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Agenda

Meeting:	Joint Public Health Board
Time:	10.00 am
Date:	19 September 2016
Venue:	Committee Room 1, County Hall, Colliton Park, Dorchester, Dorset, DT1 1XJ

Rebecca Knox (Chairman)	Jill Haynes	Drew Mellor (Vice-Chairman)
Nicola Greene	Jane Kelly	Karen Rampton

Notes:

- The reports with this agenda are available at www.dorsetforyou.com/countycommittees then click on the link "minutes, agendas and reports". Reports are normally available on this website within two working days of the agenda being sent out.

- We can provide this agenda and the reports as audio tape, CD, large print, Braille, or alternative languages on request.

- **Public Participation**

  Guidance on public participation at County Council meetings is available on request or at http://www.dorsetforyou.com/374629.

  Public Speaking

  Members of the public can ask questions and make statements at the meeting. The closing date for us to receive questions is 10.00am on 14 September 2016, and statements by midday the day before the meeting.

Debbie Ward
Chief Executive

Contact: David Northover, Senior Democratic Services Officer
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01305 224175 - d.r.northover@dorsetcc.gov.uk

Date of Publication:
Friday, 9 September 2016

Bournemouth, Poole and Dorset councils working together to improve and protect health

1. **Chairman**

To elect a Chairman for the meeting. (It was agreed at the previous meeting that the Chairmanship would rotate amongst the three authorities and that the Vice-Chairman identified at a meeting would become the Chairman at the following meeting).

2. **Vice- Chairman**

To appoint a Vice–Chairman for the meeting.

3. **Apologies**

To receive any apologies for absence.

4. **Code of Conduct**

Members are required to comply with the requirements of the Localism Act 2011 regarding discosable pecuniary interests and you should therefore:

- Check if there is an item of business on this agenda in which you or a relevant person has a disclosable pecuniary interest.
- Inform the Secretary of the Group in advance about your disclosable pecuniary interest and if necessary take advice.
- Check that you have notified your interest to your own Council's Monitoring Officer (in writing) and that it has been entered in your Council's Register (if not this must be done within 28 days.
- Disclose the interest at the meeting and in the absence of a dispensation to speak and/or vote, withdraw from any consideration of the item.

Each Council's Register of Interests is available on their individual websites.

5. **Minutes** 5 - 10

To confirm the minutes of the meeting held on 6 June 2016 (attached).

6. **Public Participation**

(a) Public speaking
(b) Petitions

7. **Forward Plan of Key Decisions** 11 - 14

The receive the Joint Public Health Board's Forward Plan.

8. **National and International Advances in Public Health**

To receive a presentation from the Director of Public Health.

9. **Developing prevention at scale** 15 - 36

To consider a report and receive a presentation by the Director for Public Health.

10. **Public Health Dorset business plan developments** 37 - 46

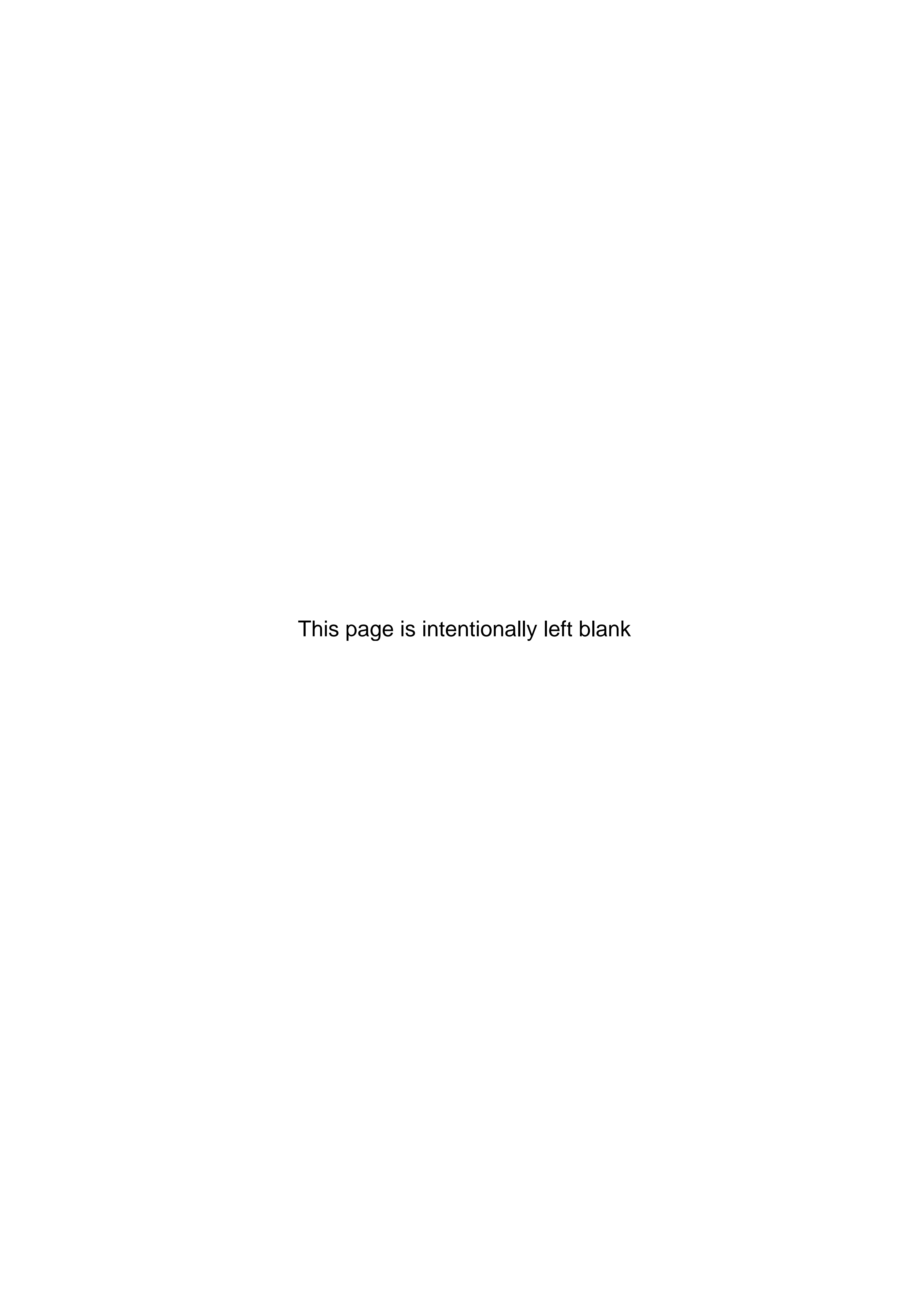
To consider a report by the Director of Public Health.

11. **Financial Report to end July 2016/17** 47 - 52

To consider a joint report by the Chief Financial Officer and the Director of Public Health.

12. **Questions from Councillors**

To answer any questions received in writing by the Chief Executive by not later than 10.00am on Wednesday 14 September 2016.



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Joint Public Health Board

Minutes of the meeting held at the Town Hall, Bournemouth Borough Council, Bournemouth on Monday, 6 June 2016.

Present:
Councillor Jane Kelly (Chairman)
Councillor Jill Haynes (Vice-Chairman)

Members Attending
Councillor Nicola Greene - Bournemouth Borough Council
Councillor Colin Jamieson – Dorset County Council
Councillor Mohan Iyengar – Borough of Poole

Officer Attending: Sophia Callaghan (Assistant Director of Public Health - Poole), Sam Crowe (Assistant Director of Public Health - Bournemouth), Jane Horne (Consultant in Public Health), Rachel Partridge (Assistant Director of Public Health), David Phillips (Director of Public Health) and Katherine Harvey (Consultant).

(Notes:(1) In accordance with Rule 16(b) of the Overview and Scrutiny Procedure Rules the decisions set out in these minutes will come into force and may then be implemented on the expiry of five working days after the publication date. Publication Date: **Monday 13 June 2016.**

(2) The symbol ( ) denotes that the item considered was a Key Decision and was included in the Forward Plan.

(3) These minutes have been prepared by officers as a record of the meeting and of any decisions reached. They are to be considered and confirmed at the next meeting of the Board to be held on **Monday, 19 September 2016**.)

Chairman

1 **Resolved**
That Councillor Jane Kelly be elected Chairman for the meeting, in accordance with Board's procedures.

Vice-Chairman

2 **Resolved**
That Councillor Jill Haynes be appointed as Vice-Chairman for the meeting.

Apologies

3 Apologies for absence were received from Councillor Rebecca Knox (Dorset County Council) and Councillors Drew Mellor, Karen Rampton, and Mike White (reserve) (Borough of Poole).

It was noted that Councillor Colin Jamieson (Dorset County Council) and Councillor Mohan Iyengar (Borough of Poole) attended as reserve members.

Code of Conduct

4 There were no declarations by members of disclosable pecuniary interests under the Code of Conduct.

Minutes

5 **Resolved**

That the minutes of the meeting held on 8 February 2016 be confirmed and signed.

Public Participation

6 There were no public questions or statements received and no requests to present petitions.

Forward Plan of Key Decisions

7 The Board considered its Forward Plan, which identified key decisions to be taken by the Board at future meetings.

The current version was published on 6 May 2016 and provided details of the key decisions due to be taken at the meetings on 19 September and 21 November 2016. It was noted that there were currently no items planned to be considered in private session.

The Director of Public Health reported that the item to be considered at the September meeting on '2016/17 Delivery – Commissioning and Performance Indicators' should include an additional bullet point on 'Children and young people health visiting', as agreed at the previous meeting.

Resolved

That the Forward Plan be agreed to include the amendment proposed by the Director of Public Health.

Strategic Direction - 2016 to 2019 / Public Health Dorset Work Plan 2016-18

8 The Board considered a report by the Director of Public Health on Public Health Dorset's business plan and priorities for 2016-18. The report was accompanied by a presentation from the Director which provided background to the current position and identified the main challenges and opportunities going forward.

The Board was reminded that Dorset was one of the lowest funded areas for public health in the country and needed to achieve savings of 20% by 2020. The Director outlined some of the achievements over the last three years in respect of effective contract and budget management, improved efficiency and equity across programmes, and building population health into corporate working and supporting transformation / innovation.

The Director explained the challenge going forward not only in financial terms but in terms of netter aligning public health activities with other systems and local initiatives e.g the STP and 'prevention at scale'. The presentation provided a breakdown of the main factors contributing to ill health/early death and an illustration of factors that were important in ensuring that the best value for money was achieved e.g need, spend outcomes and impact of activity.

The Director responded to questions from Board members and the main points raised in the discussion included:

- The importance of the prevention agenda and the need to take a joined up approach.
- The role of the Health and Wellbeing Board in taking up the issue of gaps in care under the Prevention of Scale agenda.
- The promotion of resilience and good mental health through the life course – recognising poor mental health as underlying some of the factors contributing to the burden of disease.
- The contribution of air pollution to the burden of disease was surprising for some Board members. Members commented on the complexity of the issues

and cited an example of planning guidance which encouraged, or in some cases required, high density housing to be built near major public transport routes and the impact this could have on health and potential solutions to this.
- Members commented that although the outcomes for some areas. e.g sexual health were good, there was a real need to be more efficient and effective in delivering services in order to best meet need and deliver outcomes across the system.

Resolved
That the Board note the priorities, ambitions and strategy set out in the summary of the business plan and approves the direction of travel for Public Health Dorset over the next two years.

Health and Wellbeing Framework

9 The Board considered a report by the Deputy Director of Public Health detailing the Health and Wellbeing Framework and what this entailed. Reference was made to a report to the Board in November 2015 identifying how best to integrate public health goals across Council services.

The Director responded to questions from the Board and the main points raised in discussion were:-

- The need for a more comprehensive understanding of public health amongst District Council colleagues. Whilst Public Health Dorset had achieved a considerable amount with District and Borough Councils on specific topics and key professional groups e.g. to improve standards of housing and work with the environmental health teams, there was the potential to develop the relationship, especially with members.
- Boscombe Regeneration Partnership Board was cited as a good model of public health engagement in a multi agency place- based project, and lessons and links to key officers from this were now being used to develop the Melcombe Regis Strategic Partnership.
- A more prominent role for communication in prevention e.g. training people on mental health issues. This was more difficult to undertake in rural areas. It was noted that Dorset Community Action was looking to arrange training sessions.
- Consideration given to a comment from Cllr Iyengar on the drawback of paying service providers on results, which meant that easier goals could be “cherry picked” and could limit the market for suppliers.

Resolved
That the Board approves the development of a generic Health and Wellbeing Framework pan Dorset.

Performance Update and Overview of Commissioning Plans 2016/17

10 The Board considered a report which provided a Performance Update and an Overview of Commissioning plans 2016/17. The Board’s attention was drawn to paragraphs 2.7 – 2.10 and 3.4 – 3.5 in particular. Officers explained that sexual health services needed urgent action for the reasons set out in report, the main issues being that:

- Public Health Dorset did not transfer the reduction to any providers in 2015/16, which was an unsustainable position, given savings of 20% were required by 2020;
- the non-compliance with EU/UK legal requirements on tendering;
- the cessation of “ring fence” arrangements for the public health budget from April 2018 and the lack of any central grant from 2020.

The Director responded to questions from Board members, the main points raised in the discussion centred around whether the Board should take a formal view on the next steps for future commissioning arrangements. Points which were made included:

- formal legal advice had not routinely been sought on non-compliance issues, but it was noted that the issue had been documented and was subject to a Monitoring Officer report to Dorset County Council;
- it was noted that there were now block contracts in place for 2016;
- some service models had not evolved to reflect current needs;
- there was general agreement that public health grant needed to be viewed in its entirety in terms of savings. Whilst it was recognised that this was a challenging area to renegotiate, there was a requirement to do this.

The Board decided not to take formal view for the following reasons:-

- because the report was for noting and did not form part of the recommendation, and
- because members felt comfortable that the way forward was already set out in the financial report to be considered later in the meeting in so far as them taking into consideration paragraph 4.2 as follows:

'While continuing to pursue further efficiency gains through recommissioning the service, we will look to restructuring public health activity and spend to provide as much convergence with other local authority priorities as practical'.

With regard to health checks, the Deputy Director of Public Health updated on the current position, this being:-

- GPs were not participating in health check invitations in two areas where tenders awarded to Boots plc; there were a number of factors influencing this but work was underway to try and resolved the situation. Legal advice had been sought from the County Council to manage the risk appropriately

Resolved
That the Board note the brief updates from each function area and the progress being made against agreed milestones.

Financial Report including Budget Outturn 2015/16

11 The Board considered the joint Financial Report including the Budget Outturn 2015/16 from the Chief Financial Officer and the Director for Public Health.

The Board noted that the figure given in paragraph 2.1 of the report should read *'the draft revenue budget for Public Health Dorset in 2016/17 is **£29.46m**'*.

The Board received the report as set out.

Resolved

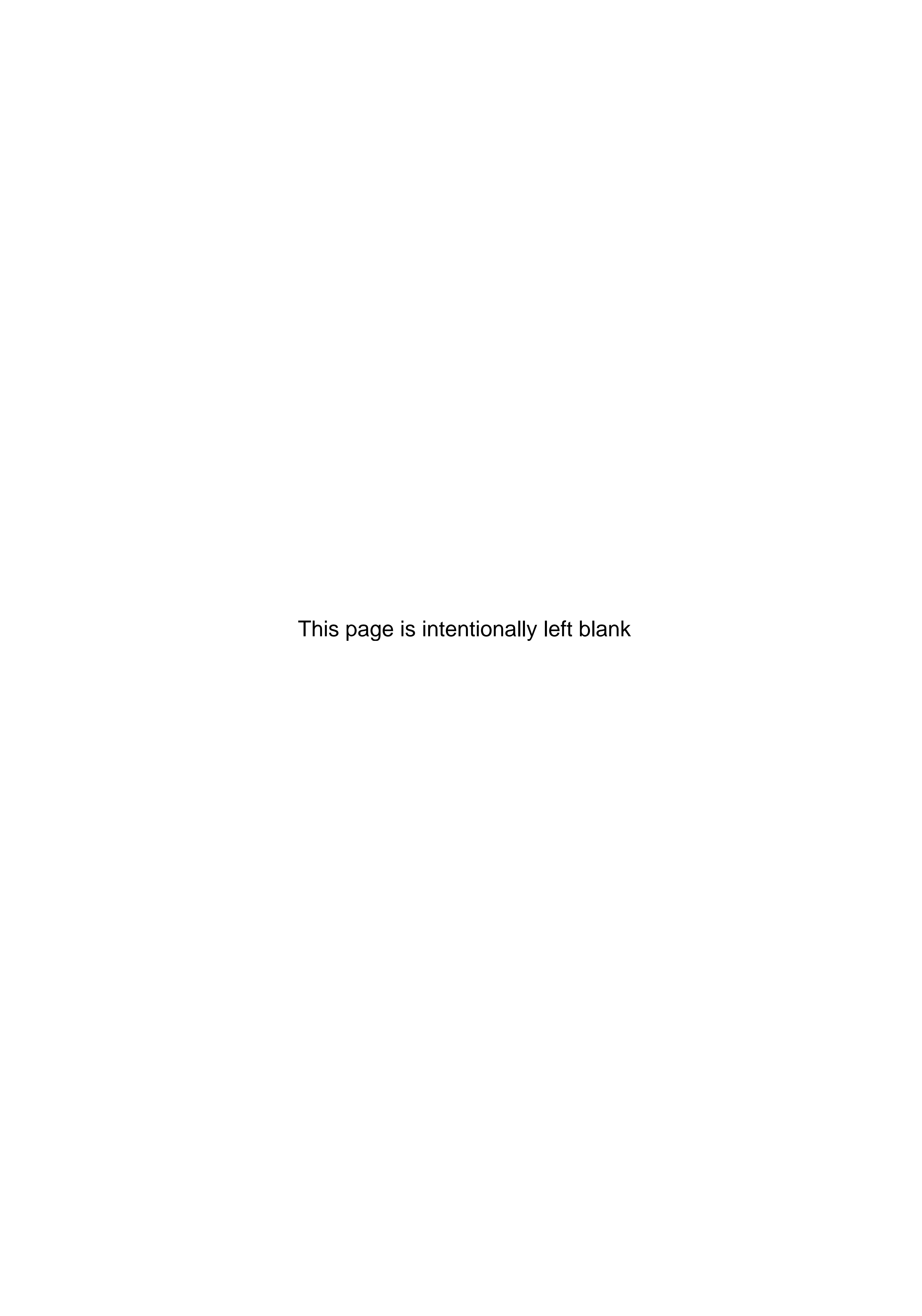
- That the approach to managing reductions in the budget based on the principles described in the report be agreed;
- That the allocations and budget for 2016/17 and for final outturn for 2015/16 be noted;
- That the transfer of the underspend into the Public Health reserve and the holding of the balance to mitigate the effect of central reductions in grant allocation be agreed.

Questions from Councillors

12 No questions were asked by members under Standing Order 20(2).

The Director of Public Health reported that the Public Health Team would be preparing a series of briefing notes and papers over the next few months and would welcome engagement and feedback on these from members of the Board.

Meeting Duration: 10.00 am - 12.00 pm



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DRAFT – Joint Public Health Board Forward Plan
(Next Public Health Joint Board Meeting Date – 19 September 2016)
(Publication date – 19 August 2016)

Explanatory note: This work plan contains future items to be considered by the Joint Public Health Board. It will be published 28 days before the next meeting of the Board.

This plan includes key decisions to be taken by the Board and items that are planned to be considered in a private part of the meeting. Key decisions are indicated by the following symbol:

The plan shows the following details for key decisions:-

(1) date on which decision will be made
(2) matter for decision, whether in public or private (if private see the extract from the Local Government Act on the last page of this plan)
(3) decision maker
(4) consultees
(5) means of consultation carried out
(6) documents relied upon in making the decision

Any additional items added to the Forward Plan following publication of the Plan in accordance with section 5 of Part 2, 10 of Part 3, and Section 11 of Part 3 of The Local Authorities (Executive Arrangements) (Meetings and Access to information) (England) Regulations 2012 are detailed at the end of this document.

Definition of Key Decisions
Key decisions are defined in the County Council's Constitution as decisions of the Board which are likely to -

"(a) result in the County Council incurring expenditure which is, or the making of savings which are, significant having regard to the County Council's budget for the service or function to which the decision relates namely where the sum involved would exceed £500,000; or

(b) to be significant in terms of its effects on communities living or working in an area comprising two or more electoral divisions in Dorset."

Membership of the Board

Bournemouth Borough Council	Dorset County Council	Borough of Poole
Nicola Greene	Jill Haynes	Drew Mellor
Jane Kelly	Rebecca Knox	Karen Rampton

How to request access to details of documents, or make representations regarding a particular item
If you would like to request access to details of documents or to make representations about any matter in respect of which a decision is to be made, please contact the Principal Democratic Services Officer, Corporate Resources Directorate, County Hall, Colliton Park, Dorchester, DT1 1XJ (Tel: (01305) 224187 or email: h.m.whitby@dorsetcc.gov.uk).

Date of meeting of the Joint Committee (1)	Matter for Decision/ Consideration (2)	Decision Maker (3)	Consultees (4)	Means of Consultation (5)	Documents (6)
19 Sept 2016	**Public Health Developments** National/International Perspective	Joint Public Health Board	N/A	N/A	Board Report
19 Sept 2016	**Business Plan Development Proposals 2017 - 2020**	Joint Public Health Board	Internal and other LA Dept	Structured & informal consultation processes	Board Report
19 Sept 2016	**2016/17 Delivery** Strategic Narrative – Prevention at Scale (PAS) / Sustainable Transformation Plan (STP)	Joint Public Health Board	Internal and other LA Dept	Structured & informal consultation processes	Board Report
19 Sept 2016	**Public Health Finances** Chief Financial Officer's Report	Joint Public Health Board	Internal + relevant LA departments	LA internal processes including audit	
21 Nov 2016	**2016/17 Delivery Commissioning & Performance Indicators**	Joint Public Health Board	Internal and other LA Dept Multiple Agencies. Public and Voluntary Sectors	Structured & informal consultation processes	Board Report

21 Nov 2016	**Public Health finances** Chief Financial Officer's Report	Joint Public Health Board			

Private Meetings

The following paragraphs define the reasons why the public may be excluded from meetings whenever it is likely in view of the nature of the business to be transacted or the nature of the proceedings that exempt information would be disclosed and the public interest in withholding the information outweighs the public interest in disclosing the information to the public. Each item in the plan above marked as 'private' will refer to one of the following paragraphs.

1. Information relating to any individual.
2. Information which is likely to reveal the identity of an individual.
3. Information relating to the financial or business affairs of any particular person (including the authority holding that information).
4. Information relating to any consultations or negotiations, or contemplated consultations or negotiations, in connection with any labour relations matter arising between the authority or a Minister of the Crown and employees of, or office holders under, the authority.
5. Information in respect of which a claim to legal professional privilege could be maintained in legal proceedings.
6. Information which reveals that the authority proposes:-
   (a) to give under any enactment a notice under or by virtue of which requirements are imposed on a person; or
   (b) to make an order or direction under any enactment.
7. Information relating to any action taken or to be taken in connection with the prevention, investigation or prosecution of crime.

Business not included in the Board Forward Plan

Is this item a Key Decision	Date of meeting of the Joint Committee meeting	Matter for Decision/ Consideration	Agreement to Exception, Urgency or Private Item	Reason(s) why the item was not included
		NONE		

The above notice provides information required by The Local Authorities (Executive Arrangements) (Meetings and Access to information) (England) Regulations 2012 in respect of matters considered by the Cabinet which were not included in the published Forward Plan.

Agenda Item 9

Joint Public Health Board

Bournemouth, Poole and Dorset councils working together to improve and protect health

Date of Meeting	19 September 2016
Officer	Director of Public Health
Subject of Report	**Developing prevention at scale**
Executive Summary	This report presents an update on work by the public health team to develop the prevention at scale approach within the Sustainability and Transformation Plan for Dorset.
Impact Assessment: *Please refer to the protocol for writing reports.*	Equalities Impact Assessment: N/A
	Use of Evidence: The prevention at scale work and presentations have drawn on national sources of evidence for effectiveness of public health interventions, including return on investment. This includes work by the National Institute for Health and Clinical Excellence, Public Health England, and individual research reports.
	Budget: The report discusses the impact on budgets for all health and care organisations if our local system does not adopt a more preventive and sustainable approach.
	Risk Assessment: Having considered the risks associated with this decision using the County Council's approved risk management methodology, the level of risk has been identified as: Current Risk: MEDIUM

	Residual Risk MEDIUM *(i.e. reflecting the recommendations in this report and mitigating actions proposed)*
	Other Implications: N/A
Recommendations	1) Members of the Joint Public Health Board are asked to note the progress with developing the approach to prevention at scale as part of the Sustainability and Transformation Plan (STP) for Dorset.
Reason for Recommendation	The STP presents and important opportunity for all health and care organisations in Dorset to take a more prevention oriented approach. This is considered an integral part of the other transformation plans set out in the STP, including changing the way acute hospitals work, developing integrated community services, and strengthening primary care.
Appendices	Annex A – Prevention at scale presentation
Background Papers	None.
Report Originator and Contact	Name: Sam Crowe Tel: 01305-225884 Email: s.crowe@dorsetcc.gov.uk

1. Recommendations

1.1 Members of the Joint Public Health Board are asked to note the progress with developing the approach to prevention at scale as part of the Sustainability and Transformation Plan (STP) for Dorset.

2. Reason

2.1 The STP presents and important opportunity for all health and care organisations in Dorset to take a more prevention oriented approach. This is considered an integral part of the other transformation plans set out in the STP, including changing the way acute hospitals work, developing integrated community services, and strengthening primary care. It is an important aspect of our priority in the business plan around systems leadership, and advocacy for improved population health and wellbeing.

3. Background

3.1 The Sustainability and Transformation Plan for Dorset sets out how the local health and care system intends to make changes over the next 5 years to close three important gaps.

- The health and wellbeing gap;
- Finance and efficiency gap;
- Care and quality gap.

3.2 These gaps represent important risks to the future sustainability of health and care services in Dorset. All local health and care systems in England have been asked to collaborate to produce STPs, setting out how transformed health and care services will work to ensure a more sustainable system in future, focusing on how the gaps will be closed.

3.3 The NHS and Public Health England, working with Councils, have called for "a radical upgrade in prevention" as part of these local plans. This paper sets out Public Health Dorset's work to date in building the local case for delivering Prevention at Scale, as part of the STP.

4. A clear story on prevention

4.1 Part of the work to develop plans for prevention at scale involves developing a clear and consistent story of what the issues are facing our population, and highlighting actions that could be delivered at scale with a judgement about likely effectiveness.

4.2 While it might be tempting to see Prevention at Scale as a separate programme, or series of interventions and activities that could be commissioned, the challenges facing Dorset will not necessarily lend themselves to being solved by this approach.

4.3 For example, many of the risk factors that we know contribute to the development of chronic diseases like diabetes and heart disease, are so prevalent in the population that providing support to change lifestyles on an individual basis alone will not be sufficient. Further, our evidence suggests that it is the variation in how these conditions affect populations in Dorset, and are managed and treated, that contributes to much of the observed health and wellbeing, and care and quality gaps.

4.4 For these reasons, a more integrated approach to prevention needs to be adopted right across the whole system, involving actions for individuals, actions for organisations, and actions for those most influential in shaping the development of places and communities. We also need to be clear what we mean by prevention, including the different approaches at different stages of life, and in different settings.

4.5 Over the summer Public Health Dorset has started work on developing a clearer story on prevention, and what it might mean in practice. We are trying to be clear and consistent wherever possible, in getting these messages across to influence our partners and the wider system.

4.6 Work so far has included:

- Ensuring there is a common story in the refreshed Joint Health and Wellbeing Strategies of both the Dorset Board and Bournemouth and Poole Boards;
- Describing prevention by using a clear life course approach, with the stages Starting Well, Living Well, Ageing Well used to segment and describe challenges and potential solutions;
- Annual Report of the Director of Public Health – due to be published this autumn, the report will make the case for prevention in Dorset using clear and simple language;
- Developing a slide deck that makes the case as to why a prevention at scale approach is needed in Dorset (see Appendix A). This has been used at Systems

Leadership Team and other Director level meetings over the summer to build the engagement with the PAS approach.

5. Next steps

5.1 During the autumn there will be a workshop hosted by both Health and Wellbeing Boards to scope and agree the elements of a Dorset Prevention at Scale programme. The output from the workshop will be presented back to both boards for agreement, and it is envisaged that a delivery group reporting to the Boards will take on responsibility for taking forward the actions that have been signed up to.

6. Conclusion

6.1. This paper summarises progress to date with developing the approach in Dorset to a systematic Prevention at Scale approach within the STP. Board Members are asked to consider the presentation attached as Appendix A, which sets out the background and rationale for the approach that we are taking in developing the options.

Director's name: Dr David Phillips
Director of Public Health
September 2016

Bournemouth, Poole and Dorset councils
working together to improve and protect health

Sustainability & Transformation Plan

‘Prevention at Scale’

The Example of Diabetes Management & CVD

Purpose of this presentation

- Describe the context for closing the H&WB gap and rationale for Prevention at Scale within the STP
- Illustrate the challenge in Dorset in regard to one of our agreed priorities i.e. Diabetes and CVD.
- Describe some ideas about moving forward

Introduction

Why are we discussing Prevention at Scale?

- Because a sustained approach to prevention is one of a limited number of options that *may* reduce the burden of disease, demand and service costs in an ageing population.

What does it mean?

- We don't know - only really good examples are mass vaccination campaigns in response to national/global epidemics and sanitation infrastructure!

Challenges:

- **Language**: the word means differing things to differing people – often not recognised or reconciled.
- **Individual behavior change:** difficult, often needs legislation e.g. seat belts, but seen as an intrusion on personal liberty etc, we know little about behaviour change in a social media world.
- **Prevention Paradox:** Lots of people not at 'risk' have to change a little to benefit the population a lot!

Prevention at Scale – Themes and Approaches

1. Three themes – 'outcomes' we wish to prevent/improve

- **Diabetes & Cardiovascular Disease: *Why*?** High levels of early death and disease, High levels of health and care utilisation. High investment.

- **Alcohol**: ***Why*?** Diverse societal outcomes across multiple agencies with high societal costs. Medium investment.

- **Mental Health/Musculoskeletal Disease**: ***Why?*** Highest global causes of loss of quality of life: large numbers of the population affected by long standing reduction in quality of life; high levels of productivity loss to society and local employers; low investment.

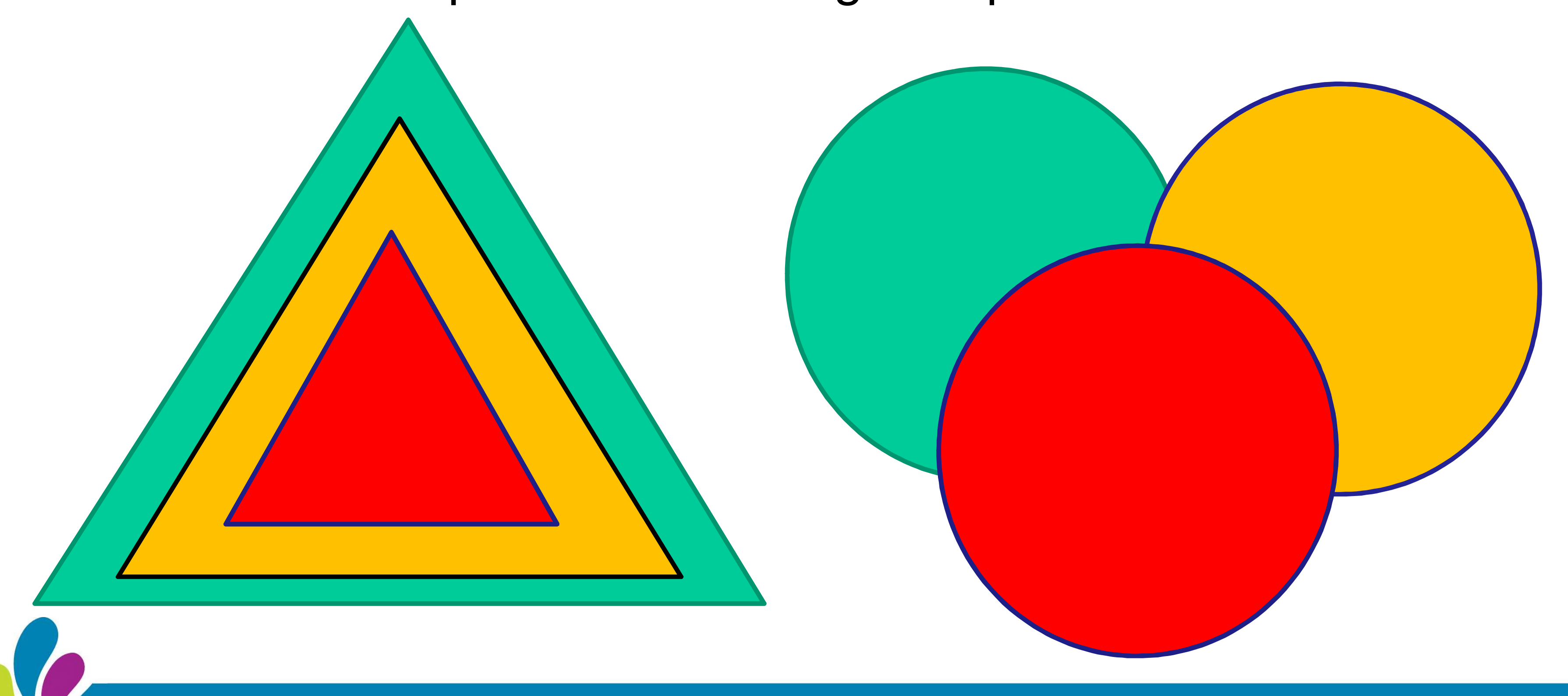
2. Three approaches: Individual + Organisational + Place based

PAS as part of the STP

The STP describes three programmes PAS, ICS & acute network.

In practice these will have important areas of commonality both of content and approach

As such that they might better be represented as below rather than discrete parts of one triangle as per STP document



The natural history of diabetes and CVD.

Risk factors…

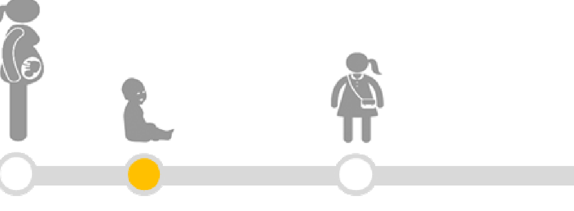
Maternal weight in pregnancy

Inactivity in childhood. High levels of sugar and fat in diet.

Excess weight in childhood then adults.

Development of other risk factors, e.g. smoking, alcohol etc.

If poor control: Complications including heart attacks, strokes, kidney failure etc.



Early death

Good antenatal care

Active transport. Access to open spaces

Early detection, e.g. Health Checks + follow up.

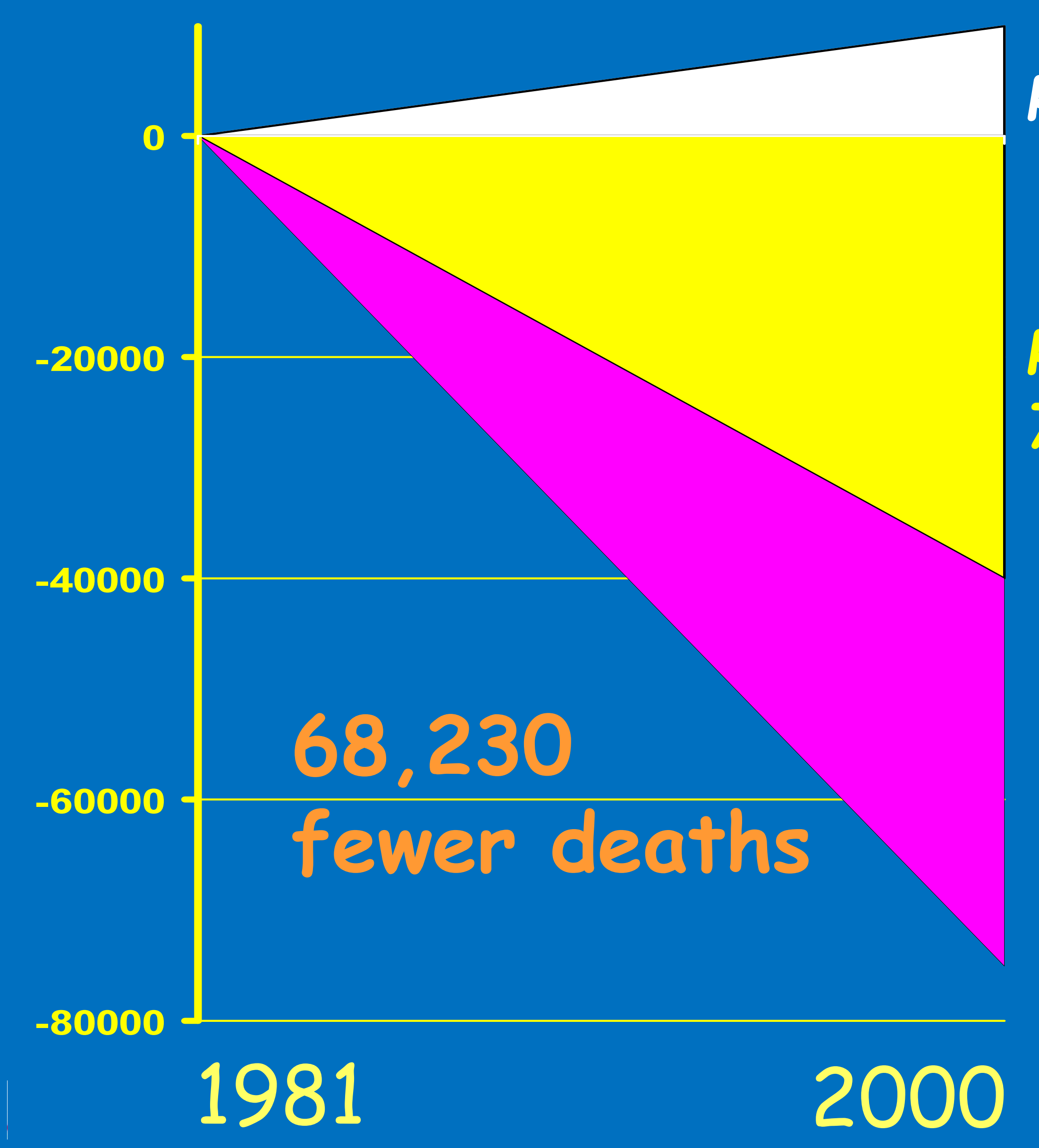
Management of diabetes / BP in health setting.

Rehab / social care.

Good life expectancy.

Protective factors…

Outcomes for CVD: How do we explain these changes? A UK perspective: 1981-2000



Risk Factors worse +13%

Obesity (increase) + 3.5%
Diabetes (increase) + 5 %
Physical activity (less) + 4.5%

Risk Factors better -71%

Smoking -41%
Cholesterol -9%
Population BP fall -9%
Deprivation -3%
Other factors -8%

Treatments -42%

Heart attack -8%
Secondary prevention -11%
Heart failure -12%
Angina:CABG & PTCA -4%
Angina: Aspirin etc -5%

Unal, Critchley & Capewell Circulation 2004 109(9) 1101-7

Local Changes: Early deaths from CVD since 2003
Changes in rates year on year

Difference in local rates compared to England

Bournemouth
Dorset
Poole

% diff from England

25
20
15
10
5
0
-5
-10
-15
-20
-25
-30
-35
-40
-45

England rate

11
-18
-17
-23
-33
-44

2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2014

Explaining local changes?

% in population

65
60
55
50
45
40
35
30
25
20
15
10
5
0

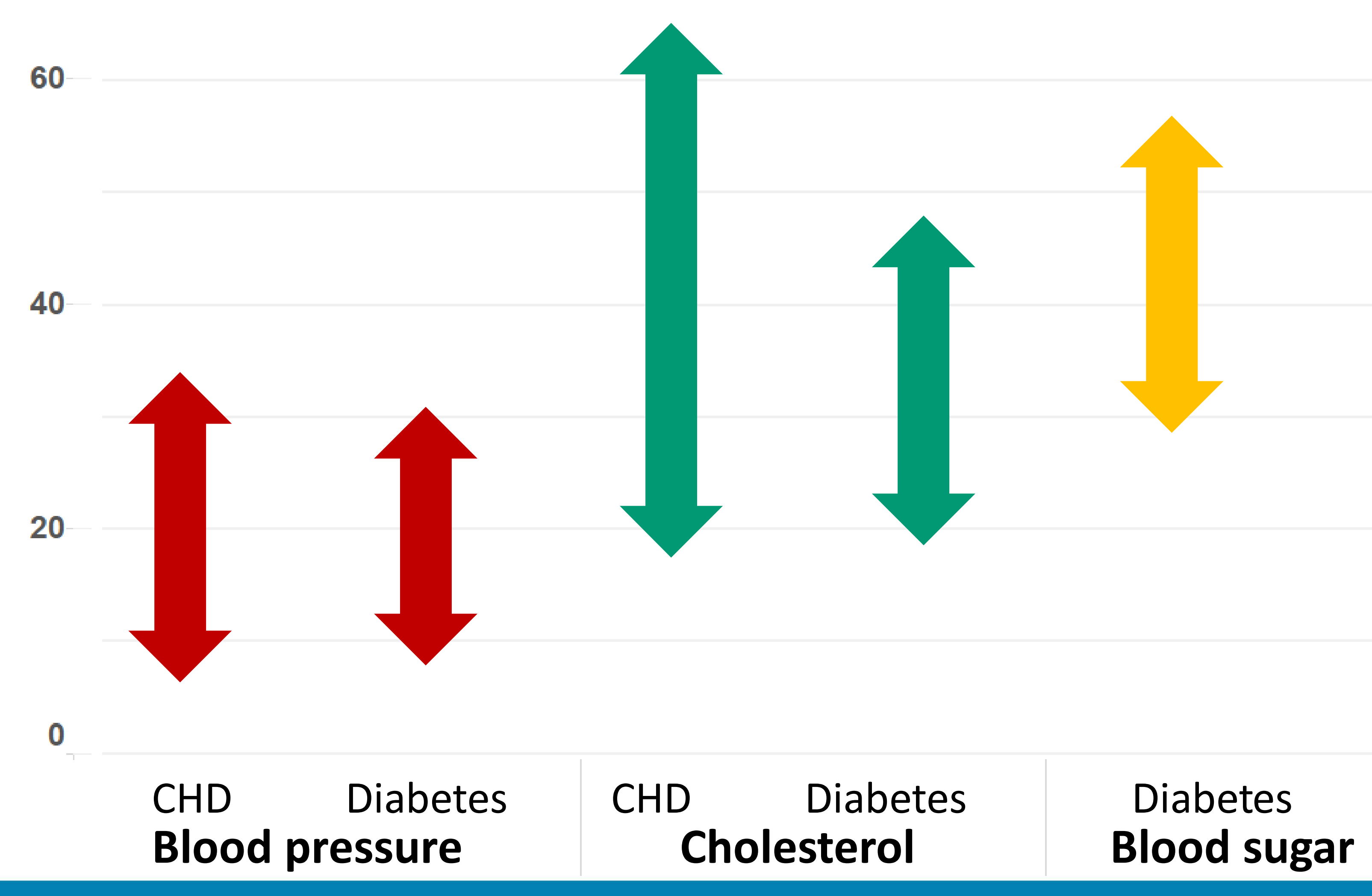
2006 2007 2008 2009 2010 2011 2012 2013 2014 2015

63
31
28
27
22
22
20
19
14
12

Excess weight (4-5 year olds)
Excess weight (10-11 year olds)
Excess weight (Adults)
Percentage inactive adults
Smoking at time of delivery
Smoking prevalence

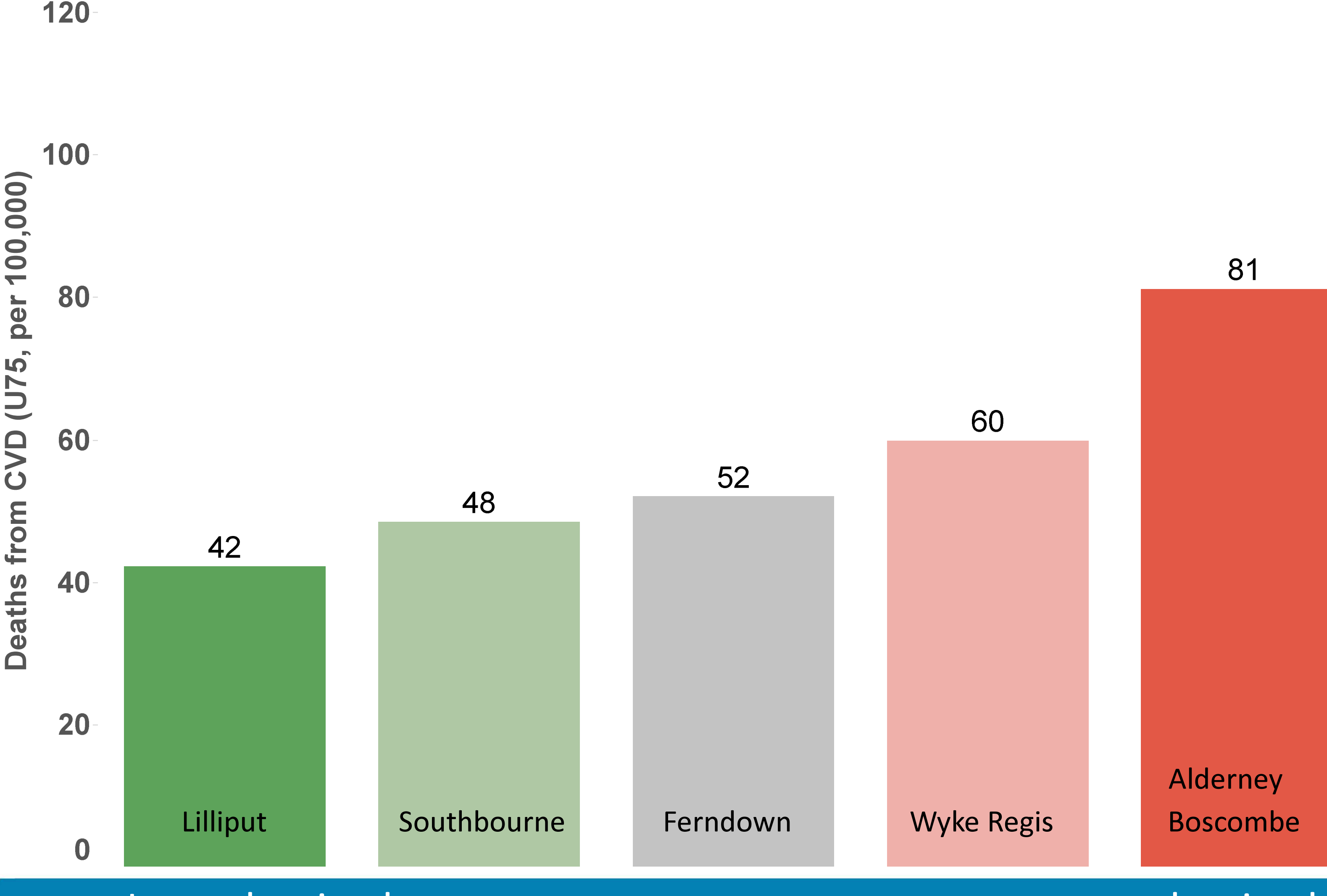
Explaining Local Changes?

2. Local differences in the management of people with risks



Explaining Local Changes?

3. Non individual factors – Poverty & Deprivation



Explaining Local Changes?

3. Non individual factors – Poverty & Deprivation II

Deaths from CVD (U75, per 100,000)

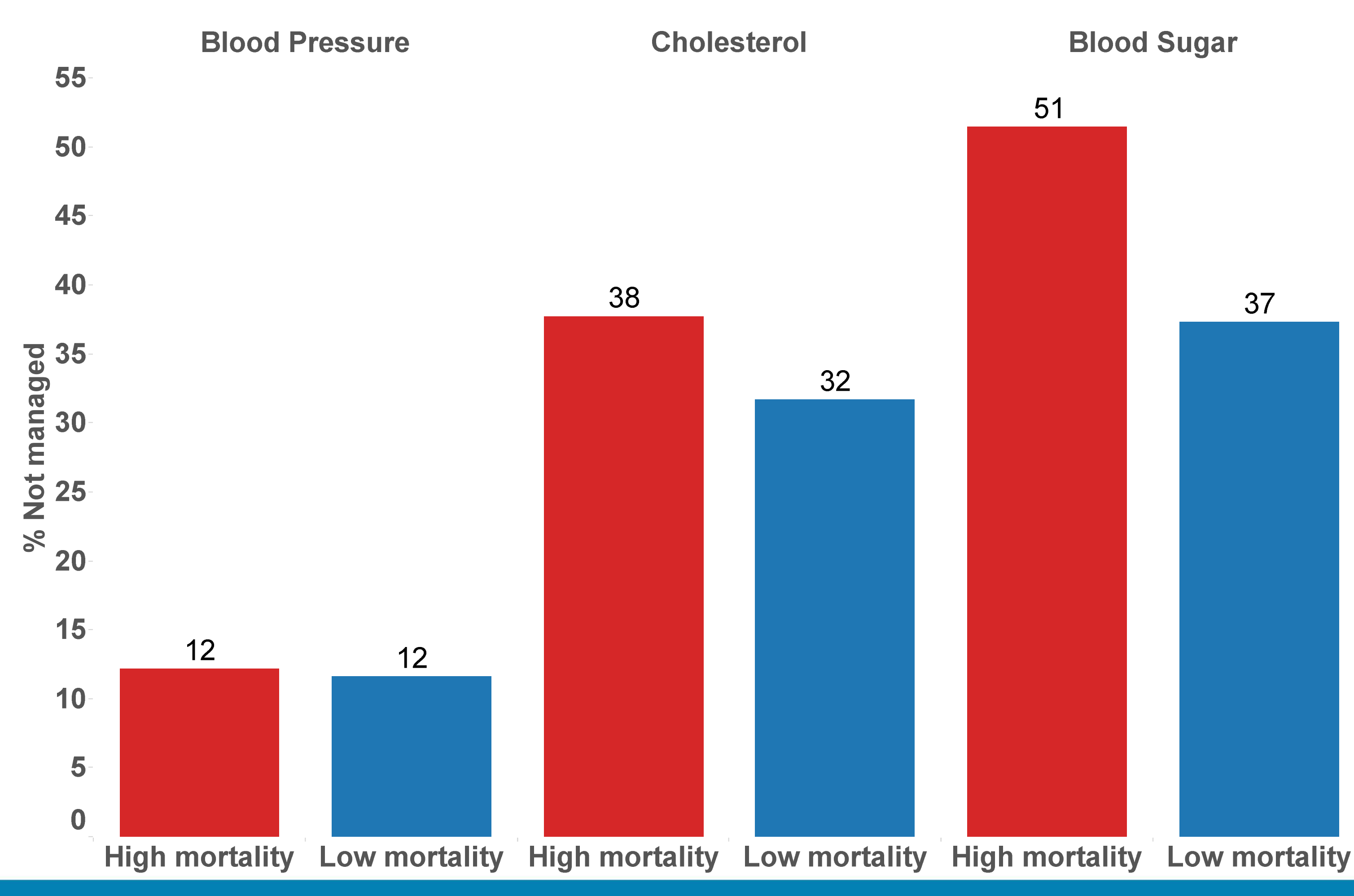
140
120
100
80
60
40
20
0

Boscombe Manor
Providence
Crescent
Shelley Manor
Herbert Avenue
Kinson Road
Carlisle House
Talbot
Holdenhurst Road
Durdells Avenue
Bridges
Abbotsbury Road
Rosemary
Royal Manor
Poole Road
Panton
Lanehouse

20
25
30
35

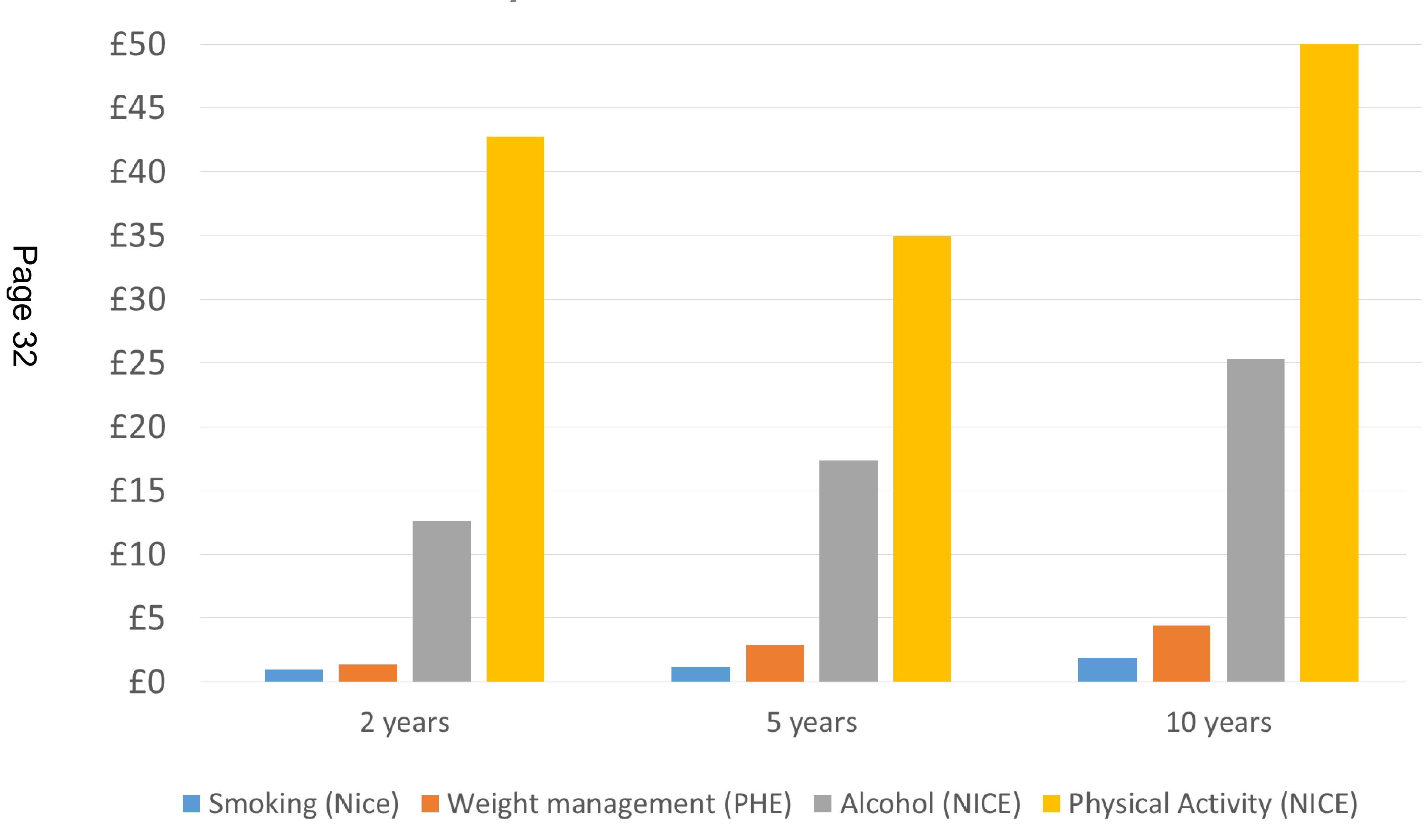
Deprivation score (high = more deprived)

Explaining Local Changes?
3. Non individual factors – Poverty & Deprivation III



Where should we focus?
1. Modifying Risks

£s returned for every £1 invested



Where should we focus?

2. Better managing existing conditions

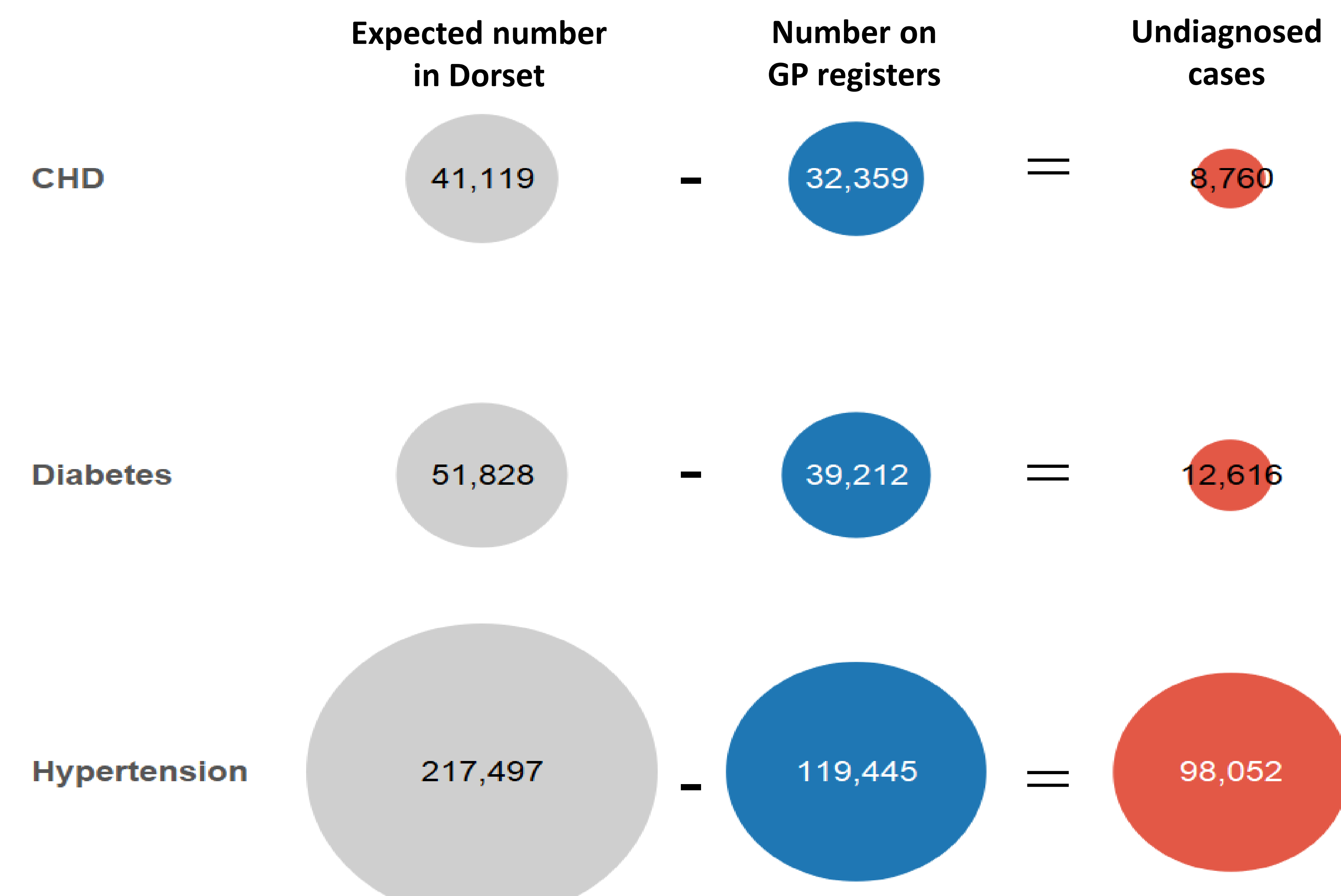
Better Blood pressure control in people with hypertension

In the next 5 years if every practice performed as top 25%

	Events avoided:	Costs saved: NHS	Costs saved: Social Care
Stroke	69	£755,200	£273,600
Heart attack	46	£401,400	
Heart failure	97	£133,700	
Deaths	37		

Total = £1.6m

Finally: Do we know what we don't know?



Summary

- The scale of the challenge is huge and given how common the risk factors for CVD are, how many remain undiagnosed, and how many new ones arise every day it makes no sense focussing on routinely finding new cases in the general population.

- In terms of return on investment for population risks the best choice is promoting physical activity & reducing overweight in the whole population.

- We need effective broad based efforts for weight reduction/physical activity e.g
  - *Individual*: social /community movements - park run/pokemon go,
  - *Place based:* regeneration and green space e.g Boscombe, Melcombe regis
  - *Organisation:* 50% of NHS/LA staff , 5KM walk, 50% of days of the week

- Intervening as early as possible is clearly best + a focus on times of important transition in life e.g. obesity, diabetes and smoking in pregnancy.

Summary - II

- Clinical practice: the clear winner is better managing high blood pressure – but, variations, wherever they are measured, are a 'failure' of the whole system and not just one part.

- We all need to take responsibility for shifting the curve, 10% for people with hypertension in whatever setting with will make a real difference. We also need to invest more where the problem begins not ends.

- We need such approaches to be central to any new models of care and partnerships – e.g. Accountable Care.

- We need to move beyond an organisational mindset of 'what's in it for me' to the system default position being 'of course we can' - beyond QoF points or PbR medals to sharing data in real time and making common consistent decisions on care.

- **The alternative is the perfect storm………**

Joint Public Health Board

Bournemouth, Poole and Dorset councils working together to improve and protect health

Date of Meeting	19 September 2016
Officer	Director of Public Health
Subject of Report	**Public Health Dorset business plan developments**
Executive Summary	This report presents an update on developments for Public Health Dorset's business plan 2016-18 in the past quarter. This includes updates on the priorities in each function, plus a summary of strategic leadership and advocacy activity to date.
Impact Assessment: *Please refer to the protocol for writing reports.*	Equalities Impact Assessment: N/A
	Use of Evidence: Public Health Dorset routinely uses a range of evidence to support the development of business plans and priorities as part of its core business.
	Budget: The report contains information about Public Health Dorset's progress against the stated intention to release further savings from the Public Health Grant over the next two financial years, particularly through major re-commissioning of drug and alcohol, children's 0-5 services and sexual health services. This is in line with our agreed commitment to release back to Local Authorities a minimum 5% over and above national reductions to the public health grant in 2016-2018 for reinvestment in local priority public health outcomes

	Risk Assessment: Having considered the risks associated with this decision using the County Council's approved risk management methodology, the level of risk has been identified as: Current Risk: MEDIUM Residual Risk MEDIUM *(i.e. reflecting the recommendations in this report and mitigating actions proposed)*
	Other Implications: N/A
Recommendations	1) Members of the Joint Public Health Board are asked to note the progress against the work plan priorities. 2) Board members are also asked to approve the recommended set of treatment target groups, which will underpin the ongoing work to develop future service model options for drug and alcohol services.
Reason for Recommendation	To ensure the continued viability and effectiveness of Public Health Dorset in supporting the legal duty of local authorities in Dorset to improve the health and wellbeing of residents and reduce inequalities in health.
Appendices	Annex A – Service review summary for drug and alcohol services
Background Papers	None.
Report Originator and Contact	Name: Sam Crowe Tel: 01305-225884 Email: s.crowe@dorsetcc.gov.uk

Director's name: Dr David Phillips
Director of Public Health
September 2016

1. Recommendations

1.1 Members of the Joint Public Health Board are asked to note the progress against the business plan 2016-18, particularly the ambitions for releasing further savings from the public health functions through re-commissioning.

1.2 For drug and alcohol services, the Joint Public Health Board is asked to consider and agree the recommended set of treatment target groups which will underpin the ongoing work to develop future service model options.

2. Reason

2.1 To ensure the continued viability and effectiveness of Public Health Dorset in supporting the legal duty of local authorities in Dorset to improve the health and wellbeing of residents and reduce inequalities in health. To identify and release further savings to be re-invested by Local Authorities in Dorset in priority outcomes including early intervention and health protection.

3. Background

3.1 The Public Health Dorset business plan for 2016-18 set out three main objectives, which were agreed at the last Joint Public Health Board in June 2016. These were:

- Moving from topic-based public health programmes to a more flexible set of broader functions;
- Setting an ambitious target to deliver further efficiencies and savings over and above national grant reductions;
- Releasing senior capacity to focus on systems leadership and advocacy, in support of developing plans to deliver prevention at scale, and supporting local public sector reform.

3.2 This report sets out progress in the past quarter against the objectives in the business plan.

4. Clinical Treatment Services

4.1 Public Health Dorset has been working with commissioning colleagues in Bournemouth Borough Council, Dorset County Council and Borough of Poole to develop service model options for **drug and alcohol services** that are sustainable in the context of the reducing public health allocations to local authorities. Initial discussions about options were held with executive directors at the Joint Commissioning Board in early September. The aim is to identify a preferred option for recommendation to the Joint Public Health Board in November 2016.

4.2 This options work builds on the findings of a service review completed in the early part of 2016 – the key findings of which are outlined in Annex A.

4.3 Following the review, the commissioners propose a new approach to service delivery, focusing on a set of agreed treatment target groups. This targeted approach to delivery with a focus on prevention and effectiveness should ensure future services are more sustainable given the forthcoming grant reductions.

4.4 In recent years the success of the drug and alcohol treatment system has often been assessed through a narrow focus on successful completion rates. Essentially, for both opiate use and alcohol dependency this is about users achieving abstinence.

4.5 The challenge with using such a narrow focus in terms of outcomes is that for a large proportion of opiate users this may be unachievable. Depending on a user's level of complexity, successful completion rates range from about 50% per annum for the least complex users to 5-6% for the most complex. Overall, completion rates for opiate service users at a pan-Dorset level are less than 10%. Therefore growing numbers of service users are in treatment for prolonged periods without ever achieving a successful completion. One-third of service users have now been in treatment for more than six years, without achieving abstinence.

4.6 As new service models are developed to support re-commissioning plans for 2017/18 and beyond, the development of a targeted approach to service provision will ensure that the greatest value is achieved through the investment in services. From a local authority perspective, there are population groups where it would make sense to focus care and support to deliver the broader social and health outcomes even where abstinence is not an achievable short-term goal, recognising the complexity of the needs of individuals and their families where substance misuse is a contributory factor.

4.7 The table below proposes treatment target groups, together with the rationale for their choice. This approach has now been agreed with the Pan-Dorset Drug and Alcohol Governance Board.

Prevention / Treatment Target Groups	Rationale
• Young people	Fit with the broader early intervention agenda; ability to prevent more serious substance misuse and associated consequences
• Young adults	More likely to achieve successful completion when treatment naive;
• Parents and families	Costs of parental substance misuse both on children, and on social care costs;
• Pregnant women	Protection of the unborn child
• Risk of adult or children safeguarding issues	Statutory responsibility for LA, with associated costs

4.8 At the same time there are a number of system priorities, many of which are not new, which are highly relevant in the context of substance misuse, where a co-ordinated approach across health and social care could reduce costs and improve outcomes including:

- Concurrent mental health issues (dual diagnosis)
- Frequent users of health services (frequent flyers)
- Increasing numbers of alcohol related deaths
- Homelessness/vulnerable housing status
- Maintaining employment and returning to employment

4.9 The Dorset Sustainability and Transformation Plan (STP) identified alcohol as one of the priorities within the Prevention at Scale agenda and promises a 'comprehensive co-ordinated approach to reduce alcohol's harm'. This gives an opportunity to build on the approach already outlined through the Bournemouth, Dorset and Poole Drug and Alcohol Strategy to develop a consistent response to the system pressures associated with substance misuse.

4.10 . For 2016/17 Public Health Dorset has updated and migrated all contracts to a Local Authority managed contractual agreement with associated terms and conditions from January 2016. The contract for April 2016/17 was 6% less than the previous and set up as a block payment contract, which has reduced the financial risk for both commissioner and provider and has encouraged providers to work collaboratively to manage activity more effectively.

4.11 Since the last Board report in June, there have been developments with both the clinical services review (CSR) and changes to commissioning responsibilities between NHS England and the Dorset Clinical Commissioning Group. These changes provide new opportunities to simplify the current complex commissioning landscape, which are set out below.

4.12 Under national guidance, sexual health commissioning responsibility was previously split between local authority public health, NHS England and the Dorset CCG. This has made it difficult to commission a whole system approach to sexual health, stifling the potential for service transformation. It has since been agreed that specialist commissioning including HIV services will move from NHS England back to Clinical Commissioning Groups in April 2018. This means that the CCG will manage HIV commissioning budgets, which are already integrated within GUM sexual health services currently commissioned by local authority public health teams, and so bring clearer opportunities for co-ordination.

4.13 Because it is predominantly a clinical treatment service provided by NHS Foundation Trusts, sexual health commissioning fits better with commissioning responsibilities of CCGs than local authorities. The changes in Dorset anticipated in acute and community services under the Sustainability and Transformation are likely to provide opportunities to change the way we commission and deliver sexual health services.

4.14 Public Health Dorset and Dorset Clinical Commissioning Group are therefore keen to work to develop collaborative commissioning opportunities to achieve the required service transformation and become more sustainable and affordable over the longer term. The current providers have stated that they are willing to consider integrating acute and community services, under a single commissioning process and within the existing financial envelope. Pending final agreement with the CCG, the proposal is to implement the new commissioning arrangements from early 2017.

5. Health Improvement function

5.1 **Health visiting and school nursing commissioning** projects have been working to develop new models that will see delivery of the services as part of the wider set of services for children and young people. This will help to ensure commissioning decisions can be aligned with local authorities , supporting the move to delivering a more comprehensive approach to prevention by the overall health and care system in Dorset, in line with the Sustainability and Transformation Plans.

5.2 Public Health Dorset is working with partners to develop options for joint investment across the services to support decision making about levels of investment once the Public Health grant ring fence is removed in 2018. This includes joint models of delivery and investment across health visiting and children’s centre services. In Dorset, this forms part of the Forward together for Children Programme (work is co-sponsored by Patrick Myers). In Bournemouth and Poole this aligns with wider children’s services commissioning discussions (co-sponsored by Carole Aspden and Vicky Wales). This work also sits within the scope of Poole’s Member-led review of early intervention services.

5.3 Interest in aligning **health visiting** delivery with other services for 0-5 year olds and their families has a long history, preceding the transfer of health visiting commissioning to local authorities in October 2015. Since the transition of commissioning in October 2015, the multi-agency 0-5 Public Health Commissioning Group and the pan-Dorset Joint Commissioning Group has supported improvements in joint provision for 0-5 year olds in a number of areas. These priorities were informed by the evidence base supporting effective integration of provision and include culture and practice, information sharing and leadership for change. Health visiting teams are currently being aligned with children's centre/Family Partnership Zone teams to enable joint models and commissioning.

5.4 Since the transition of **school nursing** commissioning in April 2013, a multi-agency group has overseen a school nurse review and a service improvement plan has been developed to improve practice. School nursing is leading implementation of several emotional health and wellbeing projects linked to the CAMHS transformation plan and pan-Dorset emotional health and wellbeing strategy.

5.5 For 0-5 year olds, considering the investment in health visiting alongside investment in children's centres offers greater opportunity to improve effectiveness and efficiency. Commissioning options are being developed for consideration by the Forward Together for Children Board, Bournemouth Early Help Board and Poole Children's Trust Board. This is also being explored for 5-19 school nursing. We would like to bring an update to the next Joint Public Health Board for discussion.

5.6 Public Health Dorset re-commissioned the core **NHS Health Checks programme** from 1 April, 2016 across 13 localities spanning Bournemouth, Dorset and Poole. 'Core' Health Checks are those that have been prompted by an invitation. GP Federations were awarded contracts to deliver core Health Checks across 6 of the localities and in these areas the GP Practices have continued to send out invitations to their patients. In the remaining 7 localities, Boots were awarded contracts to deliver the service. Despite lengthy discussions with GP groups in the areas where there is a Boots contract, GPs decided to withdraw from arrangements whereby they sent out letters to their eligible patients inviting them for a Health Check. Disappointingly, this has caused a hiatus in the delivery of Health Checks in these areas.

5.7 Replicating an equivalent 'call and recall' invitation system is not possible without access to GP-held patent records, but the public health team have worked with Boots to develop an alternative centralised method of inviting people for an NHS Health Checks using a postcard invitation.

5.8 The next phase is to develop named invitation letters. Public Health Dorset are working with information governance and legal colleagues across the 3 councils to use council tax register information, from April 2017.

5.9 The public health team will be monitoring the effectiveness of these new arrangements closely, and evaluating the impact of the new arrangements alongside the more established methods being maintained in the areas where GP Federations are inviting patients and delivering the service. Plans for the first tranche of new invitations have now been put in place, with the Royal Mail delivery service aiming to distribute invitations in the relevant communities by the end of September 2016.

5.10 Planning is also underway for the commissioning of **NHS Health Checks that target groups and communities** where there is higher risk cardiovascular disease. Where the risks are greatest, there is often a lower uptake of universal services. The targeted checks will mean that those people who could stand to benefit the most, receive an NHS Health Check. The tendering process will run from early December 2016, with a start date of 1st April, 2017. Funding of the service will be from within the existing

budget for health checks, the intention being to shift more resource from universal to targeted Health Checks over time.

6. Health Protection

6.1 The transition of Public Health Dorset to PHE South West for health protection services has been smooth, with no known operational issues. PHE staff are due to be co-located within the Public Health Dorset offices to ensure best possible communication and joint working. The target date for this is autumn 2016

6.2 The biggest ongoing health protection issue for the South West PHE Centre is an outbreak of measles, with more than 80 confirmed cases identified since May 2016. Most of these cases have occurred in Devon, but there have been 6 confirmed cases in Dorset, including cases linked with festivals such as Camp Bestival. The age group most likely to be affected is young people aged 15-19, and most confirmed cases have been unvaccinated. Public Health England has been working with the Dorset CCG to alert primary care and the acute trusts to be vigilant and consider measles as a possible presenting diagnosis.

7. Systems leadership

7.1 Work during the past quarter has focused on developing plans to deliver the prevention at scale element of the Sustainability and Transformation Plan for Dorset. Initial presentations on the three priority themes, cardiovascular disease, mental health and musculoskeletal disease, and alcohol, have been well received at the Primary Care Committee of Dorset CCG and the Dorset System Leadership Team.

7.2 Agreement has also been reached with both Health and Wellbeing Boards to host a workshop in the autumn designed to identify and agree actions that organisations can sign up to within the prevention at scale plans across Dorset.

7.3 The approach to prevention at scale has also been used as the subject of this year's Annual Director of Public Health report, which is due to go to the Health and Wellbeing Board this autumn.

8. Conclusion

8.1. This paper summarises progress in the past quarter against the main objectives of the Public Health Dorset business plan. For the major commissioning projects, actions are well underway to ensure the transformation of services, in many cases through aligned commissioning and a move to a more whole systems approach. This supports the direction of travel with the Sustainability and Transformation Plan for Dorset.

Annex A: Service review findings, drug and alcohol services

Service Review

The review assessed current need, the evidence of effectiveness of interventions, service performance, the views of service users and service providers, and comparative work looking at commissioning models nationally. Key findings are:

Service use and performance

Young people and young adults	• Between 2007 and 2016 20–45% of young people engaged in services before 18 came back into adult services with opiate use cited • 18-24 year olds with opiate issues appear to be under-represented in adult services, and 20% of those who subsequently present in the 25-34 age group are highly complex
Alcohol service users	• 85-90% are over 35 with 25% over 55, and less than 30% are in regular employment • 25-35% of females are living with children, compared to 10-20% of males • Most do not stay in treatment for longer than a year, though those in Dorset are likely to be engaged for a longer period • Completion rates are relatively high in all areas and compare satisfactorily with the national average of 39.2% for 2015-16
Non-opiate service users	• Numbers are much lower, and they are more likely to be living with children (35% of both males and females) • Completion rates are strong, comparable to national averages and most do not remain in treatment for longer than a year
Opiate service users	• 70% are aged between 35 and 55, and 10-25% are in regular employment • 30-40% of females are living with children, compared to 5-15% of males • 25-30% have been in treatment for more than 6 years, and this proportion is growing year on year – nearly 40% of this group remain highly complex • Completion rates are comparable to national average, but are less than 10% per year
Service wide	• Most service users do not have a housing problem, though there are particular individuals (most commonly in Bournemouth) facing particular challenges in relation to accommodation

Effectiveness of interventions

- There is clear evidence that accessible, appropriate needle exchange and substitute prescribing reduce risky injecting behaviour and blood borne virus transmission
- Although evidence regarding the effectiveness of talking therapies (or 'psychosocial interventions') is less clear than in relation to prescribing and needle exchange, there is some evidence to support the use of motivational interviewing
- Although the evidence is currently less strong, there is an emerging range of interventions that look at addressing substance misuse within a family setting

- People who are not in employment are less likely to complete treatment successfully[1]
- People who are not in stable accommodation are less likely to complete treatment successfully[2]

Views of service users and providers

(a) Service User feedback:

- Why are services not 'in one place'? The dentist 'analogy – injection, filling and seeing the hygienist all at different locations' and why are they so many different services?
- Service users not clear on when / or how their treatment would progress – and clients were unaware of how the process would conclude.
- Whole treatment procedure too complex

(b) Provider feedback

- Bournemouth & Poole services did not want to lose local 'connection'
- Dorset: Too many providers remote from each other – pathways overly complicated
- Dorset: Hub concept seemed universally popular – all elements of treatment in one location
- Technology needs to be incorporated into everyday business
- Can we provide clarity and purpose of treatment for those in long term treatment vs those with recovery as a realistic goal

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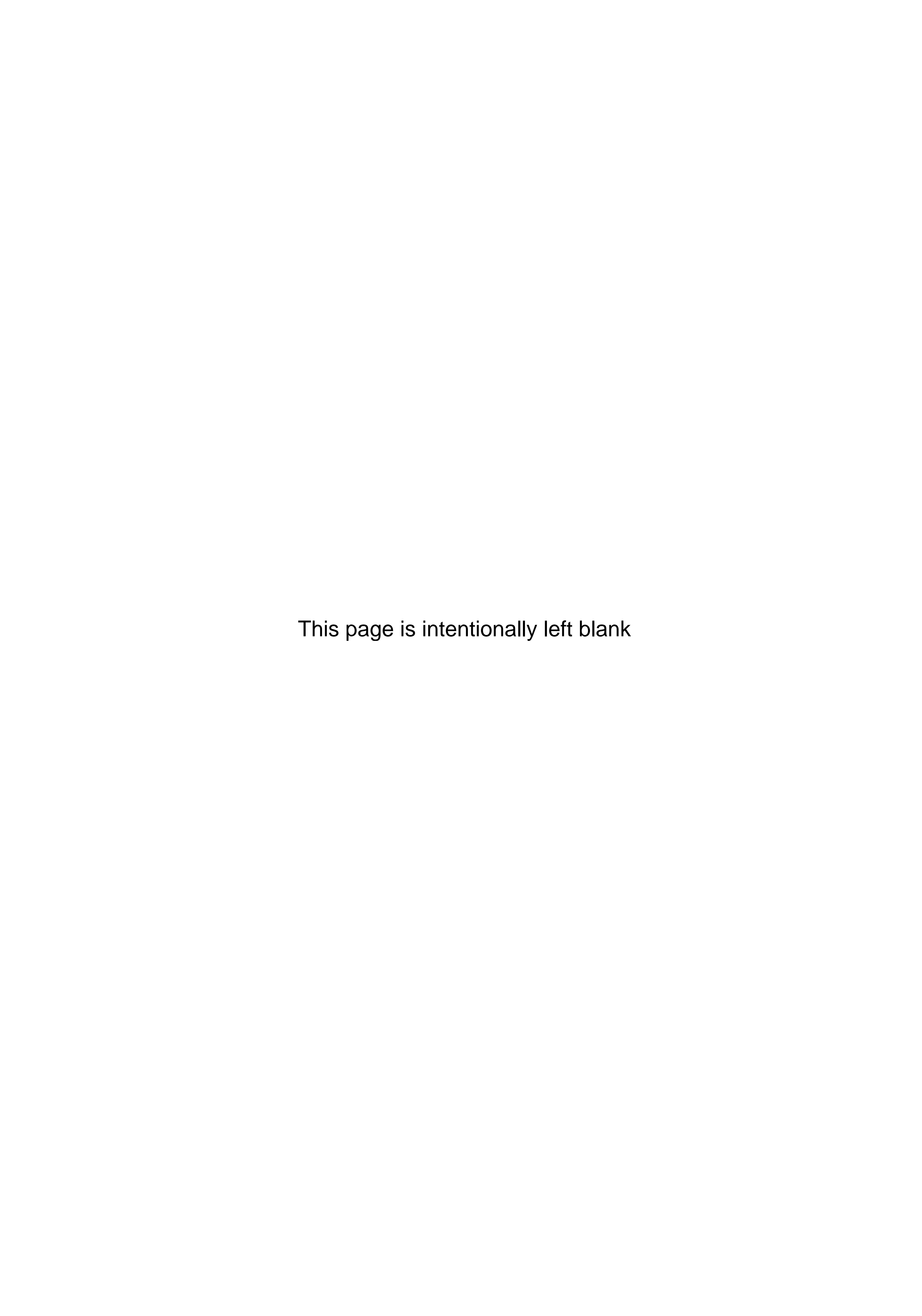
[1] E.g. in Dorset in 2012 57% of all drug users in treatment were on benefits, but accounted for only 48% of successful completions (Source: PHE (2015) *Drug data: JSNA support pack: Key data to support planning for effective drugs prevention, treatment and recovery in 2016-17*). More recent locally-derived data suggests that across Bournemouth, Poole and Dorset, more than half of those completing an episode of treatment who were in employment left free of misuse, compared to around a third of those not in employment.

[2] Locally-derived data consistently show lower completion rates for those reporting a housing problem compared to those in stable accommodation.



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Joint Public Health Board

Bournemouth, Poole and Dorset councils working together to improve and protect health

Date of Meeting	19 September 2016
Officer	Chief Financial Officer and Director of Public Health
Subject of Report	**Financial Report to end July 2016/17**
Executive Summary	The revenue budget for Public Health Dorset in 2016/17 is £29.378M. This is based upon a Grant Allocation of £35.154M. There is an update on the forecast for 2016/17. The budget has now stabilised and through more active and systematic approaches to managing activity it is planned to make approximately £1.2m saving in 2016/17 and 2017/18. Furthermore, it is suggested that these are returned to the respective authorities and, as per the agreement at the November 2014 and February 2015 boards, divided between early intervention (children) and health protection. In addition, there is now have a fairly firm grip on finances (subject to no further major central government action) and as such it is suggested that the current reserve of £2.3m is moved into an STP/Prevention at Scale (PAS) account. This will enable Public Health Dorset to fund system wide PAS work under our three themes in the STP, through collective action and appropriate system governance. This would demonstrate a commitment to collective action through PAS while minimising the risk of losing control of this asset.
Impact Assessment:	Equalities Impact Assessment: An equality impact assessment is carried out each year on the medium term financial strategy.

<table>
<tr><td rowspan="3"></td><td>Use of Evidence: This report has been compiled from the budget monitoring information provided within the Corporate Performance Monitoring Information (CPMI).</td></tr>
<tr><td>Risk Assessment:

Having considered the risks associated with this decision using the County Council's approved risk management methodology, the level of risk has been identified as:

Current Risk: MEDIUM
Residual Risk LOW

As all authorities financial performance continues to be monitored against a backdrop of reducing funding and continuing austerity. Failure to manage within the current year's budget not only impacts on reserves and general balances of the three local authorities but also has knock-on effects for the Medium Term Financial Plan and puts future service provision at risk.</td></tr>
<tr><td>Other Implications: As noted in the report</td></tr>
<tr><td>Recommendation</td><td>The Joint Board is asked to consider the information in this report and to:

(i) note the current budget position;
(ii) agree to return in year savings of approximate £1.2m per annum for 2016/17 & 2017/18 to the respective authorities as per the agreement at the November 2014 and February 2015 boards divided between early intervention (children) and health protection; and
(iii) agree to move all the current reserve of £2.3m into an STP/PAS account to enable Public Health Dorset to fund system wide PAS work under our three themes in the STP, through collective action with appropriate system governance.</td></tr>
<tr><td>Reason for Recommendation</td><td>Close monitoring of the budget position is an essential requirement to ensure that money and resources are used efficiently and effectively.</td></tr>
<tr><td>Appendices</td><td>Appendix 1 – Public Health Grant & Budget 2016/17</td></tr>
<tr><td>Background Papers</td><td>CPMI – July 2016/17 and Public Health Agreement</td></tr>
<tr><td>Report Originator and Contact</td><td>Name: Steve Hedges, Group Finance Manager
Tel: 01305-221777
Email: s.hedges@dorsetcc.gov.uk</td></tr>
</table>

1. Background

1.1 The nationally mandated goals of public health in local authorities are to:

- Improve the health and wellbeing of local populations;
- Carry out health protection and health improvement functions delegated from the Secretary of State;
- Reduce health inequalities across the life course, including within hard to reach groups;
- Ensure the provision of population healthcare advice.

1.2 The agreed aims which underpin the work of Public Health Dorset are to:

- Address Inequalities;
- Deliver mandatory and core Public Health programmes in an equitable, effective and efficient manner;
- Improve local and national priority public health outcomes as defined by the Health and Wellbeing strategy and national Public Health Outcomes Framework;
- Transform existing programmes and approaches to population health to include better coordination of action across and within all public service agencies.

1.3 The agreed principles underpinning our commissioning to deliver the above aims are improving effectiveness, efficiency and equity. This has been reflected in our on-going re-procurement and overall work-plan to date.

1.4 At the last board meeting in June 2016 we were still understanding the impact of the substantial five year cuts, amounting to 20%, published in late 2015 and as such we agreed to transfer the underspend into the Public Health reserve and hold the balance to mitigate the effect of the central reductions in grant allocation.

1.5 Previous budget savings had also been transferred into a reserve account as the majority of the contracts inherited in 2013 (from the NHS) were of a cost and volume basis and had a lot of inherent volatility. Over the last year we have transformed the majority of these contracts to block contracts and similarly transformed the remaining cost and volume contracts to be managed through a dynamic purchasing system.

1.6 Looking ahead with the removal of the ring fence in April 2018 and the continuing pressures on the NHS budget it is highly likely that there will be a further top slicing of the Public Health budget, especially if we cannot demonstrate that savings are going into supporting collective prevention work with the NHS under the STP. Many STPs are being asked to use the Public Health budget to deliver activity that gives cashable savings to the NHS – we have so far had a more ‘mature’ discussion locally.

2. Public Health Grant; 2015/16 Outturn & 2016/17 Budget

2.1 The Public Health Budget is currently forecast to be underspent by £1.582m at the end of 2016/17. This details are in the table below:

	Budget 2016-2017 £000's	Outturn 2016-2017 £000's	Underspend/ (overspend) 2016/17 £000's
Public Health Function			
Clinical Treatment Services	11,464,100	11,100,601	363,499
Early Intervention 0-19	11,575,500	11,293,190	282,310
Health Improvement	2,984,700	2,449,354	535,346
Health Protection	145,000	54,000	91,000
Public Health Intelligence	244,800	292,672	(47,872)
Resilience and Inequalities	175,000	5,000	170,000
Public Health Team	2,786,300	2,598,286	188,014
Total	**29,375,400**	**27,793,103**	**1,582,297**

2.2 We have now stabilised the budget post the revised five year public health budget and through more active and systematic approaches to managing activity we plan to make approximately an average of £1.2m savings in both 2016/17 and 2017/18. It is suggested that these savings are returned to the respective authorities as per the agreement at the November 2014 and February 2015 boards divided between early intervention (children) and health protection.

2.3 It is also proposed to not transfer to the three authorities the continuing reductions in the retained and rebated monies which equate to a further savings in 16/17 of £540,000 in addition to the rebate from the operating budget of £1.29m. This will equate to a return from the operating budget of approx. £3.03m in 16/17 and 17/18 or 11% of the operating budget per annum in addition to the retained and rebated budgets.

2.4 The budget assumptions and the sums to be borne by each partner under cost-sharing arrangements are set out in an appendix 1.

3. Reserves

3.1 The table below shows the updated reserve position.

Public Health Reserve	£000's
Public Health Underspend 2013/14	1,447
DAAT Underspend 2013/14 one off (DCC)	111
PTB Underspend 2013/14 one off (DCC)	177
Use of 2013/14 underspend Poole	(287)
Use of 2013/14 underspend Bournemouth	(356)
Use of 2013/14 underspend Dorset	(700)
Public Health Underspend 2014/15	1,381
PTB Underspend 2014/15 one off (DCC)	20
Public Health Underspend 2015/16	564
Total	**2,357**

3.2 We now have a fairly firm grip on finances (subject to no further major central government action) and as such it is suggested that we move all the current reserve of £2.3m into an STP/PAS account. This will enable us to fund system wide PAS work under our three themes in the STP, through collective action under PAS while minimising the risk of losing this budget element.

4. Conclusion

4.1 Public Health Dorset recognising the budget challenges both to the central public health grant and the wider local authority budgets has worked to ensure further significant savings. As a consequence in 2016/17 and beyond grant reductions should be manageable without compromising existing local authority commitments.

4.2 It should be highlighted there are very real risks in this, as the NHS front line services are affected. This can only be justified if we can demonstrate a) our collective commitment to the STP and PAS and b) a coherent plan for reinvesting savings as per our agreed principles

4.3 We will also as previously agreed continue to get as much harmonisation of public health budgets where appropriate with those of the three authorities, while recognising the changing shape of local government in the wider Dorset and need to retain flexibility

4.4 It should also be recognised that collectively we remain amongst the bottom 10% of funding per head of population of all local authorities. These further savings reflect our absolute delivery of value for money.

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Richard Bates
Chief Financial Officer

Dr David Phillips
Director of Public Health

September 2016

APPENDIX 1

Public Health Grant And Budget – 2016/17

	Poole £000's	Bmth £000's	Dorset £000's	Total £000's
2016/17 Grant Allocation	7,991	11,051	16,112	35,154
Less Commissioning Costs	(30)	(30)	(30)	(90)
Less Pooled Treatment Budget and DAAT Team costs	(1,300)	(2,925)	(170)	(4,395)
Public Health Increase back to Councils	(299)	(371)	(621)	(1,291)
Joint Service Budget Partner Contributions	**6,362**	**7,725**	**15,291**	**29,378**
Budget 2016/17	**6,362**	**7,725**	**15,291**	**29,378**