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Agenda

Meeting: Joint Public Health Board

Time: 10.00 am

Date: 4 June 2018

Venue: Royal Hampshire Room, Town Hall, St Stephens Road, Bournemouth BH2 6DY

Bournemouth Borough Council	**Dorset County Council**	**Borough of Poole**
Nicola Greene Jane Kelly	Steve Butler Jill Haynes	John Challinor Karen Rampton
Reserve Members Blair Crawford	Deborah Croney Rebecca Knox	Mike White

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 30 May 2018, and statements by midday the day before the meeting.

Debbie Ward
Chief Executive
Date of Publication:
Thursday, 24 May 2018

Contact: Helen Whitby, Senior Democratic Services Officer
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Bournemouth, Poole and Dorset councils working together to improve and protect health

1. **Chairman**

To elect a Chairman for the meeting. (It was agreed previously 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. **Role and Terms of Reference** 5 - 6

To note the Board's Role and Terms of Reference.

5. **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.

6. **Minutes** 7 - 10

To confirm the minutes of the meeting held on 5 February 2018.

7. **Public Participation**

(a) Public speaking
(b) Petitions

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

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

9. **Future Commissioning of Public Health Nursing (Health Visiting and School Nursing)** 15 - 22

To consider a report by the Acting Director of Public Health.

10.	**Contract and Commissioning Report Update**	23 - 28

To consider a report by the Acting Director of Public Health.

11.	**Financial Report**	29 - 34

To consider a joint report by the Chief Financial Officer, Dorset County Council, and the Acting Director of Public Health.

12.	**Prevention at Scale**	35 - 44

To consider a report by the Acting Director of Public Health.

13.	**Public Health Dorset Business Plan for 2018/19**	45 - 60

To consider a report by the Acting Director of Public Health.

14.	**Options for Public Health Dorset - Task & Finish Group**	61 - 68

To consider a report by the Acting Director of Public Health.

15.	**Director of Public Health Report**	69 - 84

To receive the Annual Report of the Director of Public Health 2017.

16. **Questions from Councillors**

To answer any questions received in writing by the Chief Executive by not later than 10.00am on 30 May 2016.

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Role and Terms of Reference of the Joint Public Health Board

1. Role

The Joint Public Health Board (the Board) is a joint executive body and will be responsible for public health functions of an executive nature of Bournemouth Borough Council, Dorset County Council and the Borough of Poole for so long as the three councils are working in partnership.

2. Membership

The Board will consist of two voting members drawn from the executives of each of the three partner councils (a total of six members). Each council may at any time appoint replacement members to serve on the Board provided that any such member must be a member of that authority's executive. Notice of any change should be provided to the Democratic Services Manager of the County Council as host authority for the Partnership.

Each authority may also nominate one non executive member to attend the Board as a non voting member.

3. Chairmanship

The Chairman shall be elected annually from amongst the six executive members by a majority vote. In the event of an equality of votes lots shall be drawn to determine the chairmanship.

4. Quorum

The quorum for meetings of the Board shall be one voting member from each of the three councils.

5. Frequency of meetings

The Board shall meet as a minimum four times a year, usually in July, November, February and May and subject to room availability the venue for meetings will rotate meeting by meeting around the offices of the three partners.

Additional meetings of the Board shall take place as determined by the Board in order to fulfil its work programme.

Further meetings shall be convened if requested by any two members of the Board.

6. Officers

The lead officer for the Board shall be the Director for Public Health and he shall recommend to the Board a proposed scheme of delegation to officers.

As host authority the County Council will convene meetings of the Board and will provide administrative, financial and legal advice.

7. Standing Orders

The business of the Board shall be regulated by the standing orders and procedure rules of the County Council as host authority except to the extent that they are superseded by the Shared Service Agreement between the three partner councils.

8. Terms of Reference

I. Discharge of the public health functions of the three councils under the Health and Social Care Act 2012 and setting of direction and policy in respect of public health.
II. Approve and monitor delivery of Public health Business Plan.
III. Receive and respond to reports from the subgroups of the Board.
IV. Monitor progress and performance in delivery of mandatory public health programmes across and within the three local authorities.
V. Monitor progress and performance against local and national indicators and outcome measures.
VI. Acting within the requirements of the Code of Practice in Local Government Publicity to seek to influence and advise, local and central government and other agencies on public health issues.
VII. Ensure that NHS and other local authority partners remain informed of developing public health issues, locally, nationally and internationally.
VIII. Support the host authority and the Director in the performance of their functions.
IX. To receive and approve the annual budget and monitor budget spend.

Public Health Dorset

Joint Public Health Board

Minutes of the meeting held at County Hall, Colliton Park, Dorchester, Dorset, DT1 1XJ on Monday, 5 February 2018

Present:
Councillor Jill Hayes (Dorset County Council) (Chairman)
Councillor John Challinor (Borough of Poole) (Vice-Chairman)
Councillor Karen Rampton (Borough of Poole)
Councillors Jane Kelly and Nicola Greene (Bournemouth Borough Council)
Councillor Steve Butler (Dorset County Council)

Member Attending
Councillor Andrew Parry – Vice-Chairman of the County Council.

Officers Attending: Nicky Cleave (Deputy Director of Public Health), Sam Crowe (Director of Public Health, Bournemouth, Dorset and Poole), Jane Horne (Consultant in Public Health, Public Health Dorset), Rachel Partridge (Assistant Director of Public Health), Jane Portman (Executive Director, Adults and Children - Bournemouth) and David Northover (Senior Democratic Services Officer).

Charles Summers, Director of Engagement and Development, Dorset CCG also attended.

(Note: 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, 4 June 2018**.)

Chairman

1 **Resolved**
That Councillor Jill Haynes be elected Chairman for the meeting.

The Board considered that the protocol for the chairmanship at each Board meeting should be refined so that the Chairman was elected from the host authority of that meeting. The appointment of the Vice-Chairman would be on the basis that this was a member of the successor host authority. The Board considered that its constitution should be amended to reflect this decision and that a report to the next meeting would help inform any formal decision taken.

The Board acknowledged the contribution made by Councillor Tony Ferrari to the Board and welcomed Councillor Steve Butler as his successor.

Vice-Chairman

2 **Resolved**
That Councillor John Challinor be appointed Vice-Chairman for the meeting. Given this, Councillor Challinor would assume Chairmanship of the Board at the next meeting on 4 June, being held in the Civic Centre, Poole.

Apologies

3 No apologies for absence were received from members. The Director of Public Health, Dr David Phillips, gave his apologies.

Code of Conduct

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

Minutes

5 The minutes of the meeting held on 20 November 2017 were confirmed and signed.

Public Participation

6 There were no public questions or public statements received at the meeting under Standing Orders 21(1) and (2) respectively.

Forward Plan of Key Decisions

7 The Joint Board considered its draft Forward Plan, which identified key decisions to be taken by the Joint Board and items planned to be considered during 2018, which had been published on 8 January 2018.

Members agreed that all the issues on the Plan remained relevant but the order in which they were considered, and at which meeting, remained fluid depending on what there was to report.

Members agreed that an Update on the Health Visiting issue should be added to the agenda for June 2018.

Financial Report

8 The Board considered a financial report jointly prepared by the Chief Financial Officer and the Director of Public Health showing the draft revenue budget in 2017/18 was £28.512m, which was expected to be underspent by £1.2m during the financial year. The grant allocation for Dorset for 2018/19 was to be reduced by 2.6%, to £33.4m, with the indicative allocation for 2019/20 being £32.5m – a further reduction of 2.6%.

Details of what the budget was being spent on, what it was achieving and how reserves and revenue were being used was set out in the report and explained by officers.

Critical to the Board's understanding of what spending was and how it was being used were the Forecast Outturn 2017/18 and Estimated Forecast 2018/19 and 2019/20 tables, at paragraphs 3.1 and 5.4 respectively. The Board asked that, for their visual convenience, these two tables be presented conjointly in future reports.

Members understood the need for the savings to be made and the way in which this was being done but wanted to ensure that, in doing this, this was not having a detrimental impact on the good progress being made. Officers considered that the way in which this was being done was by a measured and managed approach but, certain services - such as the 0-5 and 5-19 public health nursing services - needed attention to ensure standards were maintained in the face of contract reductions. Officers agreed to provide the Board with assurances around continued delivery.

How health checks were undertaken and managed and what they covered – including health checks for those individuals with a disability - was explained and what responsibility there was for this being done. Whilst General Practices had assumed this role, there were considered to be other, more practicable options for this to be done - on a locality basis. This should improve how records were kept about those checks undertaken. A Task and Finish Group had been established by the Clinical commissioning Group (CCG) to look into this more.

Resolved

That the update on the 2017/18 forecast, the final allocation for 2018/19 and indicative allocation for 2019/20 be noted.

Reason for Decision

Close monitoring of the budget position was an essential requirement to ensure that money and resources were used efficiently and effectively.

LiveWell Dorset - Update on Progress

9 The Board considered a report by the Director of Public Health which updated on progress on LiveWell Dorset. Since the previous meeting on 20 November 2017 – at which authority was delegated to the three authority portfolio holders for Health - after consultation with the Director - to make a decision on how Livewell should be delivered in future having made an assessment and a judgement of the options available – agreement had been reached to bring the Service "in-house" to ensure that a strong public health provider function could be established and maintained with Public Health Dorset.

The Board were informed of the reasoning for that decision, in that it was considered that this Service would benefit from in-house provision to ensure that it was as successful as it could be. The Board were given a better understanding of how the transition process was going; the progress being made; the practicalities of how it was to be delivered; what risks had been identified and how these could be mitigated; and the expected benefits it would bring. More work was ongoing with improving the digital communication means by which this Service could be delivered effectively.

Public Health Dorset were very satisfied with the progress being made, how the process was being managed and what governance arrangements were in place and tht this could only improve how successful it could became. In doing this there was a good opportunity to now bring this model of care directly to where it was needed, with specific groups being targeted depending on their needs. The Board emphasised the need to keep focused on vulnerability and deprivation and how this could be effectively addressed. Public Health Dorset confirmed that this commitment remained.

The Board also had the opportunity to assess the Live Well Dorset Service Plan 2018/19 which explained its strategic aim, objectives and outcomes; what had been achieved and what was coming up; and the impact it was have and how this all fitted in with the Prevention at Scale principles. They were pleased to see how the LiveWell Service was now being managed and delivered and sought to endorse what progress was being made.

Resolved

That the progress being made in establishing a successful transition of the LiveWell Service, from a commissioned to an in-house provider, from 31 March 2018, be noted and endorsed.

Future Commissioning of Public Health Nursing (Health Visiting and School Nursing)

10 The Board were informed on the progress was being made with the future commissioning of Public Health Nursing (Health Visiting and School Nursing), the assessment of the options and how an integrated approach with local authority services, including Early Help, was being developed to provide for this.

The intention had been that timescales for recommissioning Public Health nursing services with local authority commissioning of early help services should be aligned. However owing to the uncertainty about Local Government Reform in Dorset this had been unable to be achieved and the agreement of the Board was now sought for a proposed short period of re-engagement with senior stakeholders to develop an options appraisal, to be considered by the Board at their June 2018 meeting. A consequence of this would be for a contact extension for these services of another year so that these services were maintained and able to be delivered and agreement by the Board was sought for this too.

The Board learnt of the cultural change in providing this service, in moving away from the traditional provision at GP surgeries to being more relevant and accessible and provided on a locality basis in working direct with particular communities. The report

also set out the current contract position, progress on developing service models and what the next steps were.

The Board acknowledged the need for what was being proposed in the circumstances and agreed that the contract should be extended on the basis of the provisions and reasoning described in the Director’s report and that they should receive an options appraisal report at their next meeting.

Resolved

1) That progress in the integrated working across Public Health Nursing Service and Early Help services be noted.
2) That an extension to the current contracts for Public Health Nursing Services (Health Visiting and School Nursing) for one year, from March 2018 to March 2019, be agreed.
3) That a short period of engagement with senior stakeholders to inform a commissioning options appraisal for the next Board meeting on 4 June 2018 be agreed.

Questions from Councillors

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

Informal Thematic Session on Prevention at Scale

12 The formal business meeting was followed by Prevention at Scale Advisory Board - a thematic session on Prevention at Scale which updated on what progress was being made across the four interlinked workstreams:-

- Starting Well
- Living Well
- Ageing Well and
- Healthy Places

Meeting Duration: 10.00 am - 12.10 pm

Dorset County Council

Public Health Joint Board
(Publication Date – 3 May 2018)

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.
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	Steve Butler	John Challinor
Jane Kelly	Jill Haynes	Karen Rampton

Reserves

Blair Crawford	Deborah Croney	Mike White
	Rebecca Knox	

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 Senior Democratic Services Officer, County Hall, Colliton Park, Dorchester, DT1 1XJ (Tel: (01305) 224175 or email: d.r.northover@dorsetcc.gov.uk).

Date of meeting (1)	Matter for Decision/ Consideration (2)	Decision Maker (3)	Consultees (4)	Means of Consultation (5)	Documents (6)
4/06/18	Key Decision - No **Open** Chief Financial Officer's Report	Joint Public Health Board ()	Officers and portfolio holders from each member local authority.	Internal discussions, separately and jointly.	Board report
4/06/18	Key Decision - No **Open** Commissioning Update	Joint Public Health Board ()	Officers and portfolio holders from each member local authority.	Internal discussions, separately and jointly.	Board Report
4/06/18	Key Decision - Yes **Open** 0-5 and 5-19 Services - Commissioning Options	Joint Public Health Board ()	External meetings, Joint Commissioning Board.	Internal discussions, separately and jointly.	Board Report
4/06/18	Key Decision - No **Open** Public Health Business Plan for 2018/19	Joint Public Health Board ()	Officers and portfolio holders from each member local authority.	Internal discussions, separately and jointly.	Board Report
4/06/18	Key Decision - No **Open** Task & Finish Group (to look at the future of PHD)	Joint Public Health Board ()	Officers and portfolio holders from each member local authority.	Internal discussions, separately and jointly.	Board Report
4/06/18	Key Decision - No **Open** Prevention at Scale Update	Joint Public Health Board ()	Portfolio lead for Integrated Community and Primary Care Services,	-	Board Report

24/09/18	Key Decision - No **Open** Finance Report (including services update report)	Joint Public Health Board ()	Officers and portfolio holders from each member local authority.	Internal discussions, separately and jointly.	Board Report
19/11/18	Key Decision - No **Open** Finance Report (including services update report)	Joint Public Health Board ()	Officers and portfolio holders from each member local authority.	Internal discussions, separately and jointly.	Board Report
To be scheduled	Key Decision - No **Open** Prevention at Scale portfolio - focus on opportunities within one acute network	Joint Public Health Board ()	Portfolio leads for One Acute Network.	-	-
To be scheduled	Key Decision - No **Open** Prevention at Scale portfolio - focus on opportunities within enabling workstreams	Joint Public Health Board ()	Portfolio leads for Digitally Enabled Dorset, and Leading and Working Differently.	-	-

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.

Public Health Dorset

Joint Public Health Board

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

Date of Meeting	4 June 2018
Officer	Acting Director of Public Health
Subject of Report	**Future Commissioning of Public Health Nursing (Health Visiting and School Nursing)**
Executive Summary	The future commissioning of Public Health Nursing services was tabled at the JPHB in February 2018. THE JPHB requested a one-year contract extension and an options appraisal to return to the next meeting. This paper summarises progress to date, options appraised and makes a recommendation for a Competitive Tender for a Pan-Dorset 0–19 Public Health Nursing Service. The Board is asked to support the recommendation to proceed with a procurement in line with the preferred option.
Impact Assessment: *Please refer to the protocol for writing reports.*	Equalities Impact Assessment: A full EQIA will be undertaken as part of any preparations for re-commissioning to ensure a thorough understanding of use and uptake of the service by different groups in society.
	Use of Evidence: Public Health Dorset routinely uses a range of evidence in compiling reports. Evidence considered as part of the service transformation of health visiting includes national guidance from NICE, service user feedback, as well as local evidence on service use and performance. Stakeholder Engagement: To date initial stakeholder consultations have taken place with; The Joint Commissioning Board, The Integrated Children's Community

<table>
<tr><td></td><td>Health Services Reference Group (ICCHS) and senior officers from the three LA Children's Services teams, the Clinical Commissioning Group and NHS England.

Further consultations are planned with; Poole Children's Services Development Group, Dorset Forward Together for Children Board and the Strategic Alliance for Children and Young People, Bournemouth Early Help Board, the Dorset Local Medical Committee (LMC) and NHS England.

PHD recognise the complex interdependencies and opportunities for integrating care this procurement provides. The continued engagement and contribution from stakeholders, as above and including Schools and Colleges, Healthcare Providers and parents, children and young people, to develop the service model and specification is critical to both successfully engaging the right Provider and to service implementation within developing integrated care systems.</td></tr>
<tr><td></td><td>2018/19 Budget:

Health Visiting: £9,725,325

School Nursing: £1,185,505</td></tr>
<tr><td></td><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 MEDIUM</td></tr>
<tr><td></td><td>Other Implications:</td></tr>
<tr><td>Recommendation</td><td>The Board is asked to:
Note the engagement with senior stakeholders and development of the options appraisals for procurement and commissioning.
Consider the evidence and agree a Competitive Tender for a Pan-Dorset 0 – 19 years Public Health Nursing service (formally Health Visiting and School Nursing services) with a proposed contract length of 3 + 2 years and maximum annual budget of £11 million.</td></tr>
<tr><td>Reason for Recommendation</td><td>Public Health Nursing services in Dorset are currently provided by Dorset Healthcare University NHS Foundation Trust. The current contract has expired on 31 March 2018. A further one-year extension of this contract was awarded from 01 April 2018.</td></tr>
</table>

	This procurement provides the opportunity to engage with local stakeholders to develop an integrated 0 – 19 service model and specification for Public Health Nursing which embeds the principles of Prevention at Scale within a Universal offer for children, young people and their families.
Appendices	None
Background Papers	None
Report Originator and Contact	Name: Joanne Wilson Tel: 01202 261 104 Email: j.wilson@dorsetcc.gov.uk

1. Recommendation

1.1 The Joint Public Health Board Members are asked to consider the evidence provided by this report and approve the request to initiate a competitive tender for Public Health Nursing Services.

2. Reasons for recommendation

2.1 In February 2017, the Joint Public Health Board (JPHB) requested a 1-year contract extension with the intention to explore commissioning options and make a recommendation. During 2017/18 significant service improvement initiatives were implemented in both Health Visiting and School Nursing Services.

2.2 In January 2018, the JPHB recognised the service achievements and requested a further 1-year contract extension and a paper for the June meeting to make clear recommendations on future commissioning / procurement.

2.3 PHD have carried out engagement with system stakeholders, including meetings with the Joint Commissioning Board and ICCHS Reference Group. Working with senior officers from each of the three Local Authorities, the Clinical Commissioning Group, NHS England has identified important interdependencies and opportunities to embed Prevention at Scale within a more integrated Universal offer to children, young people and their families. The success of the proposed procurement for Public Health Nursing will depend on stakeholder engagement to develop a model and service specification which can select the best possible provider of services within the context of emerging LGR structures and developing Integrated Care Systems in Dorset.

2.4 This paper provides an update on progress and summarises the evidence within an options appraisal framework for the JPHB to base their decision upon.

3. Background

3.1 Public Health Nursing services in Dorset are currently provided by Dorset Healthcare University NHS Foundation Trust.

3.2 The Health Visiting service performs well against the South West PHE key performance indicators. During 2017/18 a Joint Outcomes Framework has been developed with Children's Centres with evidence based integrated pathways, the workforce had been aligned with reach areas with staff development, a greater embedding of behaviour change and a new Advisory Forum ensures continuous evidence based practices within localities.

3.3 School Nursing has been able to scale its Universal offer through integrating digital technologies including the innovative CHAT Health text messaging service, emotional health and wellbeing Podcasts and developing a repository of online resources alongside Wessex Healthier Together for professionals, parents and young people including the Self Help not Self Harm campaign.

3.4 Local Authorities are responsible for the commissioning of Public Health Nursing as the contribution to local Healthy Child Programme delivery. A review of recent publicly advertised tenders (via OJEU, the official journal of the European Union), found two local authorities had different experiences of procuring Public Health Nursing and demonstrate some of the risks and opportunities.

3.5 The Isle of Wight Council invited tenders in 2017 for a 0-19 Years Public Health Nursing Service with a three-year contract length and value of £6,450,000. A competitive tender was unsuccessful with an absence of bidders (0). The Council have undertaken a negotiated contract procedure with the local community health Trust.

3.6 The London Borough of Brent invited tenders in 2016 for a 0-19 Years Public Health Nursing Service with a contract length of three years with the option to extend for two years annually and value of £30,000,000. A competitive tender was successful following the appraisal of three bids. The Borough awarded the contract to London North West University Healthcare NHS Foundation Trust.

4. Options Appraisal

4.1 Further to the request of the JPHB in January, the following options appraisal has been developed in consultation with DCC procurement leads.

4.2 Five options were identified and considered:

A. Competitive Tender
B. Negotiated Contract without Publication (If Competition is absent for Technical Reasons)
C. Section 75 Agreement to transfer resources and mandate to another commissioning body (e.g. Clinical Commissioning Group / Local Authority)
D. Further 1-year extension to current contract
E. Develop In-House Public Health Nursing Service

Table 1. below summarises the key benefits and limitations of each procurement option.

OPTION	BENEFITS	LIMITATIONS / RISKS	RANK
A	• Legally Compliant • Opportunity to test the market for innovation • Provider performance improves as desire to win business • Service improvement at pace (described in spec) • Opportunity to focus on quality and outcomes	• No bids may be received • Disruption to service delivery during tender / mobilisation • Assurance of incumbent Provider commitment and familiarisation • Workforce disruption if TUPE required	1
B	• Legally Compliant (if absence of competition can be confirmed) • Could enable a new contract to be formed with the current provider	• Market has competition – alternative Providers in neighbouring authorities • Negotiation will produce less competitive advantages to the contract offer	N/A
C	• Opportunities to integrate with ICCHS / Maternity workstreams	• Previous unsuccessful attempt to do this for sexual health services in Dorset	2
D	• Coincide with creation of two new Unitary Councils	• Remains large, non-compliant contract / illegal spend	N/A
E	• Integration with LA workforces	• Hosting arrangements and liabilities for taking NHS / clinical services in-house • Workforce disruption / TUPE • Efficiencies mitigated by hosting costs.	3

4.3 This options appraisal and an assessment of risks and benefits was circulated to the Joint Commissioning Board for feedback. The following points were made by Joint Commissioning Board Members.

4.4 The CCG would prefer not to market test as they believe this has the potential to fragment children's services and does not support the direction of travel of one Integrated Care System. However, the CCG recognised the risk held by the DCC Monitoring Officer and has welcomed the opportunity to contribute to the development of the specification for the service, and procurement evaluation criteria.

4.5 NHS England commission School Aged Immunisations and Newborn Hearing Screening, both are currently operationally integrated within the Health Visiting and School Nursing services. There are risks to service delivery should the incumbent provider be unsuccessful. However, plans are under discussion to reduce risks. NHSE also welcome the opportunity to contribute to the development of the service specifications and maintain appropriate service pathways within the future model.

5. Development of service model

5.1 The current Public Health Nursing Services are contracted through a single contract with a single contract value. However, the model is underpinned by two distinct service specifications for Health Visiting and School Nursing. This reflects the significant difference in the delivery model for the Healthy Child Programme 0 - 5 years and 5 – 19 years.

5.2 Local Authority Officers from each of the three localities were invited to consider future models for Public Health Nursing Services. Key shared ambitions for all authorities is a focus on earlier identification and intervention and whole family working.

5.3 There are additional interdependencies to consider:

- The impact of LGR on Local Authority Children's Commissioning
- The delivery of New-born Hearing Screening and Childhood Immunisations by the current provider, which is commissioned by NHSE.
- Opportunities for integration within the ICCHS and Maternity workstreams lead by the CCG.
- The delivery of the National Childhood Measurement Programme by the current providers, which is commissioned by PHD.

Table 2. below summarises the key benefits and limitations of commissioning options:

OPTIONS	BENEFITS	LIMITATIONS / RISKS
Pan Dorset	Equity of provision / outcomes/ spend across population. Commissioning and contracting efficiencies (PHD model) Geographical integration drives culture Midwifery aligning "reach" areas	Ensuring service sufficiently balances needs in Urban and Rural areas with diverse demographics and deprivation
Bournemouth, Poole and Christchurch footprint and Dorset footprint	Closer LA influence / working Alignment with local EH models	Uncertainty within LGR process Maybe more than one provider = increased risk to outcomes / accountability / overhead costs
Single 0-19 Services	Economies of scale through operational integration Whole Family Working model Safeguarding continuity (HV/SN)	Healthy Child Programme is substantially different for HV / SN Expectations from partners of single service with two discrete HCP offers
Separate 0–5 and 5-19 Services	Clear focus of service delivery to key age populations Alignment with (0 – 5) Children Centre and (5-19) School offers	SN service less attractive to the market independent of larger HV contract Maybe more than one provider = increased risk to outcomes / accountability / overhead costs

5.4 Several combinations of options are possible across Local Authority geographies and pan-Dorset, however, the shared and agreed recommendation from consulting Local Authority officers is for a single 0–19 Public Health Nursing Service, pan-Dorset.

5.5 Whilst a pan-Dorset service is preferred it is recognised that it will be important to have flexible local delivery to meet needs and achieve shared outcomes.

6. Summary and conclusion

6.1 This paper describes the benefits and limitations of five commissioning options for Public Health Nursing at the request of the JPHB. This paper recommends the Board support Option A, a competitive tender.

6.2 This paper goes on to describe the benefits and limitations of different contractual configurations for service commissioning. This paper recommends a single pan-Dorset , 0– 19 age Public Health Nursing Service.

Sam Crowe
Acting Director of Public Health
June 2018

Joint Public Health Board

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

Date of Meeting	4 June 2018
Officer	Acting Director of Public Health
Subject of Report	**Contract and Commissioning Report Update**
Executive Summary	This paper provides the Board with an outline of the progress that has taken place within the main Public Health commissioned programmes.
Impact Assessment:	Equalities Impact Assessment: An equality impact assessment is carried out each year on the medium term financial strategy.
	Use of Evidence: This report has been compiled from the budget monitoring information provided within the Corporate Performance Monitoring Information (CPMI).
	Budget: The Public Health budget for 2018/19 is £28.6m.
	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: LOW Residual Risk LOW As in all authorities, 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.
	Other Implications: As noted in the report
Recommendation	**The Board is asked to note the update and agree the following recommendations:** 1. To agree the proposal to amend the existing governance arrangements for the Drug and Alcohol Treatment system as outlined in the paper. 2. Public Health Dorset review other community provider contracts with GP practices and pharmacy with an aim to fully integrate sexual health service provision by March 31st 2020. 3. The NHS Health Checks locality-based service model to be developed for consideration by JPHB at the next Board
Reason for Recommendation	Close monitoring of the commissioned programmes is essential requirement to ensure that services and resources are compliant used efficiently and effectively.
Appendices	None
Background Papers	None
Report Originator and Contact	Name: Sophia Callaghan, Assistant Director of Public Health Tel: 01305-225 887 Email: s.callaghan@dorsetcc.gov.uk

Contract and Commissioning update

1. Drugs and alcohol

1.1 The Pan-Dorset Drug and Alcohol Governance Board was established in April 2015, following a review of the arrangements for drug and alcohol commissioning in Bournemouth, Dorset and Poole. The Board has reported to the Joint Public Health Board and been supported by a Lead Officer Commissioning Group involving service leads from the three Local Authorities and Public Health Dorset, and representatives from Dorset CCG, National Probation Team, Community Rehabilitation Company, and the Office of the Police and Crime Commissioner.

1.2 The terms of reference of the Board were reviewed at its meeting in July 2017, and the resulting discussion focused on the future role of the Board given the system wide changes that have already taken place and those that are anticipated:

- The Governance Board has been well supported by all partner organisations, but there is recognition that the same partners meet in a number of strategic partnerships and often have similar discussions to those at the Governance Board.
- The Governance Board has performed an important role in providing oversight of the procurement of treatment services, but has had a more limited impact on strategic issues.
- The Lead Commissioners Group has proved to be an effective way to manage service performance issues and make decisions about service development.
- It is not yet clear what impact Local Government Reform (LGR) will have on the future commissioning arrangements for substance misuse treatment services, or on strategic partnership arrangements.
- The evolution of the Integrated Care System may influence future arrangements for commissioning.

A small working group subsequently met to consider the role of the board in more detail. Five core governance functions were identified which are summarised in the table below.

Function	**Discussion points**
Oversight of the commissioning and procurement process	This role has been very useful, but new contracts now in place for the next 3-5 years.
Review of performance of the treatment system	A key responsibility and clarity is needed on where this sits.
Oversight of the Drug and Alcohol Strategy	The strategy covers Prevention, Treatment and Safety and so has significant crossover with other strategic work streams e.g. STP, Children's Trust Boards, Community Safety Partnerships.
Partnership approach to managing impacts of substance misuse	The same partners meet in a number of different strategic groups and have similar discussions.
Oversight of Needs Assessment and JSNA	The responsibility for the JSNA sits with Health and Wellbeing Boards. Treatment system needs assessment informs treatment system commissioning and service improvement.

	The broader system impacts of substance misuse are assessed in other strategic partnerships.

1.4 Three options for the future governance of the drug and alcohol agenda were proposed to the Governance Board in January 2018.

1.5 The consensus of the Board was that its value as a group had primarily been to provide oversight of the procurement process and that the other governance functions could be adequately managed in alternative ways. They therefore propose to stop meeting as a Governance Board and to cover off the other governance functions by:

- Ensuring adequate member oversight of strategic performance by providing regular six-monthly treatment system performance reports to the Joint Public Health Board.

- Extending the role of the Lead Commissioners Group to highlight issues to the Joint Public Health Board, reviewing the membership of the group, and inviting other partners as needed according to the agenda. The Lead Commissioners Group would also report to the Joint Commissioning Board for any Joint Commissioning issues.

- Increasing the visibility of drug and alcohol system-wide issues within other existing strategic groups. Joint commissioning and cross cutting strategic issues would be referred to the appropriate governance group, Children's Trust Boards for children, Criminal Justice Board and Community Safety Partnership for Crime.

2. Sexual Health Services

2.1 At the last Joint Public Health Board (JPHB) Public Health Dorset sought the Board's approval to pursue our recommended option for securing sexual health services via a direct award to Dorset Healthcare University NHS Trust, under a lead provider model. This was agreed and the JPHB delegated authority to the Director of Public Health to develop the business case for direct award and proceed outside of the formal meeting.

2.2 The sexual health service development has made significant progress over the last three months. Public Health Dorset have successfully negotiated the contract with Dorset Health Care Foundation Trust (DHCFT). The integrated sexual health service specification, and relevant collaborative working documentation has been agreed and signed off by all providers, to work together within the agreed contract envelope. The due diligence and quality assurance processes for DHCFT are also complete.

2.3 The VEAT notice (Voluntary Ex-Ante notice) was published in April 2018 for the 10 day standstill period, which publicised the Council's recommendation to award directly, and allowed for the market to challenge. No challenge was forthcoming during this time and the deadline has now expired.

2.4 Through the agreed delegated authority, the Director of Public Health then signed off the recommendation to award report (RTA), which is required for all procurement processes.

2.5 This has enabled Public Health Dorset to issue and sign contracts and award directly to Dorset Healthcare as lead provider. This means that all the necessary contracts have been issued in time for the integrated service to start on 1st May 2018.

The next stage will be to fully mobilise, establish and monitor the integrated model to ensure savings are met during 2018/19 financial year. As part of planning for 2019/20, it is recommended that DHCFT and Public Health Dorset review other community provider contracts with GP practices and pharmacy with an aim to fully integrate sexual health service provision by 31 March 2020.

3. Children and Young Person commissioning

3.1. Since the last JPHB, a further one-year contract has been awarded from April 1st 2018 for Public Health Nursing services. Engagement has taken place with senior stakeholders in order to develop options for procurement and commissioning. The options paper has been placed as a separate item on this agenda for the JPHB to consider.

4. Health Improvement including Health Checks

4.1. The LiveWell Dorset service was successfully transferred in-house on 1 April 208 and is now building capacity to support more people in line with its service plan. The new digital support service, is also live (the interactive website that the JPHB viewed at the last Board meeting). Website analystics data for the first months' usage shows that more than 3,000 unique users have viewed the site, leading to more than 60 requests for a coach to call them back, and 50 online coaching chats.

4.2. The NHS Health Checks programme continues to show variable performance across Dorset, partly due to a lack of GP invitations in several localities. A task and finish group has been set up to discuss new ways of working with Public Health Dorset, the Dorset Clinical Commissioning Group, Primary Care leads and Dorset Health Care. There is a real opportunity as the Integrated Care System evolves to put the programme back at the heart of locality public health plans, with greater ownership by local GP practices to ensure they meet population needs more closely.

4.3. The task and finish group is developing a framework for a new service model that would be used as a basis to re-tender the service. Among the principles we are seeking agreement on is ensuring people are invited from the GP register, and that outcomes and actions such as health improvement changes, are recorded properly on the GP clinical systems. Each locality will agree the mix of providers of health checks to ensure the right model of service is in place for different populations. The task and finish group is also looking at how other population health checks could also be brought into the model. This includes checks for learning disability or people living with severe mental health conditions, recorded on GP registers.

4.4. The service model will be co-designed with service users, for consideration by the Board later this year. The tender timescales will be planned to ensure new contracts begin from April 2019.

5. Conclusion

5.1. This paper describes the progress that has taken place within key Public Health commissioned programmes.

5.2. The Board are asked to note the update and agree the following recommendations:

- To agree the proposal to amend the existing governance arrangements for the Drug and Alcohol Treatment system as outlined above;

- Public Health Dorset review other community provider contracts with GP practices and pharmacy with an aim to fully integrate sexual health service provision by 31 March 2020;

- The NHS Health Checks service model to be developed for JPHB consideration.

Sam Crowe
Acting Director of Public Health

June 2018

Joint Public Health Board

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

Date of Meeting	4 June 2018
Officer	Chief Financial Officer and Acting Director of Public Health
Subject of Report	**Financial Report**
Executive Summary	The draft revenue budget for Public Health Dorset in 2018/19 is £28.592m. This is based upon an indicative Grant Allocation of £33.407m. The report also includes the final outturn for 2017/18 and an updated reserve position.
Impact Assessment:	Equalities Impact Assessment: An equality impact assessment is carried out each year on the medium term financial strategy.
	Use of Evidence: This report has been compiled from the budget monitoring information provided within the Corporate Performance Monitoring Information (CPMI).
	Budget: The Public Health Dorset budget is currently forecast to be underspent in 18/19.
	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 in 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.
	Other Implications: As noted in the report
Recommendation	The Joint Board is asked to consider the information in this report and to: 1. Note the 17/18 final outturn; 2. Note the updated reserve position and continued commitment to PAS from within the reserve; 3. Note the confirmed budget allocation for 2018/19 and indicative budget for 19/20.
Reason for Recommendation	Close monitoring of the budget position is an essential requirement to ensure that money and resources are used efficiently and effectively.
Appendices	Appendix 1: 2017/18 Outturn, Reserve Position, Public Health Grant Allocations and Partner Contributions, confirmed for 18/19 and indicative for 19/20
Background Papers	Previous finance reports to Board
Report Originator and Contact	Name: Steve Hedges, Group Finance Manager Tel: 01305-221777 Email: s.hedges@dorsetcc.gov.uk

1. Background

1.1 The Health and Social Care Act 2012 established new statutory arrangements for Public Health which came into effect on April 2013. Significant responsibilities for public health were transferred to local councils from the NHS, and locally these are delivered through Public Health Dorset, a shared service across the 3 local authorities, funded through the ring-fenced Public Health grant. Public Health England was established and is responsible for public health nationally, and NHS England and Clinical Commissioning Groups also have some continuing responsibilities for public health functions.

1.2 Since 2013 there has been a further national transfer of responsibility for the Health Visitor service, which moved to local authorities in October 2015; the local agreement was that this was commissioned by Public Health Dorset. Public Health Dorset have also taken on additional responsibilities for drugs and alcohol from each local authority in 2015 and again in 2017.

1.3 Public Health Dorset have made significant returns to the 3 local authorities in line with principles previously agreed at the Board. These returns are also subject to the ring-fence grant conditions.

1.4 Alongside the publication of the final allocations for 2018/19, PHE announced that the Public Health Grant ring-fence and grant conditions will remain in place until 31 March 2020.

2. Budget Outturn Position 2017/18

2.1 The final outturn figure for 2017/18 was an underspend of £365k (see appendix 1). This takes account of:

- the return to local authorities of an anticipated £1.2M underspend;
- approx. £100k income from small scale grants and payments;
- movement in from reserves of £1M to support PAS, as agreed at JPHB;
- spend against PAS of £439k.

Public Health Reserve

2.2 The updated reserve position as at 31 March is £1,817k (see appendix 1).

2.3 Although the Board committed £1M to PAS in November 2016, this work has taken some time to come to fruition. There are ongoing commitments to better connect LiveWell Dorset across the system, and continue working with localities to embed prevention and population health in how they work. To date spend against the £1M has totalled £439k, leaving £561k of the reserve committed to PAS. An element of the reserve is specific to DCC due to savings made within DCC prior to transfer of drugs and alcohol into PHD (£308K). These are also now committed against PAS.

3. Public Health Grant

3.1 The revenue budget for Public Health Dorset in 2018/19 is £28,592k. This is based on a Grant Allocation of £33,407k, a 2.5% reduction over the grant allocation for 2017/18, and a further shift in responsibilities for drug and alcohol services reflected in retained PTB and DAAT elements. The Public Health Grant Allocations and partner contributions are shown in appendix 1.

3.2 Indicative allocations are available for 19/20 and shown in appendix 1. These will need to be amended to reflect new footprints following LGR, but the overall envelope is expected to remain the same, and the ring-fence grant conditions will remain in place.

3.3 Preliminary forecasts for 2018/19 and 2019/20 were shared at the last Board. Public Health Dorset is expecting an underspend in 2018/19. This will be on a smaller scale than in previous years as re-commissioning of services and the substantial efficiency gains this has delivered is now nearly complete. Further efficiencies will be delivered through restructuring public health activity and spend to align with other work across the system. Any savings as a result of this work are likely to impact over a longer timescale and with savings made in other parts of the local authority.

4. Conclusion

4.1 The Joint Board is asked to consider the information in this report and to note:

- the 17/18 final outturn;
- the updated reserve position and continued commitment to PAS from within the reserve;
- the confirmed budget allocation for 2018/19 and indicative budget for 19/20.

Richard Bates
Chief Financial Officer
June 2018

Sam Crowe
Acting Director of Public Health

APPENDIX 1: 2017/18 Outturn, Reserve Position, Public Health Grant Allocations and Partner Contributions, confirmed for 18/19 and indicative for 19/20.

Table 1: Outturn 2017/18

2017/18	Budget 2017-2018	Outturn 2017-2018	Over/underspend 2017/18
Public Health Function			
Clinical Treatment Services	£10,080,800	£11,252,812	-£1,172,012
Early Intervention 0-19	£11,366,400	£11,209,091	£157,309
Health Improvement	£2,804,458	£2,347,443	£457,015
Health Protection	£245,036	£66,391	£178,645
Public Health Intelligence	£344,800	£215,178	£129,622
Resilience and Inequalities	£1,909,608	£462,880	£1,446,728
Public Health Team	£2,760,898	£2,353,494	£407,404
Underspend to Poole BC		£240,000	-£240,000
Underspend to Bmth BC		£300,000	-£300,000
Underpsend to Dorset CC		£700,000	-£700,000
Total	**£29,512,000**	**£29,147,289**	**£364,711**

£364,711 transferred to Public Health reserve ringfenced for DCC PAS/STP budget in 2018/19

Table 2: Public Health reserve

Public Health Reserve	£'s
Opening balance 1/4/17	2,452,000
STP/PAS DCC	-1,000,000
Public Health underspend 2017/18	365,000
Balance in reserve at 31/03/18	**1,817,000**
PH Dorset commitment to STP/PAS costs	-869,000
Balance uncommitted in reserve	**948,000**

Table 3: Allocation 2018/19 and Estimated Allocation 2019/20

2018/19	Poole	Bmth	Dorset	Total
	£	£	£	£
2018/19 Grant Allocation	7,594,000	10,502,000	15,311,000	33,407,000
Less Commissioning Costs	-30,000	-30,000	-30,000	-90,000
Less Pooled Treatment Budget and DAAT Team costs	*-461,000*	*-2,924,800*	*-170,000*	-3,555,800
2014/15 Public Health Increase back to Councils	-299,000	-371,000	-499,100	-1,169,100
Joint Service Budget Partner Contributions	**6,804,000**	**7,176,200**	**14,611,900**	**28,592,100**
Budget 2018/19				**28,592,100**

2019/20	Poole	Bmth	Dorset	Total
	£	£	£	£
Estimated 2019/20 Grant Allocation	7,393,000	10,225,000	14,907,000	32,525,000
Less Commissioning Costs	-30,000	-30,000	-30,000	-90,000
Less Pooled Treatment Budget and DAAT Team costs	*-461,000*	*-2,924,800*	*-170,000*	-3,555,800
2014/15 Public Health Increase back to Councils	-299,000	-371,000	-499,100	-1,169,100
Joint Service Budget Partner Contributions	**6,603,000**	**6,899,200**	**14,207,900**	**27,710,100**

Estimated Budget 2019/20 **27,710,100**

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Joint Public Health Board

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

Date of Meeting	04 June 2018
Officer	Acting Director of Public Health
Subject of Report	**Prevention at Scale**
Executive Summary	The Joint Public Health Board agreed in February 2016 to take on the role of Prevention at Scale Programme Advisory Board. This paper provides a written update to the Board, highlighting progress across all four work streams
Impact Assessment:	Equalities Impact Assessment:
	Use of Evidence: Development of the STP and the agreed PAS portfolio approach is based on a range of national and local evidence.
	Budget: The Joint Public Health Board has previously approved approx. £1m non-recurrent funding from savings made from the public health grant for investment into the Prevention at Scale programme, of which £439k has been spent to date. Partner organisations each commission and work on a range of prevention activities with associated budgets. As the Prevention at Scale work progresses further there may be further impacts on these budgets, yet to be determined.
	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: LOW Residual Risk LOW
	Other Implications: Wider implications of the PID's and the Prevention at Scale programme include the sustainability of future public services, improving health and wellbeing, and the future role of localities, communities and the voluntary sector within this.
Recommendation	The Joint Board is asked to o note highlights across the prevention at scale portfolio o agree the development of a series of impact reports by each workstream that aim to capture the wider benefits in the system arising from this work.
Reason for Recommendation	Governance of prevention at scale will support effective delivery across the portfolio.
Appendices	Appendix 1: Measuring impact and benefit in Prevention at Scale Programme
Background Papers	'Our Dorset' Future direction of public health in Dorset, Feb 2017
Report Originator and Contact	Name: Jane Horne Tel: 01305 225872 Email: j.horne@dorsetcc.gov.uk

1. BACKGROUND

1.1 'Our Dorset', the local Sustainability and Transformation Plan (STP), was published in 2016 in response to the Government's challenge to the NHS and local Councils to work together and re-design more sustainable health and social care services. The plan sets out five key strands of work including Prevention at Scale that together will address three gaps:

- Health and wellbeing gap
- Care and quality gap
- Finance and affordability gap

1.2 Prevention at Scale has four interlinked workstreams which match the lifecourse stages of Starting Well, Living Well and Ageing Well plus Healthy Places. This paper provides a written update to the Board, highlighting progress across all the work streams.

2. HIGH LEVEL PROGRESS

2.1 Engagement with both Health and Wellbeing Boards continues. Dorset HWB discussed the Healthy Places workstream in March, including case studies in spatial planning for health and wellbeing, increasing access to green space, enabling active travel and work to improve homes in Dorset. Bournemouth and Poole HWB received a progress report at its last meeting in May. Members noted progress with projects, but requested a clearer demonstration of impact and benefits arising from the changes.

2.2 Following the production of the locality profiles, link workers have been identified for 11 of the 13 localities from within current public health resources. A successful bid to the STP transformation fund held by the CCG was made to support the two remaining localities in a similar way.

2.3 Work continues about how this resource links with those within GP localities and adult services community development workers, recognising that this may depend on locality.

3. STARTING WELL

3.1 Healthy lifestyle assessment is now embedded routinely within the Better Births project. Scoping is complete and the next stage is to co-produce options for implementation. Discussions are planned with Bournemouth University to include healthy lifestyle training within the midwifery curriculum for newly trained midwives.

3.2 Work on building whole school approaches to health and wellbeing, with a focus on physical activity and emotional health and wellbeing is progressing well. A survey has been sent to schools about potential actions for schools, and a workshop was held to discuss next steps which will lead to production of a more detailed business case.

3.3 An intensive programme of work with health visitors and children's centres has ensured much closer working between teams, and is already having an impact on outcomes.

4. LIVING WELL

4.1 The LiveWell Dorset service transitioned in-house on 1 April and the new digital platform was launched at the same time.

4.2 Work is progressing on providing support for the workforce. The new digital platform will be used with local key stakeholders to inform plans for skills development and training. Following development with the Dorset Workforce Action Board a programme of workshops are planned from May that will also support this.

5. AGEING WELL

5.1 Two pilot programmes for Escape Pain which aims to improve self-management of hip and knee pain have been run. These pilot programmes were in East Dorset and the intention is to roll out the programme across Dorset. Work is ongoing with the MSK triage service, primary care, and LiveWell Dorset to ensure that the service and referral pathway is embedded for future cohorts.

5.2 Altogether Better have now appointed a Development Manager and have confirmed the list of practices that will be engaging in the Leadership Programme for the Collaborative Practice model. Seventeen practices across Dorset have engaged.

5.3 Active Ageing – the steering group has met, a project manager has been appointed, and the first engagement event with stakeholders and interested organisations has been held. North Dorset locality have expressed an interest in being involved in the pilot.

5.4 The award for the diabetes prevention programme (funded nationally) has been made to Living Well Taking Control (Health Exchange). Mobilisation of the service has commenced, working closely with the CCG and LiveWell Dorset and the service will start in 18/19.

6. HEALTHY PLACES

6.1 Spatial Planning – good links made between local planners and the Primary Care Infrastructure work. Broader development to be discussed at the Dorset-wide workshop planned for end June 2018.

6.2 Active travel – working alongside the Integrated Transport Planning project to include travel planning and maximising active travel in healthcare plans around access and how strategic plans for Poole and Bournemouth hospitals and hubs within GP localities are implemented.

6.3 Access to green space – A range of projects are now set up to encourage different groups of people to access their local green spaces, and these will be evaluated using the same framework to establish their impact and how well this is sustained. In Poole the projects focus on engaging young families through facilitated activities; in Dorset the projects are improving path conditions and removing barriers to public rights of way along specific routes with particular connections in mind e.g. connecting Littlemoor residents with Lorton Meadows nature reserve; in Bournemouth the project is to develop a group of volunteers (referred in by partners) with a focus on building positive mental health.

6.4 Healthy Homes – we have already upgraded over 160 homes against a target of 150 for Phase 2 and secured additional funding from the national Warm Homes Fund for specific areas of development. Key to ongoing development is better integration within GP localities to allow better targeting to vulnerable residents with specific cold-related conditions.

7. CONCLUSION

7.1 Members are asked to note highlights across the prevention at scale portfolio.

7.2 In addition, Members are asked to support the development of a set of visually engaging metrics designed to show the wider impact and benefit of the changes as they take root across the system (see Appendix 1 for a very draft schematic to show how this might look).

Dr Jane Horne
Portfolio Director for Prevention at Scale
January 2018

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Appendix 1: Measuring impact and benefit in Prevention at Scale Programme

The PAS workstreams have well-defined project milestones for 2017/8 and 2018/19. Progress to date against implementing these milestones is good, with most on track for delivery. The real question is over time, what impact will they make in the wider system, and how do we measure the benefits that will arise from Prevention at Scale?

We are starting to be able to measure some outputs from these projects directly, as part of a set of metrics we collect. Using the Living Well example, we can identify how many additional people are supported within the service. What is harder to measure is the impact of embedding behaviour change within the wider system. For example, in the workforce projects being developed with other system employers:

- what will be the impact of training an additional number of frontline staff to have healthy conversations
- can we identify and measure how many people may be supported to change their behaviours as a result of this activity?
- Over time, what does the evidence suggest will be the benefit of these changes, if maintained (in outcomes, and reduced cost)?

This short briefing sets out a proposed approach that we aim to develop over the next couple of months to be able to capture the impact and benefit from wider changes in the system as a result of these Prevention at Scale projects.

The excerpt below shows the current milestones for the Living Well workstream.

Prevention at Scale

Milestones	17/18	18/19	19/20	20/21	21/22
Living Well					
Scale up individual behaviour change through:					
• Launch of digital platform of Live Well Dorset (LWD)		Qtr 1			
• Number of referrals generated from health checks and primary care doubled		Qtr 3			
• Number of people supported by LWD doubled			Qtr 2		
System wide approach to supporting staff health and wellbeing in place		Qtr 1			
Workforce plans and training plans complete		Qtr 1			
Review point 1 of workforce plan implementation		Qtr 2			

They are helpful markers of when project outputs are expected to be finished. But they don't provide an indication of system impact and benefit.

The diagram on page 2 is a proposed approach to developing an impact and benefits evaluation framework to start to provide better information to Boards about the wider impact in the system of these projects. Board members are asked to note and comment on the proposed approach.

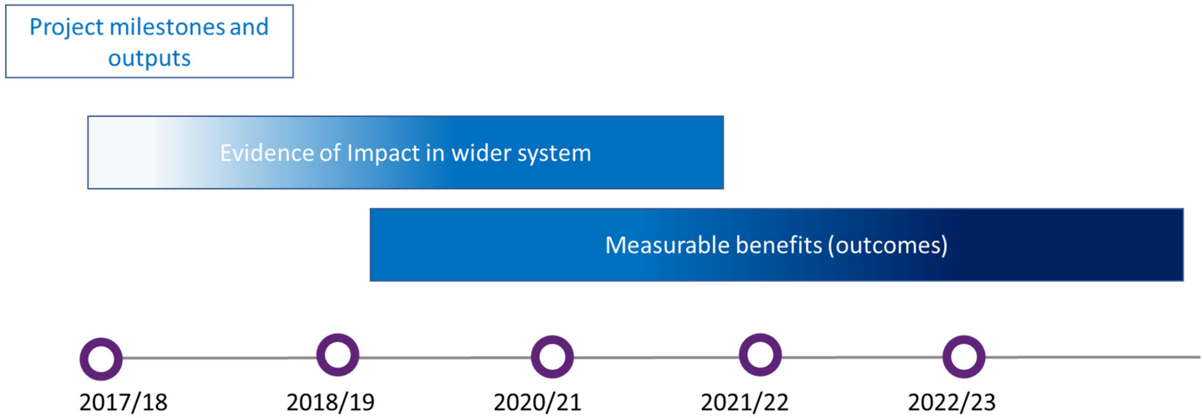

Diagram 1. Proposed approach for an impact and benefit evaluation framework.

The table below shows how this approach could be developed to measure the benefits arising from embedding LiveWell Dorset more clearly within the Dorset Integrated Care System over the next 5 years. The data are for illustrative purposes only at this point.

	2017/18	2018/19	2019/20	2020/21	2021/22
Project outputs	Transfer LWD in-house	Develop training capacity and capability Launch digital offer	Embed coaches more directly with localities and GP at scale New Health Check model at scale begins		
Evidence of impact in system		Digital offer routinely used to register people with service LWD train 500 frontline health and care workers in system 2-week wait lung cancer pathway all offered smoking cessation support Workforce plans for all large employers	CQUINs targets for acute hospitals agreed – all will use LWD to refer clients for alcohol and smoking Increase in health checks and numbers supported to change behavior		

Measurable benefits / outcomes	6,500 people supported 3,000 weight (59% lose 5% or more) 2,000 smoking (50% quit) 1,000 physical activity (750 become more active) 750 alcohol (60% drink less)	Numbers of people trained, Additional numbers of people referred from system for support	Clear data on % of people successfully making changes, reported back to GP practice systems	% of people making changes as a result of health check as recorded on GP registers	Modelled estimate of cost benefits arising from people supported to make changes

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Joint Public Health Board

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

Date of Meeting	4 June 2018
Officer	Acting Director of Public Health
Subject of Report	**Public Health Dorset Business Plan 2018/19**
Executive Summary	The Public Health Dorset Business Plan for 2018/19 sets out the main deliverables for the team in the coming year. This includes the Prevention at Scale programme, commissioning and contracting activity, and wider actions aimed at ensuring the team remains an efficient and effective public sector partner. Members are asked to note and support the Business Plan.
Impact Assessment:	Equalities Impact Assessment: A separate equality impact assessment is not carried out for the business plan. However, where activity in the business plan affects service delivery, such as via commissioning and contracting decisions, equalities impact assessments are carried out in line with policy.
	Use of Evidence: The business plan is a summary of the Public Health team’s planned activity for 2018/19. A range of evidence is used to inform how we plan to work, including national guidance and standards for delivery of public health services.
	Budget: The Business Plan identifies how we will spend the 2018/19 budget of £28.6m.
	Risk Assessment: Having considered the risks associated with this Business Plan using the County Council’s approved risk management methodology, the level of risk has been identified as: Current Risk: LOW

	Residual Risk LOW As in all authorities, performance continues to be monitored against a backdrop of reducing funding and continuing austerity.
	Other Implications: None.
Recommendation	The Board is asked to note and support the Business Plan for 2018/19.
Reason for Recommendation	Close monitoring of the commissioned programmes is essential requirement to ensure that services and resources are compliant used efficiently and effectively.
Appendices	PHD Business Plan 2018/19.
Background Papers	Various including current Prevention at Scale Plans, commissioning and project plans associated with the delivery of team business,
Report Originator and Contact	Name: Sam Crowe, Acting Director of Public Health Tel: 01305- Email: s.crowe@dorsetcc.gov.uk

Business Plan 2018/19

Introduction

Public Health Dorset is a shared service that provides public health leadership, services, and advice to Dorset County Council, the Borough of Poole and Bournemouth Borough Council. This helps the Councils fulfil their statutory duty to improve the health and wellbeing of their residents, and to reduce differences in health outcomes within each of their respective areas.

Strategy

To improve and protect the health and wellbeing for residents by working with Councils, Dorset Clinical Commissioning Group and other partners. Our long term strategic focus is shaped and guided by:

- Development of an integrated care system (ICS) for Dorset, Bournemouth and Poole;
- Proposed creation of two new Unitary Authorities for Dorset – Local Government Reform (LGR).

Our medium term (3-5 year) strategy is called Prevention at Scale, which forms a major programme of work within the Sustainability and Transformation Plan for Dorset (see Appendix 1).

How we will make a difference

1. **We will provide effective and accessible public health leadership to the reforming system (see Appendix 2), through the Prevention at Scale programme.**

System need: The ICS and LGR require public health leadership tailored to meet their needs (effective) within critical timeframes (accessible). We have also identified that providing local public health leadership within CCG localities is essential.

Measurement of progress: Review evidence of influence through public health action appearing in wider policies and strategies. In addition, the Joint Strategic Needs Assessment process will be used to interview clients in the system to assess the extent of prevention being incorporated into plans.

2. **We will be a reliable public-sector partner that delivers more than expected (Appendix 2)**

System need: We work within a complex system of organisations and delivering into this sector requires us to be ever more flexible and innovative – aka ‘client centred’.

Measurement of progress: Engage in professional project management and evaluate delivery of key projects. Ensure measurement of progress is reflected in milestone reports to the system.

3. **We will provide and commission effective, equitable and efficient public health services**

To continue the transformation of public health services in local government, reshaping wherever possible so that they are effective, efficient and equitable.

System need: Resources are becoming scarcer through the reductions to the Public Health Grant. There is a need to increasingly align public health service delivery and integrate it into the health and care system, in line with the plans for ICS.

Measurement of progress: Monitoring of compliance, spend and outcomes, savings returned to the system, population take up of services to ensure equity.

Outputs and activities – what we will do and deliver in 2018/19

1. **Deliver the main Prevention at Scale projects across the four workstreams (Appendix 3).** This includes 20 major projects that we directly manage, in addition to capacity building to improve prevention skills through our workforce work with the wider system.

2. **Commissioning intentions (Appendix 4).** The ambition has been to ensure effective, efficient and equitable services which are affordable in the context of a reducing public health grant, and so far, we have transformed delivery models for sexual health, drugs and alcohol and community provider services. In some areas this has resulted in a much more collaborative approach to delivery. The innovative health improvement hub that has been developed as LiveWell Dorset, has now brought together lifestyle services into a single system. For 2018/19 the principles of model redesign to improve effectiveness will continue. The major focus will be on children and young people with plans to recommission universal services for health visiting and school nursing. Business as usual activity such as quality assurance and service development will continue across all contracts and will include mobilising LiveWell Dorset as an inhouse service and redesigning community provider services for health checks, contraception and smoking cessation. This will enable a more collaborative commissioning approach to meet both system and locality need.

3. **Lead locality working.** To facilitate delivery of Prevention at Scale, Public Health Dorset is keen that real progress is made on the ground, with demonstrable impact for local communities. Real change involves embedding prevention in local delivery mechanisms, meeting the specific needs of local populations; and this means staff working more directly at a locality level. From 1 April 2018 each of the 13 localities will have a member of the PHD team aligned to it. Those working in localities will still need to work across the system, engaging not only with the commissioners and providers of NHS and local authority services, but also other public-sector services, the private, voluntary and community sectors. The locality liaison roles (up to 2 days per week) will involve the following:

- linking with key stakeholders within the locality,
- using intelligence to support local planning for Prevention at Scale,
- highlighting links with existing initiatives in other areas,
- embedding prevention actions within the local transformation plans,
- evaluating progress, with a focus on scale,
- communicating success and learning across stakeholders and the wider system.

The work in localities is supported by the production and maintenance of locality profiles – a collation of locality level data that describes the local population's health needs and helps with problem solving / prioritisation. The profiles will need to be reviewed and updated during 2018.

Inputs – resources required

The main resources are staff and revenue from the Public Health Grant. The Grant is ring fenced to ensure spend on public health services (including the mandated public health programmes as set out

in the Health and Social Care Act) and is pooled between the three Upper Tier authorities under a shared legal agreement. The Government has signalled its intention to lift the ring-fence by 2020/21 and also consider funding public health services in Local Authorities differently, via retained business rates. Further detail is required to understand how this will impact on services in Dorset.

1. Staff profile

As of 1 April 2018, Public Health Dorset had the 31 whole time equivalent staff working within it. This represents a reduction of 2 WTEs from the previous year's staffing levels. Our total staff budget is £2,245,000 (8 per cent of total revenue).

Post level	Number	Whole Time equivalent
Consultant or above	**6**	**5.2**
Heads of programmes	**4**	**3.8**
Senior HPAs	**4**	**3.5**
Senior analysts	**3**	**3.0**
Health programme advisors	**10**	**8.8**
Analysts	**4**	**3.2**
Business support	**5**	**4.6**
Total	**36**	**31.1**

On 1 April 2018, an additional 20 staff transferred across under TUPE arrangements to the public health team as part of the transfer of the LiveWell Dorset service in-house. This staff group is managed as a separate service by Public Health Dorset, based on an agreed service plan.

2. Revenue budget

The total revenue budget for 2018/19 (staff and operations, not including Local Authority retained elements of Pooled Treatment Budget) is shown in detail in the table below, along with a forecast for 2019/20.

Total: £27.6m **Change from previous year: -6%**

Budget description	18/19	19/20
Public Health Dorset budget (total)	**27,631**	**26,749**
Clinical Treatment Services	10,409	10,233
Health Improvement (adult)	2,530	2,620
Health Improvement (0-19)	11,038	11,038
Health Protection	67	67
Public Health Intelligence	139	139
PAS and advocacy	482	154
Public Health Team	2,500	2,440
Forecast spend	**27,166**	**26,651**
Difference (under)/over	**(465)**	**(151)**

Table 1. Public Health Dorset budget and forecast spend for 18/19 and 19/20

3. Support services and business processes (Appendix 5)

As well as staff and revenue, our deliverables and programmes of work, Public Health Dorset runs a number of internal work programmes and projects aimed at improving effectiveness of what we do. This includes organisational development activities, business support and project management, intelligence support including development of tools to support analysis and output for partners. Public Health Dorset is also an accredited training location for Higher Specialty Training in Public Health, and several consultants are GMC-accredited Educational Supervisors.

Currently we have 3 Public Health Specialty Registrars in training at various stages of development.

Appendix 1: Strategy

Planning	Timescale	Description	Governance
Future Dorset / Integrated Care System	5-10 years	Long term guiding strategy for Dorset public services – shift to population-based health and care system	System Partnership Board New Unitary Councils (shadow from 2018)
Prevention at Scale	3-5 years	Medium term strategy to deliver public health at scale within the evolving integrated care system and Sustainability and Transformation Plan	Health and Wellbeing Boards (Dorset, Bournemouth and Poole) PAS advisory board (Part 2 of JPHB)
Starting well	3-5 years	Universal services for children and young people delivering improved outcomes for them and their families.	
Living well	3-5 years	Scaling support for adults to change unhealthy behaviours, system workforce health and wellbeing, training and capacity building	Interdependencies with Integrated Community Primary Care Services board, Health and Wellbeing Boards
Ageing well	3-5 years	Support those experiencing or at risk of ill-health of a long-term condition by better support to help with lifestyle issues and managing living with the condition.	Interdependencies with One Acute Network
Healthy places	3-5 years	Maximize the potential of Dorset's natural and built environment to improve and support good health and wellbeing outcomes.	
Business plan	1 year	Deliverables and priorities for the Public Health Dorset team during that year (work plan)	Joint Public Health Board, senior management team (internal),

Appendix 2: How we will make a difference

Workstream	*Description*	*Benefits*
Lead the prevention at scale programme	Delivery of public health strategy either through projects or working to embed prevention approaches in the wider system. Organised into 3 clear life stages: Starting well, Living Well and Ageing Well, supported by the cross cutting Healthy Places workstream.	More children and families getting the best support during the first 3-5 years of life, through modernised health visiting and early intervention services, whole school approaches to health and wellbeing; Many more people supported to change health behaviours and delay the onset of chronic conditions; Less variation in how people with existing conditions are supported and managed, with less variation in outcomes between affluent and less affluent areas; Easier access at a local level to different types of support, including social support, for people with multiple health and wellbeing needs; More health and care staff equipped to support people with basic health and wellbeing issues, or connect them with support easily, including making better use of our natural resources like parks, the coast and countryside.
Ready and able to support integrated care and local government reform	Prepare to support the two new unitary Councils being created as part of the Future Dorset proposals. In 2018/19 this will involve convening a task and finish group via the Joint Public Health Board membership to consider how the public health function could change to accommodate the new Councils.	Provide public health leadership to bridge to work of the NHS with Local Authorities - particularly where the health and wellbeing of the population is concerned; Ensure the NHS through the STP recognises the contribution of local authorities to longer term health and wellbeing improvements; Ensures join up between the work to embed prevention and make the NHS more sustainable and the strategic work of local authorities as place shapers.
An innovative, flexible, efficient, and effective public sector partner	Internal work programme to become more efficient and effective, focusing on better business processes and innovation. Continue to develop partnerships with sectors that help	Better contract management and commissioning efficiency – releasing capacity for locality working More self-service and automation of public health intelligence, including further development of the data warehouse and links to LiveWell Dorset Skills and organisational development of team members to fully implement our client centred

	with delivery of strong public health performance.	consulting model, and demonstrate improved outcomes where this has been used to deliver Prevention at Scale projects with partners Implementation of a clear project management discipline and supporting technologies. Improving communications including implementing the new strategy, supported by new channels (website and social) and staff training and development; Developing and delivering the in-house public health provider function, including understanding how best to integrate fully within the health and care system.

Appendix 3: Activities and Outputs – Prevention at Scale Projects

Key Activities	Lead	Target date	Deliverables	Dependencies
Starting Well				
Embed behaviour change and lifestyle support in maternity care pathways	Fiona Johnson	Dec 18	Prevention incorporated as part of pathway and evaluation	One Acute Network CCG
Ensuring an effective, single 0-5yrs offer	Jo Wilson	Jun 18	Agreement on commissioning options and clear timetable for tender	LG reform
Build whole school approaches to health and wellbeing	Vicky Abbott	Mar 19	Increased engagement of young people in physical activity	Headteachers Alliance
Build community capacity to support children and young people THRIVE	Vicky Abbott	To be agreed with LA's	MHFA training delivered to school support staff	
Living Well				
Launch LiveWell Dorset digital	Stuart Burley	Apr 18	1,000 users, 50 organisations using	Primary care, One Acute Network
Market LiveWell Dorset to GPs	Stuart Burley / Emer Forde	Q2 19	Number of people supported by LiveWell Dorset doubled	Primary Care, Locality working
Healthchecks	Sophia Callaghan	Dec 18	Number of referrals from health checks and primary care to LiveWell Dorset doubled	Primary Care Third sector Pharmacy
Develop a co-ordinated health and wellbeing offer with health and care system	Sophia Callaghan	Jun 18 Ongoing	Workforce plans and training plans complete Delivery of plans	Leading and working differently Secondary care One Acute Network

Ageing Well				
Active Ageing	Rachel Partridge	Apr 18	Increased physical activity in the 55-65 age group (detailed deliverables to be scoped)	Active Dorset Sport England
Transform diabetes pathways	Nicky Cleave	Mar 19	Launch and initial roll out of National Diabetes prevention programme	NHSE CCG Provider
Escape pain	Vicki Fearne	Q1 19	Support to the roll out of Escape Pain programme pan Dorset	Active Dorset Referral process from primary care via LiveWell Arthritis UK HIN
Collaborative Practice	Susan McAdie	Q4 18	Practice health champions recruited and active in GP practices in 3 priority localities	Primary care Altogether Better, CCG social prescribing model, ICPCS
Healthy Places				
Build capacity to address inequalities in access to greenspace	Amy Lloyd	Dec 18	Access enhancement in Bournemouth, Alderney and Poole; PRoW improvements Mapping of green space accessibility Support to delivery of Stepping into Nature project and evaluation of phase 1	 Exeter University
Embed planning for health and wellbeing across spatial planning system	Rachel Partridge	Dec 18 Jun 19	Delivery of process to deal with PHD response to planning applications Proactive process in place to contribute to local plan development and contributions made to latest plans	Planning departments
Improve poor quality housing (Healthy Homes Dorset)	John Bird	Jun 18 Mar 19 Sep 18	Evaluation of phase 1 Ongoing delivery of phase 2 Work with primary care to identify referrals	CSE Primary care

Air quality	Rupert Lloyd	Q2 18	Rescoping of phase 2 following re-engagement with stakeholders	

Appendix 4: Activities and Outputs – Commissioning Intentions

Commissioning & contracting	Link with strategy	Lead	Timescale	Outputs	Dependencies
Drugs and Alcohol service management	Living Well Ageing Well	Will Haydock	Apr 19	Improving engagement rates in Bournemouth and maintaining performance in Dorset and Poole.	Primary care, One Acute Network DCR integration Recovery Hub delivery Reviews of opiates, DSUF, and needle exchange
Sexual Health Service implementation and monitoring	STP	Sophia Callaghan	Apr 18	Dorset wide integrated service delivery in place	Primary care, One Acute Network
Children and Young People Universal services development	Starting Well	Jo Wilson		Extend health Visiting as single service and School Nursing service model for one year and plan to re-tender for April 19.	Dorset Health Care Local Authorities
Smoking Cessation and midwifery pathway	Starting well	Jo Wilson		Extend current contract with 3 hospitals for one year and review	Acute Trusts
Breast feeding support delivery	Starting well	Business support	Apr 19	Extend as a grant and review	Acute Trusts
Health Improvement- Live well Dorset	Living Well	Stuart Burley	Apr 18	Transfer LWD service in house, and mobilise/contract monitor service	Primary care, One Acute Network
Health checks Targeted and core service development	Living Well	Sophia Callaghan	Apr 19	Redesign single Dorset-wide service	Primary care, One Acute Network Third sector
Community providers for EHC, LARC, smoking cessation	Strategic Commissioning	Sophia Callaghan Barbara O'Reilly	Apl 19	Extend one year and plan redesign	Primary Care, Dorset Health Care, Pharmacy

Appendix 5: Enabling services and support

Activity	Lead	Timescale	Outputs
INTERNAL COMMUNICATIONS			
Introduce and maintain an intranet. Weekly summarise SMT & PMT. Populate Calendar. Evolve team profiles and organisation charts on intranet	Amy Taylor	April 2018 onwards	Well used/functioning intranet site
Review Project Place, improve and provide training and support	Clare Hancock	Q4 17 onwards	Consistent use of Project Place across the team ensuring that it supports management and reporting of PAS
Review Wiki in light of the Wall and website developments	Chris Skelly	April 2018	Determine future development of Wiki
Team meetings, prioritise and regularly review format	Sam Crowe, Chris Ricketts	April 2108 onwards	
Organisational values on Intranet	Amy Taylor	Q4 17 onwards	
EXTERNAL COMMUNICATIONS			
Develop new PHD website for contractors and partners	Chris Skelly and Jenni Lages	Q1 2018	
Produce e-newsletters and other comms for partners			
Review Project Place with partners	Clare Hancock	Q1 2018	
Recruit Communications Manager, Officer and LWD Marketing Officer	Chris Ricketts Stuart Burley	Q4 2018	Staff in post.
Develop content for Prevention at Scale area of new ICS website	Chris Ricketts	Q1 2018	
Consider STP/PAS partnership branding			
Shift narrative and digital storytelling through website(s) and social media			
Facilitate specific PAS themed events/workshops	Chris Ricketts, Rachel Partridge	Ongoing	
BUSINESS SUPPORT			

Review business support roles and operating procedures	Barbara O'Reilly	April 19	Future processes to meet business need
Review Contract and Commissioning C&C group function	Sophia Callaghan	April 18	To meet procurement and contract needs
Develop project support offer			
INTELLIGENCE FUNCTION			
JSNA – reengineering of the process with a view to refocussing on identified 'need' before attempting to assess evidence.	Chris Skelly – PM Vicky Ferne – Lead engagement Nat Miles – lead analyst	Ongoing	Monthly updates on dedicated webpage
Locality Support – create and implement a process for providing 'information for action' across localities	Anne Scott – PM and lead analyst	Ongoing	Updating of the Locality webpages as needed
Inequality Evidence – review and revamp of our evidencing of inequality and deprivation to improve our understanding and narrative	Dave Lemon – PM and lead analyst with Anne Scott	June 2018 August 2018 December 2018	Review of lit and analysis of situation Prj Plan for Revamp Revamp Delivered
Si2N Programme Evaluation – co-development of our first large (3+ years) programme evaluation with significant capacity building focus	Vicky Abbott – PM Nat Miles – lead analyst	April 2020	Annual Report
Air Quality client system – this is a 'trending issue' and with technical network being developed we really need to understand what intelligence people think they want	Sara Ireland – PM and lead analyst with Dave Lemon	April 2018 Sept 2018 Oct 2018 Dec 2018 Feb 2019	Project Plan Lit review Client system map Interview analysis AQ client system paper
LiveWell Dorset Analytics – bringing LiveWell in-house has created a need to for taking on and improving the data analytics underlying LiveWell BI	Chris Skelly – Temporary PM Lee Robertson – lead analyst	Ongoing	Data management, data analytics and dashboard development
Commissioning BI – review business needs and redevelop the business intelligence dashboards as required	Lee Robertson – PM and lead analyst	Review – June Redev – Sept Maintain – Ongoing	Produce a review paper. New Dashboard. Data management & data analytics
Primary care payment information – commissioned activity is processed in-house for payment	Darryl Houghton – data manager	1st Week July, Oct, Jan, Apr	Data extracted from data warehouse, QA with Business Support
Population health decision-support – client support for data and evidence requests	Lee Robertson and Dave Lemon – lead analysts	Ongoing April 2018 June 2018 ??? ???	Client deliverables CBA paper CBA reporting Cardiff Model report Capacity building event

Improving shared understanding – client support for data and evidence requests	Nat Miles – PM and lead analyst	Ongoing	Client deliverables Capacity building event
Data Governance – ensuring that we continue to be compliant	Haley Haynes – lead analyst With Jane Horne and Darryl Houghton	Ongoing Oct 2018	Engagement w process Annual compliance review
The Daily Mile Evaluation – creating some local evidence around one of the potentially most scalable child obesity intervention	Cathryn Taylor – PM and lead analyst	June 2018 Sept 2018 December 2018 April 2019	Project Plan & Team Evidence review paper Evaluation frame/plan Evaluation complete

Joint Public Health Board

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

Date of Meeting	June 2018
Officer	Acting Director of Public Health
Subject of Report	**Options for Public Health Dorset – task and finish group**
Executive Summary	Public Health Dorset has existed as a hosted service supporting three upper tier authorities since the legal transfer of responsibility for public health to local authorities in 2013. In March this year, the Ministry of Housing, Communities and Local Government gave a green light to the creation of two new Unitary Councils for Dorset, subject to Parliamentary approval, from April 2019. This paper recommends a short Member-led task and finish group to: i) consider the effectiveness of the Public Health Dorset service to date; ii) consider how Public Health Dorset can continue to best support the two new Councils in discharging their statutory public health responsibilities; iii) provide a report and recommendations back to JPHB in time for the November 2018 meeting.
Impact Assessment:	Equalities Impact Assessment: a screening exercise to determine whether any of the proposed options will be detrimental to groups with protected characteristics will be carried out as part of the task and finish work.
	Use of evidence: Public Health Dorset routinely uses evidence from a range of sources to ensure that the service it provides is effective, efficient and equitable.

	Budget: £28.59m 2018/19 £27.71m 2019/20
	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 The main risk is to ensure a smooth transition during local government reform, and preserve the current level of performance and delivery for public health in Dorset, Bournemouth and Poole.
	Other Implications: As noted in the report
Recommendation	Members of the Joint Public Health Board are asked to note the progress made in establishing a successful public health model to support the Dorset, Bournemouth and Poole upper tier Councils, and agree the terms of reference for the task and finish group set out in the Appendix.
Reason for Recommendation	To ensure that the future Public Health Dorset model is fit for the future needs of local government, post reform, and remains able to support the evolving opportunities to improve population health as part of the Dorset Integrated Care System.
Appendices	Terms of reference for Task and Finish Group.
Background Papers	None.
Report Originator and Contact	Name:Sam Crowe, Acting Director of Public Health Tel: 01305-225884 Email: s.crowe@dorsetcc.gov.uk

2 Background

2.1 In October 2012 the Leaders and Chief Executives of the three upper-tier authorities together with the Chief Executive and the Chairman of the Cluster Primary Care Trust commissioned the local Directors of Public Health to develop options for the transfer of the local public health functions.

The principles agreed to guide this work were that any options for transfer should be tested against a set of clear principles, namely:

- A resilient and cost-efficient service with effective risk management.
- The promotion of coordinated action across all parts of local authorities and the public sector.
- Commissioning programmes efficiently and that respond to need.
- Clear local accountability, particularly in relation to Elected Members and Chief Executives and ownership by other relevant stakeholders (particularly the Clinical Commissioning Group).
- Minimising disruption in the transition process.
- Ensuring appropriate skills and resources are available.

2.2 Other considerations that were factored into the final model included:

- The ability for effective local communication and action;
- The costs for all organisations;
- The capacity to respond in an emergency/threat to public health e.g. influenza pandemic;
- The capability to ensure coverage of all core public health domains while sharing skills and promoting innovation with local partners;
- The ability to support health and wellbeing boards and develop local needs assessments and strategies while promoting the identification of cross organisation or cross geographical issues (system and population issues);
- Being an attractive destination for people wanting to practice public health;
- Recognise the nature of the financial challenge and structural change in the wider public service and ensure as much local resilience as practical during this transition.

2.3 A paper describing the main options was submitted to the relevant committees of all three LAs and the local NHS. All organisations were unanimous in supporting a model with one specialist team hosted by Dorset County Council covering Dorset, Bournemouth and Poole. This would be led by one Director of Public Health reporting to all three LA Chief Executives with

an Assistant Director of Public Health and Head of Public Health Programmes for each Local Authority.

2.4 This arrangement was to be supported by a formal joint governance board to enable clear accountability to each local authority as well as enable the development of effective cross-authority working. This thinking was formalised in the Transition Plan for all three LAs which was submitted to and agreed by the Department of Health in May 2012. An advisory group comprising representatives from all three LAs, district councils, the NHS and the Clinical Commissioning Group was set up to oversee the implementation of this plan.

2.5 The current configuration of Public Health Dorset has served well over the past five years. However, two strategic developments (the Future Dorset proposal to create two new Unitary Authorities, and the wave one Integrated Care System in Dorset), mean that the time is probably right to review the model of delivery, to ensure that the future provision of public health is fit for the two new Unitary Councils.

2.6 A draft set of terms of reference for a time limited task and finish group is included in Appendix 1. In summary, the TORs propose that the scope of the work should be to review the effectiveness of the model to date, generate insight on the future requirements of the new Unitary Councils, and make recommendations on the future leadership structure for the public health team, and role of the Joint Public Health Board in relation to the two Health and Wellbeing Boards.

3 Progress to date

3.1 The following paragraphs set out a high-level progress report of how the Public Health Dorset function has performed against some of the initial principles behind its design.

3.2 **A resilient and cost-efficient service with effective risk management**

- Budgets have been managed well and at all times staffing and running costs have been maintained at less than 8 per cent of overall budget;
- Significant return on investment to all three Local authorities from public health services (see paper on cost-effectiveness of Public Health Dorset spend, 2017).
- Total savings returned amount to around £14.7m. This equates to £3m per annum average, over and above the national 20 per cent reduction in Public Health Grant.

4.3 **The promotion of coordinated action across all parts of local authorities and the public sector**

- Development of the Prevention at Scale Plans within the Integrated Care System; support to both Health and Wellbeing Boards with a common Joint Health and Wellbeing Strategy, aligned with Prevention at Scale.

4.4 **Commissioning programmes efficiently that respond to need**

- Transformation of health improvement services through commissioning of LiveWell Dorset (recurrent annual savings of £0.25m) – 30 per cent of service users from most deprived areas of Dorset, Bournemouth and Poole.
- Re-tendering of drug and alcohol services pan-Dorset, delivering recurrent savings of about £1m per annum, and capping the risk around prescribing costs.
- Transformation of sexual health services from separate community and acute hospital GUM model to integrated, community led service (savings achieved by 2019/20 will equate to £1.5m per annum);

4.5 **Clear local accountability, particularly in relation to Elected Members and Chief Executives, other stakeholders including Dorset CCG**

- Designated Assistant Directors and heads of programmes have maintained ongoing and effective dialogue within LAs but also on behalf of LAs with NHS and other parts of the public service.

4.6 **Minimising disruption in the transition process**.

- The transition was seamless with minimal loss of capability and capacity. All contracts successfully novated to Dorset County Council, with significant progress in reducing the number of unstructured, non-compliant contracts working with procurement. About 95 per cent of contract spend is compliant with contract procedure rules.

4.7 **Ensuring appropriate skills and resources are available**.

- Skills have been retained and enhanced as needed with significant development undertaken by the team over the 5 years so that they are more politically astute, externally and client facing, and ready to work more directly on place-based approaches to prevention through the PAS work.
- External perspective: Widely regarded as the best model for rural/urban mix. Currently Public Health Dorset is the only situation in England where public health exists as a shared service across urban Unitaries and a largely rural County Council.

4 Preparing for the future

4.1 There are several national changes being proposed in addition to LGR that need to be considered in the wider context of future delivery of public health. This includes how the current ring-fenced grant will be paid, emerging tensions nationally about inappropriate use of the grant in some local authority areas, the continued impact of reductions in local Government finances, and increasing expectations around developing preventive services as part of the national Integrated Care System work.

4.2 In Dorset, the public health grant has been well managed to date, with clear criteria established for any savings returned to LAs for re-investment against the grant conditions. However, there are signs that Public Health England will expect greater accountability around delivery of mandated programmes such as NHS Health Checks and sexual health services, and may link this to future grant conditions.

4.3 The concern around inappropriate use of the public health grant in some parts of the country has led to a national consultation on whether there should be increased mandation around the use of the Grant. This risks a loss of flexibility and freedom to deploy spend dependent on local priorities, and is counter to the direction of travel in local government for more local accountability and determination.

4.4 The current Public Health Dorset model has successfully ensured we have retained some highly experienced public health specialists, who are increasingly working across the system to deliver the requirements of the Integrated Care System and Local Government Reform. Any future model should consider how best to retain public health staff at an appropriate level to meet the system population health challenges.

5 Next steps

5.1 To better understand the opportunities ahead presented by Local Government Reform and the Integrated Care System it is proposed that a short task and finish group led by Joint Public Health Board Members consider progress to date against the original principles of transition. It would be helpful for the group also to consider how the model could be revised so that it is fit for the future business of the two new Unitary Councils.

5.2 A draft set of terms of reference for a time limited task and finish group is included in Appendix 1. In summary, the TORs propose that the scope of the work should be to review the effectiveness of the model to date, generate insight on the future requirements of the new Unitary Councils, and make recommendations on the future leadership structure for the public health team, and role of the Joint Public Health Board in relation to the two Health and Wellbeing Boards.

5.3 Members of the Joint Public Health Board are asked to note the progress made in establishing a successful public health model to support the Dorset, Bournemouth and Poole upper tier Councils, and agree the terms of reference for the task and finish group set out in Appendix 1.

Sam Crowe
Acting Director of Public Health

June 2017

Appendix: Terms of reference for task and finish group

The task and finish group will involve the portfolio holders for public health from the current Joint Public Health Board, plus officer representation. This is to be drawn from executive directors of the three Councils, Dorset CCG, and potentially Public Health England South West.

Terms of reference

1 To examine progress made to date in establishing a robust public health model to support Upper Tier Councils in Dorset, and deliver an effective public health function.

2 Assess how far the current model has achieved the original principles, using the criteria set out in the main paper (paragraphs 2.1, 2.2).

3 Generate insight to help inform and agree the proposed leadership model for Public Health Dorset in the context of Local Government Reform in Dorset and the developing Wave One Integrated Care System.

4 Review the political leadership and governance of public health in the local system, including the role and remit of the Joint Public Health Board, Health and Wellbeing Boards, and Joint / Separate Scrutiny.

Inputs

5 Two review meetings between Board members and officers to consider the questions posed under the terms of reference. Findings from these meetings will be used to produce a short report.

Outputs

6 Produce a final report with a clear recommended option for approval by the Joint Public Health Board in November 2018. Recommendations in support of a preferred leadership structure may be required in advance of the final report, to allow sufficient time for restructuring.

Out of scope

7 This task and finish group does not have a remit to look at delivery options for the public health service as a whole, as currently defined by the shared services agreement between Bournemouth, Dorset and Poole Councils.

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Joint Public Health Board

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

Date of Meeting	4 June 2018
Officer	Acting Director of Public Health
Subject of Report	**Director of Public Health Report**
Executive Summary	The Annual Report of the Director of Public Health is an independent report of the DPH on the health of the local population. This year the report has focused on understanding how three localities with challenging health outcomes are working to embed prevention in different ways. The report offers pointers for how the developing locality plans for prevention could improve some of these outcomes, and where the next phase of work should focus.
Impact Assessment:	Equalities Impact Assessment: None – the subject of the report is understanding how inequalities affects outcomes for people living in different communities in Dorset.
	Use of Evidence: This report has been compiled from routinely available public health information and outcomes for the three localities.
	Budget: None specific.
	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: LOW

	Residual Risk LOW
	Other Implications: As noted in the report
Recommendation	**The Board are asked to note the report and continued focus on developing prevention approaches in localities.**
Reason for Recommendation	To help the Joint Public Health Board and Local Authorities fulfil their legal duty to improve the health and wellbeing of the population and reduce inequalities in health.
Appendices	Annual Report of the Director of Public Health 2017
Background Papers	None
Report Originator and Contact	Name: Sam Crowe, Acting Director of Public Health Tel: 01305-225887 Email: s.crowe@dorsetcc.gov.uk

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Annual Report Director of Public Health Dorset 2017

Public Health Dorset

Welcome

Welcome to my report on the population of Dorset for 2017.

The focus of my 2016 report was on the introduction of our prevention strategy “Prevention at Scale”, as part of Dorset’s Sustainability and Transformation Plan. I explained our need for a comprehensive strategy as our current prevention activities were not delivered widely or quickly enough to significantly reduce the amount of preventable disease, early death or disability in our society.

During the past twelve months, we have been working hard with local partners to embed the Prevention at Scale strategy within all our work. I am pleased to report that we have made good progress and many projects are up and running as part of the Sustainability and Transformation Plan.

My report this year focuses on how we make the prevention at scale activities best meet local needs by looking at three areas and how these communities have implemented activities in response to variations in health and wellbeing outcomes. They demonstrate how effective and timely preventative action, including the Prevention at Scale programme, can make a difference.

The three areas are: Weymouth and Portland, Bournemouth East and Poole Bay. These communities have big differences in outcomes and, as mentioned, interesting stories about approaches to prevention within their populations.

By comparing their stories, we see why it is important to have a clear understand of local realities when thinking about what to do, in the context of prevention.

We then look briefly at how the Prevention at Scale programme might best function in these areas to support existing work and get the best mix of activities.

Thank you for reading this, as a member of our local community, you have a vital role in making prevention part of our everyday life. If you would like to discuss your involvement further, please contact Clare Hancock at Public Health Dorset on 01305 224 400 or Clare.hancock@dorsetcc.gov.uk

If you wish to look at more information on these three areas or any other parts of Dorset there is a wealth of information on our website at http://www.publichealthdorset.org.uk/home/intelligence/locality-working

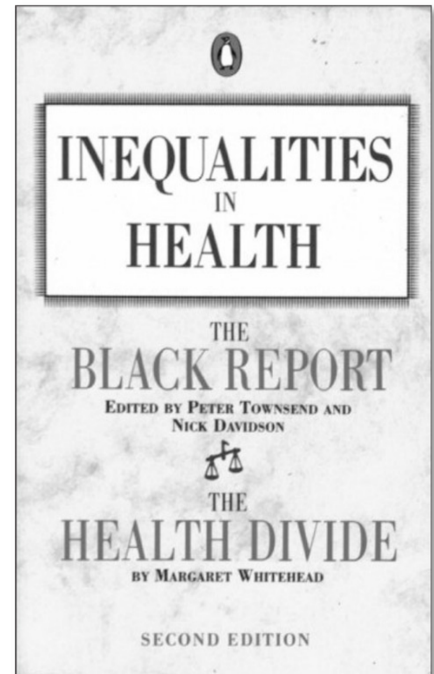
Best wishes

Dr David Phillips
Director of Public Health Dorset

Introduction

Large differences in health outcomes in populations have been recognized for many years, in recent times they were highlighted by the findings in 1980 of the 'Black Report'.

Our understanding of the reasons for this have grown over the years, more recently, in 2010 Sir Michael Marmot looking at the 'cost' of health inequalities in England, in addition to the costs to individuals and families, estimated the wider costs as:

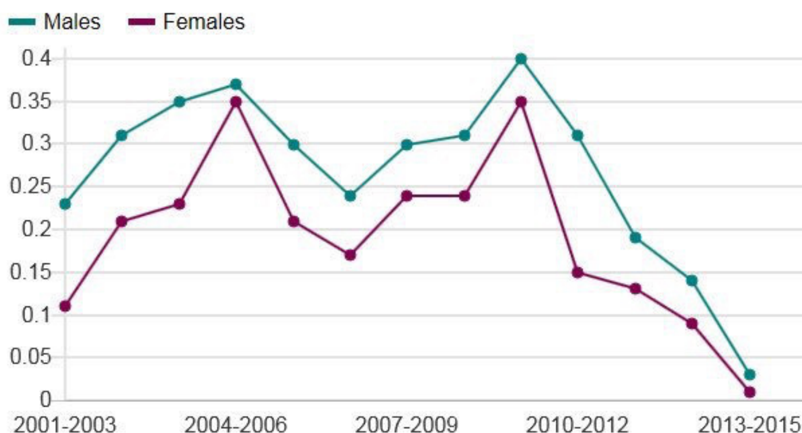


- Productivity losses of £32 billion/year
- Lost taxes and higher welfare payments of £20 – 32 billion/year
- Additional NHS healthcare costs in excess of £5.5 billion/year

He identified a series of six policy objectives to address inequalities:

- Early child development
- Education
- Employment and work conditions
- Minimum income for healthy living
- A sustainable environment
- A social determinants approach to prevention

Despite this knowledge the most recent information suggests differences in many health outcomes are widening in many places and the drops in early death rates and life expectancy that have been the norm for many years are changing rapidly as is shown in the figure below.



Looking at quantity of life, i.e. how long we live, three diseases make a huge difference locally:

- Heart disease,
- Stroke and
- Cancer.

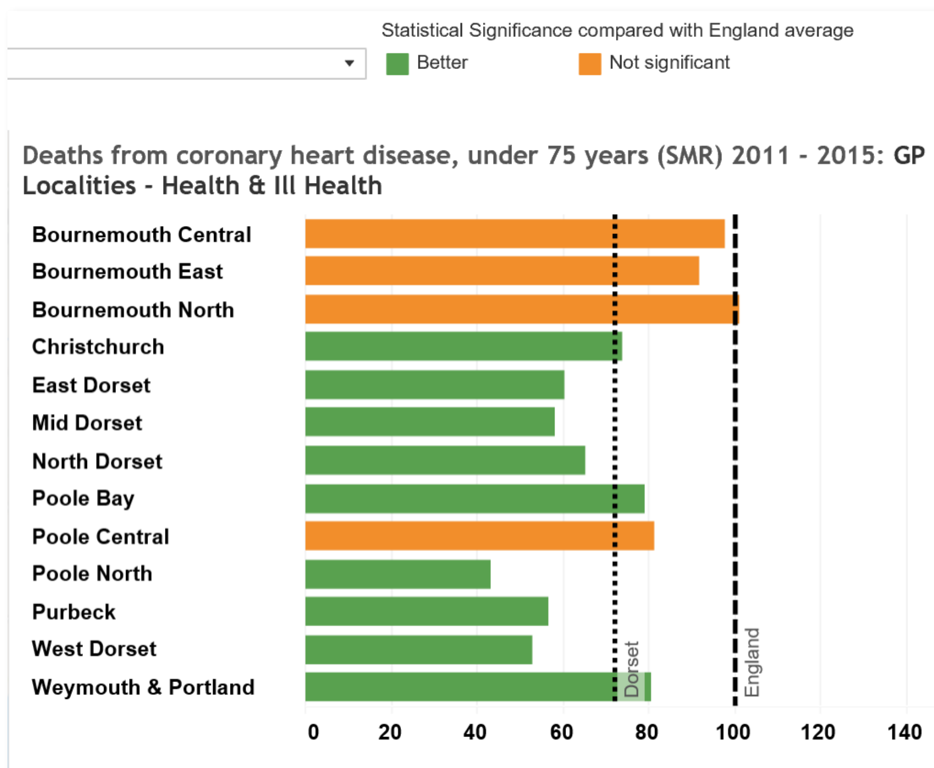
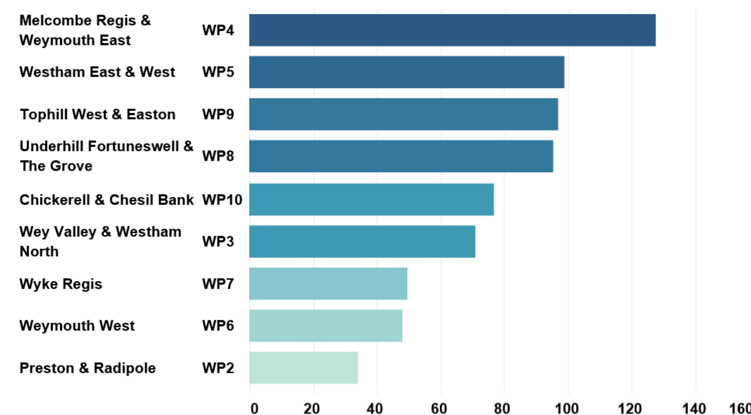


Figure 1. Variation in coronary heart disease across localities in Dorset

Here in Dorset the charts show how early death rates from heart disease vary across our localities in Dorset (Figure 1).

The early death rate from heart disease in Bournemouth North is twice what it is in Poole North, even more striking are the differences within localities – for example in the wards of Preston and Melcombe Regis in Weymouth & Portland locality there is a four times difference in early death rates (see Figure 2, below right).



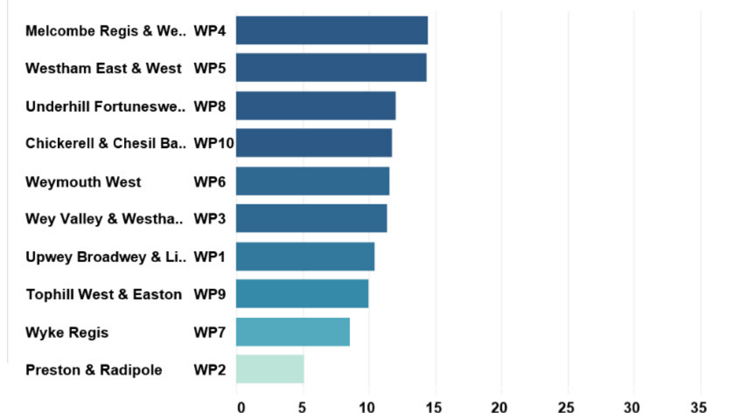


Figure 2. Variation in coronary heart disease within a single locality, compared with childhood obesity

Looking ahead, we know many of the risk factors for people developing heart disease and diabetes start early in life and being overweight in childhood is one of these. The charts on page 5 show how the difference in rates of early death for heart disease in Weymouth and Portland are mirrored in the rates of overweight children. This tells us these differences are going to get worse unless we do something different.

Taking the six objectives from Marmot in the context of our local information and discussion, and translating them into a focus on prevention throughout the life of an individual we would focus on:

- Where we live, work and play.
- How we live.
- Access to advice/services [health, transport etc.]

This is illustrated on page 6 overleaf in the context of preventing heart disease.

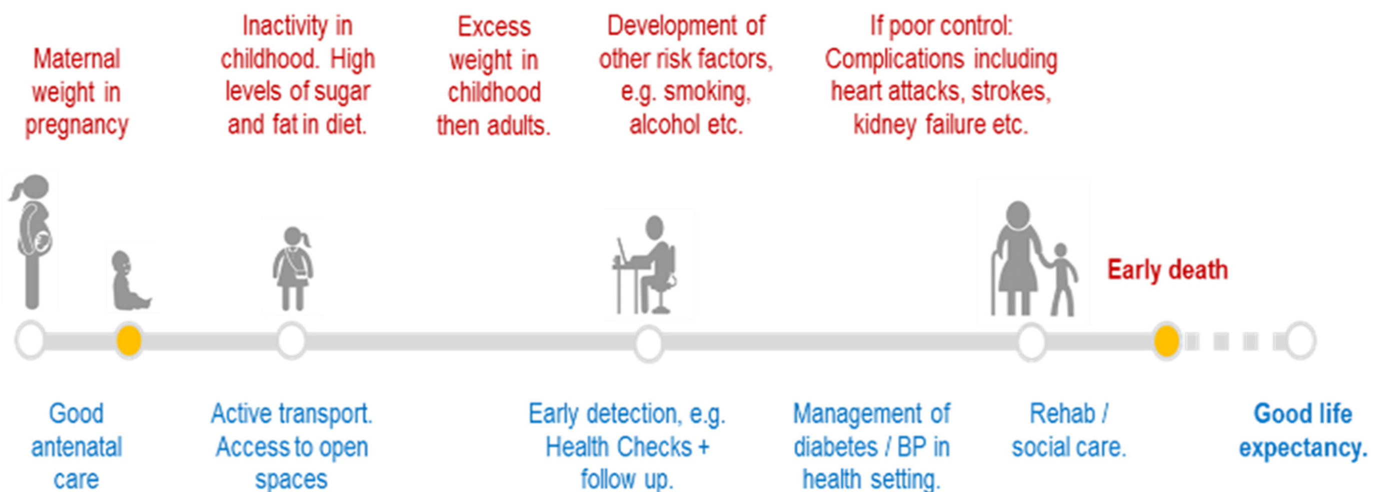


Figure 3. Schematic to show prevention of heart disease across life stages

In terms of quality of life, i.e. how well we live, two conditions make a major contribution:

- Mental health and
- Bone and joint problems, particularly back problems.

As individuals we respond to ill-health in various ways including seeking advice from many places; friends, internet, GPs etc. Some advice we act on, some we don't, the reasons for this vary from individual to individual, as do the reasons for many of our illness, so, when planning prevention be it for an individual or a group of people it is vital to remember one size does not fit all.

Equally, just focusing on the individual and 'how we live' and forgetting the 'where we live and work' can miss opportunities to make a difference for a lot of people.

This report looks at these issues in respect of three different localities, Weymouth and Portland, Bournemouth East and Poole Bay to try and see how different places respond differently and what we might learn from this for future work.

The tables presented with each of the localities link some of the current issues in the locality with projects within the Prevention at Scale workstreams. The final column of each table explores what we might do as part of a wider system view.

Bournemouth East

The Bournemouth East locality has a diverse population, including both poor and wealthy neighborhoods, especially in the east.

The area has a higher proportion of people living with long-term illness or disability. This is reflected in many of the indicators of health (See Table 1 and also on our website referenced earlier) for more detailed information).

Much of the housing in poorer areas is all that is affordable for people with long term ill health, people with addiction and mental health conditions. There is a lot of private rented accommodation, much of it single units in houses of multiple occupancy ("bedsits").

As many of these challenges are complex, the council and partners established a regeneration partnership board in one of the areas of greatest need, to focus efforts to improve housing, education, crime, employment, environment and health.

The Boscombe Commitment document provides further detail on the actions being carried out to improve health and wellbeing in the area.

Since the regeneration partnership began five years ago, the area has seen a considerable fall in very early deaths (occurring under age 65 years). While it is hard to separate out what has directly led to these improvements, a combination of change in housing type and tenure, improvements to schools and the environment, growing the local economy and improving access to health and wellbeing services may all have contributed.

The work to improve housing and the environment will continue to be shaped by the Boscombe and Pokesdown Neighbourhood Plan. This community-led plan ensures that future developments in the area are through a planning framework fit for the area & its people.

The plan aims to tackle overcrowding, poor quality and ramshackle shops, loss of important heritage features in the local buildings, and identify appropriate sites for building affordable housing. Discussions are also underway to identify a suitable site for a health and wellbeing centre, with a view to improving access to services for the local population.

Achievements and approach

- Under 65 deaths have fallen from 500 deaths per 100,000 population to 300
- Our health improvement service has been heavily promoted in the area, with 28% of all referrals now coming from these most deprived areas
- Regeneration has made a big difference in a short time in outcomes for very young children (readiness for school at age 5), which should set them in good store for life
- A playground outside a large primary school was redeveloped to improve the quality of outdoor play space and it is now much busier, and people stay longer

Table 1: East Bournemouth

Prevention at Scale Workstream	Locality-specific challenges	Prevention at Scale Objective	Who could have an influence on these indicators? Could you?
Starting well	High rates of childhood obesity in some areas	Better early years nutrition support Better school nutrition Increasing physical activity	Schools: Mile a day, free school meals, water fountains, sales of soft drinks Health visitors & childrens centres: support & advice to mothers Local authorities: Active transport; Limiting fast food outlets
Living well	High rates of cancer diagnosis	Improving identification of & changing lifestyle risk factors Increasing uptake of national cancer screening programmes	Primary care: Health Checks and cancer screening programmes. LiveWell Dorset: Behaviour change service Voluntary services: Park Run etc
Ageing well	High rates of hip fractures in older people	Preventing Frailty Preventing Falls	NHS: Identifying people at risk early, e.g frail elderly Fire service: ‘safe and well’ programme Active ageing programme Voluntary Sector: ‘Handyman’ and like home support
Healthy Places	Poor quality housing especially for people with long standing ill health Poor access for physical activity	Increasing uptake of measures to reduce cold homes for vulnerable people Improving access to green space	NHS: ‘social prescribing’ Local authorities: warmer homes programme Fire service: ‘safe and well’ programme

Poole Bay

Poole Bay locality is largely urban with a mix of poorer and very affluent neighborhoods. There is a higher than average proportion of older people. Lifestyles and behaviours such as eating habits, smoking and alcohol consumption do vary across the area (see Table 2 and our website).

In the North of the locality, Alderney has the most significant need with 30% of children living in poverty, long-term unemployment & low-income rates are also among the highest in Poole. There is also a large settled Gypsy and Traveller community residing in Bourne Valley.

Much of the housing is rented and a quarter of adults have no formal qualifications. This area has high hospital admission rates for hip fractures, heart attacks and strokes as well as for emergency admissions in the under 5s.

Poole Bay enjoys a good quality environment with heathland and open spaces, but not all communities are aware or have access to such spaces.

Many of these challenges are complex and often linked, so the Council made a commitment to improve outcomes in Bourne Valley, and established a Local Executive Group, which has helped drive improvements in health and wellbeing in the area which have included:

Local schools and children services for those aged 0-5 are working together to help improve skills and reading for parents and children. This has led to successful adult literacy programmes, mental health support for mothers and improved school exam performance, with less school absenteeism.

Other services are working with local shops to help reduce the number of takeaways, improve healthy eating choices in the area & tackling sales of alcohol to young people under 18.

Achievements and approach

- Our health improvement services have been accessible to those most in need with the result that 53% of Poole Bay referrals are from the two areas with the greatest health need
- Last year's exam results for disadvantaged students improved significantly.
- Work on adult literacy has improved not only their own opportunities, but has also improved their children's achievement at school entry
- Engagement with local retailers has shown an impact with sales of alcohol to under 18s having gone down.

Table 2: Poole Bay

Preventionat Scale Workstream	Locality-specific challenges	Prevention at Scale Objective	Who could make a difference? Could you?
Starting well	Some children are not developing as well as others	Ensuring an effective, single early years and school nursing service Building whole school approaches to health and wellbeing	Schools: emotional health & wellbeing programmes, school nursing Health visitors & childrens centres: healthy child programme
Living well	Smoking rates in some areas are particularly high	Ensure health checks reach those who most need them. Ensure suport to people wanting to quit smoking is effective & easy to access	Livewell Dorset: behvavior change service Primary Care:screenign for smoking status & referral LAs: trading standards – unde age sales.
Ageing well	High early death rates from heart disease & cancer	Better mangement of risks, e.g. high blood pressure, diabetes Improve uptake of national screening programmes for cancer	NHS & Public Health England: national awareness campaigns Primary care: better management of risks e.g high blood pressure & active promotion of screening services. Voluntary sector: local awareness campaigns
Healthy Places	Poor quality housing especially for people with long standing ill health Easy access for physical activity	increasing uptake of measures to reduce cold homes for vulnerable people Improving access to green space	NHS: social prescribing Warmer homes programme Voluntary organisations Fire service: 'safe and well' programme

Weymouth and Portland

The population of Weymouth and Portland is relatively diverse and young. It is a popular tourist destination with a striking harbor environment, including beaches and accessible coast paths, cycle networks and urban parks. While the tourism industry is a significant asset for the local economy, with low unemployment levels, a significant proportion of the local employment opportunities are seasonal and relatively low paid (see Table 3 and our website).

There are some areas of Weymouth and Portland that experience significantly high levels of lifestyle risk factors and high levels of limiting long-term illness or disability and early death which are above the England average. Within areas of deprivation there are some important differences in the uptake of preventive actions, e.g. immunization, with lessons for the wider Dorset community.

Similarly, Weymouth has been one of the leaders in the evolution of primary care and has developed a primary care hub at Westhaven hospital. Significant changes to the way the community hospital in Weymouth works makes it easier for local people to access all sorts of hospital diagnostic and treatment services. This has made a real difference to getting quick and early support to people, close to home, and thus avoiding hospital admissions.

Key public services are working closely together to try to support the residents of Weymouth and Portland to improve health and wellbeing, particularly in areas of greatest need. The borough council has been leading a programme of work including community development activity in areas including Littlemoor &Underhill.

In recognition of the particularly complex underlying factors affecting the health outcomes of Melcombe Regis residents, a multiagency board has been set up to improve the area in and around the Weymouth town centre. The board focuses on key issues, such as good quality housing, community development and improvements in the physical environment.

Achievements and approach

- General practitioners in Weymouth & Portland have come together to better use their expertise and community beds to manage people closer to home – the evidence suggests they are successful in this

- Changes to the way services are provided in Weymouth hospital have made a big difference to the ease with which local people can access diagnostic and treatment services

- Practices in Weymouth have been successful in maintaining high levels of coverage of preventive services, e.g. cancer screening, immunization coverage even in populations where levels have traditionally been low.

Table 3: Weymouth and Portland

Prevention at Scale Workstream	Locality-specific challenges	Prevention at Scale Objective	Who can make a difference? Could you?
Starting well	High levels of emergency admissions in young children High rates of smoking in pregnancy some areas	Better early years service Better prevention focus in antenatal services	Midwifes: specific resources for midwives for smoking qutting Health visitors & childrens centres: focus on areas of greatest need
Living well	High rates of many lifestyle factors for heart disease and cancer	Ensure stop smoking support is effective & easy to access Ensure health checks reach those who most need them. Improve takeup of preventive programmes e.g. HPV programme	Primary Care: better management of risks e.g high blood pressure Livewell Dorset: behaviour change servcie Local authorities: trading standards, under age sales of tobacco and alcohol
Ageing well	Very high early death rates from cancer and heart disease	Better identification & management of risks, e.g. high blood pressure, diabetes Improve uptake of national screening programmes for cancer	NHS & Public Health England: national awareness campaigns Primary care: better management of risks e.g high blood pressure & active promotion of screening services. Voluntary sector: local awareness campaigns
Healthy Places	Poor-quality housing especially for people with long standing ill health Easy access for physical activity	increasing uptake of measures to reduce cold homes for vulnerable people Improving access to green space	NHS: social prescribing Warmer homes programme Voluntary organisations: & handyman programmes. Fire service: ‘safe and well’ programme

Final Thoughts

The above three stories show:

- The huge amount of change and potential for positive change that exist within most communities.

- How differing times and issues offer the opportunity for creative solutions be they about how you live, where you live or access to services.

The solutions to problems in health and care in 2017 are very different from those of only 20 years ago and in many ways, they are far more difficult to achieve. As society changes, so too must its organisations and our approaches to health and wellbeing.

Building hospitals and clinics is an important contribution to improving health, but once a disease has become well established in an individual or population, as is the case for many of today's chronic diseases, e.g. diabetes, new buildings and technology alone are not enough.

Preventing these diseases in the first place makes absolute sense in every way, and tackling these issues relies not just on national action (e.g. legislation for smoke free public places), but, as the stories in this report show, how local knowledge and an understanding of people and place, makes a real difference to what you do and how you do it.

Public Health Dorset is committed to support localities on their transformation journey. The locality profiles that have been developed to support this journey are available to view on the Public Health Dorset website www.publichealthdorset.org.uk

Increasingly, we look to work more as a part of wider health and care system, to improve the lives of people living in Dorset. This will need leadership that goes beyond organisations and joins up work across all parts of the public service e.g. police, fire, NHS, local authorities and the private and voluntary sectors. We are all leaders in this endeavor.