated with environmental measures that bring about reductions in speed, or reduce car usage.

Overall, rates of road traffic collisions that cause death or injury are significantly higher in Dorset when compared to England as a whole. It is thought that this is largely due to the extensive rural road network in the county. Of all the collisions that result in death or injury, the majority occur on single-track rural roads.

Vision: To improve the health and wellbeing of people in Dorset and to reduce the inequalities in health outcomes that exist between different parts of the population.

1. People live in environments that support their health and wellbeing	• Road design that discourages speed and risk taking in high risk areas • Speed restrictions, 20mph areas in urban areas and adjustments on rural roads in light of new guidance • Infrastructure development that prioritises public and active travel as alternatives to the car. • Speed cameras • Pedestrianisation schemes.	
2. People, families and communities are enabled to live healthy and fulfilling lives	• Explore/lobby for strategies to delay licensing post 17/gradation of licensing schemes. • Driver education / awareness • Work with local driving tutors to promote safer attitudes to driving • Promotion of alternatives to car	
3. People with increased risk of poor health are identified early on and are supported to prevent premature problems developing	• Effective enforcement of traffic regulations and legislation which includes the involvement of communities. • Work with parents and local communities to influence the behaviour of younger drivers. • Partnership work to reduce incidents of drink driving	
4. People living with long-term health problems avoid complications and maintain a good quality of life.	• Rapid response and treatment of casualties. • Effective treatment and rehabilitation following injury • Maximise the use of teachable moments • Carers support and reablement for people with permanent disability • Support for people who have been bereaved	

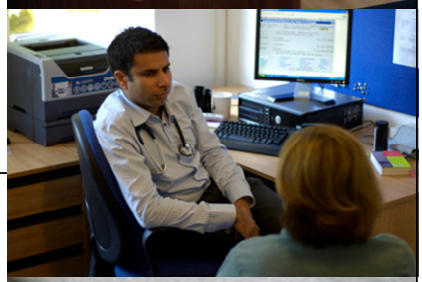
Priority: Reducing harms caused by Type-2 Diabetes

Diabetes mellitus (diabetes) is a chronic metabolic disease marked by high levels of glucose in the blood, which is a result of too little insulin being produced, or a resistance to insulin. Type 1 diabetes is an auto-immune disease, compared to Type 2 diabetes which results from genetic and lifestyle factors. Diabetes produces a high level of blood sugar if untreated. A person with diabetes has an increased risk of coronary heart disease and atherosclerosis. Diabetes is also linked to kidney failure, nerve disease in the lower limbs and blindness.

Prevalence of diabetes is higher in Dorset, partly due to the population having more older people than other areas. There are considerable inequalities associated with type-2 diabetes and the condition is largely preventable. There is good evidence that it is possible to prevent or delay the onset of type 2 diabetes, whilst good management of the condition itself prevents the onset of serious disability or related disease.

Vision: To improve the health and wellbeing of people in Dorset and to reduce the inequalities in health outcomes that exist between different parts of the population.

1. People live in environments that support their health and wellbeing	• Planning a built environment that encourages physical activity. • Healthy workplaces • Sustainable healthy food production and supply • Transport systems that encourage physical activity
2. People, families and communities are enabled to live healthy and fulfilling lives	• Programmes to improve early life experience e.g. promote breastfeeding • Programmes to increase levels of physical activity • Health education programmes: good nutrition, safer drinking etc
3. People with increased risk of poor health are identified early on and are supported to prevent premature problems developing	• Promote NHS Health Checks to target audiences • Diagnosis of prediabetes, type 2 diabetes and gestational diabetes. • Early advice and intervention to delay or prevent onset of type 2 diabetes amongst those with high risk: dietary control, regular physical activty , smoking cessation, limit alcohol. • Reassess risk every 3 or 5 years.
4. People living with long-term health problems avoid complications and maintain a good quality of life.	• Blood glucose lowering therapy • Identifying and managing long-term complications • Managing cardio-vascular risk: blood lipids, blood pressure • Anti-thrombotic therapy • Expert patients • Care for people in community or hospital



Priority: Reducing anxiety and depression

Anxiety and depression are the most common form of mental health problems. They can be diagnosed as separate disorders, but very often co-exist or are considered manifestations of the same problem. Research indicates overreactivity of the stress response system, causing extreme emotions along with a sense of being overwhelmed. Sufferers can experience heightened anxiety and panic attacks, prolonged periods of depression, or both. Risk factors associated with anxiety and depression include: living in poverty, lack of social or familial support, having a chronic illness, low self-esteem, childhood trauma and stress. If left untreated, anxiety and depression can lead to further social isolation, drug or alcohol misuse, self-harming, other forms physical or mental illness, or suicide.

Anxiety and depression are amongst the most common diagnosis in primary care. Indicators suggest that prevalence varies significantly amongst localities in communities in Dorset, with greatest need identified in more deprived areas. By reducing the incidence of depression and anxiety, many other health and wellbeing outcomes are likely to be improved.

Vision: To improve the health and wellbeing of people in Dorset and to reduce the inequalities in health outcomes that exist between different parts of the population.

1. People live in environments that support their health and wellbeing	• Planning built environments that reduce stress e.g. Those that increase access to open spaces and vegetation and encourage social networks. • Healthy workplaces that support work life balance. • Affordable good quality housing for people on low incomes.
2. People, families and communities are enabled to live healthy and fulfilling lives	• Timely support and nurturing for children who experience trauma or who have additional care needs. • Improving social capital and resilience in communities • Purposeful employment that maximise income.
3. People with increased risk of poor health are identified early on and are supported to prevent premature problems developing	• Early diagnosis and treatment in primary care • Support for women that suffer post natal depression. • CBT/talking therapies that improve resilience and wellbeing. • Mediation services • Debt counselling, maximising benefit uptake/managing reforms • Expert patient, self help. • Managing associated risks e.g. alcohol or drug misuse
4. People living with long-term health problems avoid complications and maintain a good quality of life.	• Work to promote recovery • Maintaining or regaining meaningful employment • Reducing risk of self harm or suicide • Early diagnosis and treatment of other mental or physical health problems • Health and social care services for people in community or hospital • Supported housing that maintains independent living

Monitoring progress

Progress in relation to each priority will be measured through a single over-arching outcome indicator. The indicators are as follows:

- Road injury and deaths (rate per 100,000 population – 3-year rolling average)
- Early deaths: heart disease and stroke (Directly standardised rate per 100,000 population – 3-year rolling average)
- Percentage of people on GP registers with a recorded diagnosis of diabetes.
- Percentage of adults (aged 18 and over) who smoke.
- Percentage of adults (aged 18 and over) with a recorded diagnosis of depression.

Further indicators will measure performance as they relate to the programme of activities under each priority. These will be decided upon as more detailed programme plans are developed.

When working with these indicators, the Board will not only monitor progress as it relates to the whole of Dorset population; where appropriate, it will also seek to monitor differences between localities and socio-economic groups. In this way, progress will relate directly to the overall vision of the Board: to improve health and wellbeing and to reduce inequalities.

Progress will be reported on annually by the Health and Wellbeing Board.

Appendix 1: Prioritisation matrix

	Timeframe for change: <2,2-5,>5	Preference expressed by Dorset Residents	Observed inequalities between localities	Observed inequalities between social groups	Outlier compared with England	Effect on premature mortality	Effect on morbidity	Financial cost to public sector	How measurable?	Effectiveness of intervention	Cost effectiveness of interventions	Impact on multiple outcomes	Requires multi-agency working	External imperatives	0
Road Traffic Collisions	Medium		3	3	3	1	1	2	3	3	2	3	2	1	27
Circulatory disease	Medium		3	3	0	3	3	3	3	4	4	3	2	3	34
Dementia	Medium		2	3	3	1	3	3	1	1	1	2	2	3	25
Diabetes	Long		3	3	3	3	3	3	3	4	4	3	2	1	35
Harms caused by smoking	Long		3	3	0	3	3	3	2	3	4	3	2	1	30
Excess winter deaths	Short		0	3	0	1	0	1	3	4	2	2	2	1	19
Harms caused by alcohol	Long		3	3	0	1	2	3	2	2	2	3	2	1	24
Harms caused by environmental pollution	Long		1	1	0	1	1	1	1	1	1	3	2	3	16
Anxiety/Depression	Long		3	3	3	1	3	3	1	4	4	3	2	1	31
Obesity	Long		2	3	0	3	3	3	2	1	1	3	2	3	26
Harms caused by smoking in pregnancy	Short		0	3	3	1	1	1	3	3	4	3	2	1	25
Melanomas	Long		0	3	3	1	1	1	3	2	2	1	2	1	20
Blandford fly	Short		3	1	1	0	1	1	1	1	1	0	2	0	12
Harms caused by poor sexual health in young people	Medium		3	3	0	1	2	2	2	2	2	1	2	3	23
Harms caused by inequalities in GCSE attainment	Long		3	3	0	3	3	3	1	2	3	3	2	3	29
Suicide	Long		0	3	0	1	1	3	2	1	0	3	2	1	17
Harms caused by poor housing	Medium		1	3	1	1	2	2	1	2	0	3	2	3	21
Teenage pregancy	Short		3	3	0	1	1	1	3	1	1	3	2	1	20
Harms caused by poor self esteem	Medium		3	3	0	3	3	3	1	2	3	3	2	1	27
Benefits from carers support	Short		3	1	1	1	2	3	1	2	0	3	2	1	20
Harms caused by drugs	Medium		3	3	0	1	1	2	2	2	2	3	2	1	22

Appendix 2: Responses to the consultation

You told us…	Our response
Clear and more consistent use of language. Technical language is fine as long as its meaning is explained well and it is used consistently.	Some technical language has been removed and further explanation of terms included.
Where is the 'story of Dorset'? There needs to be a better use of the JSNA in terms of setting the scene.	We have included a summary of key findings from the Dorset JSNA
There is no indication as to how the aspirations set out in the strategy will be paid for.	There is no additional funding made available to Health and Wellbeing Board to implement their plans. All improvements must be made through better use of existing resources.
It is important not to lose sight of individual responsibility. There should be a greater emphasis on education.	We have now referred to the importance of personal responsibility, and the role that health education can play as part of a broader set of strategies to improve health and wellbeing.
We would like more information on the Health and Wellbeing Board itself. Who sits on it? Who is accountable for delivering the strategy?	Information on the composition of the Health and Wellbeing Board, including the Terms of Reference can be found on the Dorset For You website: dorsetforyou.com
We want great clarity on measurable outcomes. What exactly is going to be delivered?	Objective measures have now been included and further measures will be identified as programme plans become more developed.
Will safeguarding children and vulnerable adults be reflected in the work of the Health and Wellbeing Board?	Safeguarding children and vulnerable adults is of paramount importance in terms of protecting health and wellbeing. Several board members also sit on the Safeguarding Boards in Dorset.

There needs to be a greater emphasis on outcomes for older people. The ageing population is an issue specific to Dorset.	The priorities in the strategy have incorporated key issues affecting older people – whilst the emphasis remains on improving health and wellbeing across all stages of life. Aim 4 articulates the issues relating to ageing population.
Not enough emphasis on reducing inequalities. The phrase 'differences in outcomes' is insufficient.	References to 'differences' have been taken out and reducing inequalities have been put centre-stage.
When considering environmental influences on health, there needs to be explicit mention of housing, the value of open/green spaces, and active travel.	These issues have been included.
What are the plans you have for involving the public in delivering the strategy?	Implementation of the strategy relies on collaboration across all stakeholders including people in local communities. The strategy makes this clear.
There needs to be a greater emphasis on mental health issues.	This has been picked up through the prioritisation process.
The scope of the work is very wide, how is the board going to engage all the stakeholders?	The Board is a strategic body that will seek to engage with and influence a large number of stakeholders. The Boards sub-structures are still being worked out.
There is no mention of the role of carers, and this needs to be addressed.	The need to support carers is referred to in Aim 4, and this is a cross-cutting issue for all the priorities.