Public Health Dorset

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.
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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.