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.
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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

[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.