Task and finish group on future of Public Health Dorset – a shared service model for Dorset, Bournemouth and Poole

Findings from interviews with stakeholders

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1. Background

Members of the Joint Public Health Board agreed in July 2018 to run a task and finish group. This was in the context of local government reorganisation (LGR) and the creation of two new Unitary Councils to replace the current arrangements from April 2019. In addition, the area is a first wave Integrated Care System. The project considered how well the shared service model worked over the past five years, and aimed to provide some insight into how it could evolve to best support the new Councils and Integrated Care System.

2. Methodology

The task and finish group agreed the scope of the project and the framework of questions to be used in a series of interviews with 10 key stakeholders. This is attached as appendix 1.

An independent provider, M Maddison Consulting Ltd, was selected to conduct the interviews. The criteria for selection included good knowledge of the local government and NHS system in Dorset, Bournemouth and Poole and previous experience of working in Public Health elsewhere.

The Public Health team compiled a set of briefing information as background and this was sent to all those being interviewed.

Two interviewers conducted 9 semi-structured interviews, 7 by telephone and 2 face-to-face, during September and October 2018. The interviewees were elected members and senior officers representing the three existing upper tier Councils and the Clinical Commissioning Group (CCG).

One potential local government interviewee was contacted through a number of routes but did not respond to requests to take part in the process.

Interviewees were advised that their responses to questions would be written down and summarised, but not recorded, and that these responses would be anonymised in the written report and not attributed to any individual.

This report summarises findings from the interviews. It will be discussed with members of the task and finish group at a moderation meeting on 24th October 2018 and will then be used by the group to report to the Joint Public Health Board (JPHB) in November.

3. Summary of responses

Overall, the majority of interviewees felt that the delivery of Public Health (PH) over the past 5 years as a shared service has been good. PH was regarded as well managed and performed well during a period of significant change and the nationally imposed 20% reduction in budget. PH was felt to have made a positive difference in some areas of major service delivery for which they are responsible. System leadership was demonstrated in the influence on and strong contribution to the Sustainability and Transformation Plan (STP) and the profile of Prevention at Scale. The benefits of the service operating at a pan-Dorset level were emphasised by a significant majority of those interviewed.

The interviews also revealed some areas for future development. All highlighted the importance of PH to the success of the wider business of the Councils and NHS. There was a desire to see a greater emphasis on health and wellbeing throughout corporate plans, decision-making and delivery in the new Councils. Several interviewees consistently raised the importance of PH staff developing the way in which they work with Councillors, enabling elected members to fulfil their leadership roles. Many felt there are opportunities to communicate the work of PH more widely, to ensure all elected

members and senior managers are informed and engaged in supporting PH delivery, and that comprehensive and balanced information for decision-making is provided. Some suggestions were captured about how to address these issues. Communicating more widely with members of the public to raise awareness of the role and scale of PH was also proposed by several interviewees

No interviewees gave comments on the health protection function of the PH service without prompting during the interviews and no examples of this type of work were given. At national level the lines of responsibility between Public Health England and local PH services have not always been clear. However, in the opinion of the interviewers, the responses suggest that local arrangements for health protection could usefully be subject to assurance by the Joint Public Health Board.

4. Positive progress

Eight respondents specifically identified the pan-Dorset shared service as something they valued and that had delivered benefits from its scale of operation. Interviewees highlighted the importance for strategic planning, the ability to play a strong role in the STP, the benefits for some contracts and the benefits for the intelligence function. The positive impact on attracting and retaining professional staff was also noted.

Good progress was also identified in the following areas:

- **Management of the PH Grant.** All the interviewees felt that the PH budget had been managed well. Steady progress has been made on reducing costs and achieving more for less. The use of the grant was described as more focused, coherent and effective than when it first moved to the Councils. Financial reporting to the JPHB was felt to have improved over the past 2 or 3 years, now being clearer, more consistent and easier to follow at Board meetings. This has enabled members to compare budgets, and to agree with or challenge spending more effectively. Some spending in the past was not felt to have been providing value for money, and some outcomes were unclear. However, resources were now felt to be more targeted, spending was allocated differently, tighter controls were in place and PH was more accountable. Interviewees were pleased that priority areas appear to have been protected. Savings appear to have been made without any major problems evident in service delivery, and it was felt that members of the public would not be aware of savings made. Some further savings through LGR and internal restructure were anticipated.

- **Delivery and performance of PH function.** PH was felt to have made a significant and positive difference to some of the services for which they are responsible.

    - **Prevention**

      The majority of interviewees described the importance of the **Prevention at Scale** approach, whilst recognising the challenges of intervening earlier to achieve better outcomes. It was felt to be crucial as a means of delivery in the future, and as an important way of PH being seen to work. The work to embed Prevention at Scale in the STP and at the Health and Wellbeing Boards was commended.

      The Live Well programme was described very positively and seen as a key part of the PH programme for Prevention at Scale. The focus on areas of deprivation was welcomed along with the evidence of take-up of the service by individuals with higher need. One example given was work in Boscombe and the spin-off from Live Well in terms of a focus on men's health. Interviewees were keen to see more data as the service continues to

develop. The changes in arrangements for providing Live Well and bringing it back in-house were viewed positively.

Work in localities was highlighted by some interviewees. Examples were given of the PH team working alongside other colleagues in local communities in relation to early help, substance misuse and links to children's services. A specific example of beneficial work in schools in Poole on children and young people's mental health was given. Other examples included the benefits of PH's engagement in the regeneration work for Boscombe and West Howe.

- **Commissioning**

Commissioning was felt to have improved, being more targeted, evidence based and managed by competent and thorough staff. Some interviewees described the inefficient contractual arrangements the Councils inherited from the preceding NHS organisations and the opportunities that gave for rationalisation, especially in the context of the cuts to the PH grant.

The recommissioning of the **drug and alcohol service** was highlighted as a positive example by several interviewees. The new service was felt to be more targeted and more effective. Governance was felt to have improved as it was more centralised and not in separate places - this has reduced duplication and more members can contribute to debate. Flexibility in reporting was felt to be useful, with members being given separate data, but with the opportunity to request additional information if needed which has enabled better discussion.

Some interviewees cautioned that it was still too early to really know the impact from the changes to the drug and alcohol and sexual health services.

- **Enabling and supporting elected members in their leadership roles.** As noted above this is an area for development. However, experiences varied by Council. The most positive had been where the PH lead met regularly with the Cabinet lead member and was seen as very accessible and responsive. The PH lead was well embedded in the Council's senior team, with other PH colleagues visible in the organisation. The complexity for one set of officers to manage relationships across 3 councils was recognised and a view expressed that this should become easier with the move to the two new Unitaries. Many interviewees gave feedback that the Information provided at the JPHB had improved over the last year - it was identified as being easier to follow and provided a basis for support or challenge.

- **PH leadership across the wider system.** The approach to **Prevention at Scale** is detailed above. This was quoted by many as an example of the way in which PH were making a strong contribution to wider system leadership. The work being done was valued by the CCG. The role of PH in the STP was described as rebuilding the PH presence in the NHS, providing leadership and taking the plans in the right direction.

  The support from PH for **work with GPs in localities** was identified as a good start and an area for further development. The PH team were drawing a range of NHS colleagues in to working with the Councils. An example was given were they facilitated input from NHS staff at leadership sessions for Elected Member (for example from a GP, and a midwife discussing breastfeeding and helping women to stop smoking). This had helped bring PH to life and enabled members see how there is join up between areas.

One interviewee shared a specific personal example of the progress that was being made in general practice. *During a recent visit to the GP for a flu injection, she and her partner were also offered a blood pressure check, and were advised to monitor their blood pressure regularly in future - the GP used the opportunity given by a brief consultation to add value to the discussion and to make the intervention more effective. Both individuals felt they had received extra, relevant and timely advice.*

5. Areas which could be further improved

All the interviewees acknowledged the good progress of the shared PH service and offered views about how it could continue to do even better in the future.

- **Management of the PH Grant.** Some interviewees highlighted that they felt the decision-making about the reductions in the grant had been too managed. They would have welcomed more options in relation to setting priorities and weighting of different services before decision-making about how to apply the reductions.

- **Delivery and performance of PH function**

    - **Prevention**

      There was felt to be need to **improve communication and co-ordination** between the Health and Well Being Board, locality groups, and Family Partnership Zones. Locality groups were sometimes felt to be 'doing their own thing' (for example, teenage mental health was raised as a concern by several locality groups) and it was suggested that some issues could be better addressed at a pan Dorset level.

      More **engagement with schools**. It was acknowledged that work in this area was relatively new, but that there was potential to achieve more, for example, to encourage more pupils to be more active.

    - **Commissioning**

      Linked to the comments above on the wider prioritisation in the use of the PH grant, some interviewees felt that the approach to commissioning could be broadened to include more innovation and service redesign.

      The speed of some of the commissioning work was felt by some to be too slow. One example was the length of time it took to make the changes to sexual health services and another was the loss of some external grant funding linked to the work on drug and alcohol services.

      The challenges associated with **collecting and analysing data**, ensuring data collection systems were consistent and recording outcomes were highlighted. An example was given relating to exercise referrals – data should ideally be able to track source of referrals, any increase in physical activity, whether this is sustained and any longer term outcomes.

      Several commented on the current work on **Health Visiting and School Nursing** suggesting that the re-commissioning was still not yet where it needed to be and

that there had not been enough information in the Board about the impact of the changes.

The commissioning of **Health Checks** was also given as an example of work that had not gone so well, and a question was raised about their effectiveness, and whether their purpose was clear. Ambitious targets had been set for the programme, but it was noted that these should be met by targeting the right people, who could take steps to change less healthy behaviours, which could then make a positive impact on the decision of others (for example parents stopping smoking, which could in turn support children not to smoke). It was noted that there had been an opportunity to give feedback to the PH team about communication problems as part of the changes made and that the feedback had been taken on board.

- **Health protection**

  No interviewees gave comments on the health protection function of the PH service without prompting during the interviews and no examples of this type of work were given. Following prompting some interviewees thought the arrangements worked well. Another commented that the pan-Dorset arrangement for the service was beneficial for the health protection function.

  At national level the lines of responsibility between Public Health England and local PH services for this topic are not always clear. However, in the opinion of the interviewers, the responses suggest that an understanding of the local responsibilities and arrangements for health protection could usefully be subject to assurance by the Joint Public Health Board.

- **Enabling and supporting elected members in their leadership roles**

  This was the area which generated the greatest feedback. Many interviewees commented that elected members could still be supported more to fulfil their leadership roles – whether as cabinet members or in their work in their local communities. The balance between the role of members and officers was not consistent and the PH team need to continue to develop their working style to **ensure PH is member led**.

  Information for elected members. Information provided at the PH Board was felt to have improved but could still be further developed. Members need to be enabled to set the agenda and priorities for work, exploring and grappling with policy choices rather than an emphasis on being given briefings on service change decisions. It was suggested that PH could more fully present both sides of a proposal, rather than offering a protected or restricted viewpoint. Members should be more informed about risks and threats as well as strengths and opportunities, to then be in a position to make more informed and carefully considered decisions.

  Several interviewees felt that elected members, unless directly involved in PH, may have very little idea about the function and scope of PH. Initial **training for new members** was reported to effectively cover safeguarding and other requirements, but could usefully include PH – what it is, what the budget is, expected outcomes, and how PH works in their communities. This could also be refreshed at mid term, for example through a member

engagement forum to provide updated information. It was also suggested that PH officers could be more evident in healthy place shaping meetings.

Some members without expertise in PH could benefit from **simpler language** or better explanation of acronyms and technical information in some reports.

Members involved in **Scrutiny** were perceived to have some knowledge of PH but were not engaged enough to be able to constructively challenge.

- **Communications**

Generally, there was felt to be scope for better communication and messaging with members of the public about what PH do, who they work with and the impact that they can make. Several interviewees felt that there was relatively little understanding about the extent of the PH role, including how it integrates with the whole health and social care system. A concern was expressed about outside influences that were outside the control of PH locally, and that could have significant and often negative consequences. An example given was that some residents (and members) need to be better informed about drug and alcohol problems, and the value of drug and alcohol services. PH needs to continue to develop its profile – to be more visible and ensure residents see the value of its work.

- **PH leadership across the wider system**

The CCG reflected that it was a **challenge for the NHS** when PH moved back to Local Authorities and that a hard-won focus on reducing variation was lost within the NHS in the first few years. However, that ground has been recovered with the current work on the STP.

Several interviewees noted that the **CCG could be more involved** in the shared PH service given that it has a formal responsibility to provide support to the NHS.

Although the approach to Prevention at Scale on a life stages basis ('Starting well' through to 'Ageing Well') was seen as very positive. However, it was suggested that this still needed to be able to identify and add some **local needs issues**, for example the high incidence of falls and surgery for fractured neck of femur.

6. How can PH Dorset most effectively support the future delivery of PH function and services to two new Unitary Authorities and the Integrated Care System?

The JPHB met in September 2018, during the interview process. At this meeting it was agreed to maintain the current arrangements for the Board and shared PH service from April 2019 for one year. The decision acknowledges that it will be for the new Unitaries to then make decisions about the future arrangements for Public Health.

There was strong support for a pan Dorset service – there was felt to be so much that has been positive in the current framework that it would not be good to lose it. Two interviewees commented on concerns about other discussions that were taking place about splitting the service but were not specific about these.

It was felt that existing members need to be provided with as much balanced information as possible (highlighting pros and cons) ahead of the new structures, and with as much flexibility in the system maintained so that the new administrations can decide upon the best model for the future.

PH still needs to make the case for spending in order to convince some other elected members of the value of PH – support is not universal and some members have other priorities (for example, adult social care).

The importance of helping to develop the target **operating models for the new Councils – raising the profile and presence of PH** was highlighted. A number of suggestions for the future were captured through the interviews. These included:

- **Health and Wellbeing in all decision-making**. Interviewees stressed the importance of ensuring health and wellbeing is at the centre of Council activity and corporate planning. Health and wellbeing should be considered in every decision. It was suggested that all policy decisions and service plans should include a PH impact assessment – highlighting and reporting on PH in this way would ensure that it becomes part of corporate policy and could not be ignored. Although it is evident in some areas, and in the thinking of many staff, this would serve to raise the profile of PH across all departments, and would help encourage positive interventions and discourage negative ones.
- **Locality working.** Many interviewees talked about the importance of continuing to develop the PH role to support locality working, being alongside elected members, other Council staff and community groups. Suggestions included identifying link PH staff for localities and keeping a focus through PH to help the GPs develop a 'locality lens' to accelerate work in primary care on population health. PH was described as the glue between localities and the wider Council functions.
- **New member induction.** There is an opportunity to plan now for development support for the Councillors who are newly elected in May 2019.
- **PH involvement in corporate leadership.** The service was still seen by some to be separate and removed from other Council functions, and it was suggested that it should become a more integral part of the Councils. The Councils need to establish **clear reporting for the Director of Public Health** and how the role will be part of two senior management teams. Similarly working arrangements for other PH team members need to be developed in a way that engages with colleagues from other Council departments, building on the best of current practice. **Office arrangements** could be adapted to try and overcome a physical sense of separation. Several interviewees referred to the service as being a bit isolated in Princes House in Dorchester. A suggestion was made about trying to follow the CCG's example of their twin base approach in which neither office is perceived to be an HQ.
- **Communications.** It would be useful to aim for a higher profile for PH communications and ensure they are linked even more to the Councils' corporate communications and the STP. Cabinet leads and local members could be utilised more to front communications and there should be more opportunities created to enable this.
- **Clarifying the roles of the JPHB and the Health and Wellbeing Boards.** A mixture of views were offered by interviewees. Some suggested that the JPHB should be more about governing the PH service with the policy and priority setting for Prevention at Scale sitting with the Health and Wellbeing Boards. A smaller membership was proposed to include the lead cabinet members and the DPH's line managers plus a representative from the CCG. The JPHB under this model would not need to hold meetings in public, helping to reduce bureaucracy, and would be dealing with budget oversight, service performance and the

running of the service for example skill mix and grading. Examples of similar shared service arrangements were given including adult learning, the youth offending team and aspire adoption.

Alternative views were expressed that the current JPHB mixes strategic and executive functions at the same time and that is not a balance that works well. One interviewee suggested that PH should not be treated as a service that is purchased by the Councils and that the DPH role and service function needs to be governed in the same way as other statutory functions and senior officers, through the relationship with the lead cabinet member, cabinet and committee structure including scrutiny and executive line manager in each Council.

Decisions taken to date by the JPHB about the future arrangements for the shared service clearly acknowledge there is more work to do to shape the future governance arrangements for the service, and that options need to be presented to the two new councils for decision.

Some interviewees suggested extending an invitation to the CCG to join the current JPHB meetings.

- **Strengthening profile in Scrutiny.** There is scope to strengthen how PH is scrutinised. It was suggested that both new authorities should have PH scrutiny once a year, and information/briefing sessions at the beginning of term and mid term.
- **System leadership.** PH can continue to build its role as an intermediary and catalyst for work on the wider determinants of health. It was argued that the shared service is well placed to make that happen. One suggested option for the future was that part of the PH service could provide a hub for a shared approach to strategic commissioning when it makes sense to plan on a bigger population footprint, making good use of the information and intelligence skills within the service and recognising the wider system changes in relation to integrated care.
- **Learning from others.** Some interviewees were interested in opportunities to better understand good practice from elsewhere in the country. It was suggested there may be potential to align more with other neighbouring authorities, to share good practice and learn from each other's experiences.

Appendix 1 – Project brief and outline questions for interviews

Purpose

Update Members of the Joint Public Health Board on the remit and scope of the task and finish group, agreed approach, and interview questions

Proposed approach

The following steps will be used to draw out learning from the delivery of the public health service over the past five years, and look ahead to ensure the service is fit for supporting the two new Unitary Councils:

- Briefing information sent to Members (by 6th Sept)
- Interviews scheduled (Sept)
- Moderation meeting (October)
- Report to JPHB (19 November).

The Terms of Reference considered by the Joint Public Health Board in June also included a question about the future leadership and governance of public health, including links with the Health and Wellbeing Boards. It has been agreed that the potential options to help answer this question will be worked up as part of the partnerships workstream under the LGR programme, which is taking place between September and October 2018. We will consider options at the moderation meeting in October. Consequently this topic will not be directly included in the telephone interviews.

Briefing materials

Members will receive three background reports that the Public Health team has prepared, summarising some of the past achievements and progress made since transfer to Councils.

a) The shared service model for Dorset, Poole and Bournemouth
This describes how the shared service was established, and has evolved over the past 5 years. It also offers some comparisons with other models in England.

b) Transforming commissioning and services
How Public Health Dorset working with colleagues across the system have transformed a number of public health services, in meeting the challenge of national reductions to the public health grant. This includes health improvement services, sexual health services, drug and alcohol services, and the proposed changes to public health nursing services planned for 2019.

c) *Public health leadership in the system*
Describes how Public Health Dorset has supported Councils and the NHS to improve health and wellbeing, through Health and Wellbeing Boards, locality working, and the Prevention at Scale programme in the Dorset Integrated Care System. It also describes the role and development of the health protection function across the Dorset system, including the Local Health resilience Forum, Dorset Immunisations Board and the Dorset Health Protection Forum.

d) *Appendix on Resources*
Details of how the Public Health Grant has changed over the past five years, including staffing changes.

Interviews and questions

The Joint Public Health Board agreed that an effective way of gaining a variety of views from Members about the future of public health would be via telephone interview. The proposal is for these to be carried out by Miriam Maddison and a colleague of hers, Lyn Fisher, due to a combination of knowledge about the local system and experience of working in Public Health.

Question	Rationale
1. What is your overall impression of the way that public health has been delivered in the past 5 years as a shared service to Councils in Dorset?	General introductory question, allowing space for Members to comment and add personal reflections to the work.
2. How well has the Public Health Grant been managed in your view? Please consider savings made, investments in prevention, commissioning and service changes.	This is an important statutory responsibility for the service, and Director of Public Health on behalf of the Councils. The Grant has been cut by more than 20% since transition, requiring changes to services.
3. How well do you think that the public health function has performed overall, considering local issues, and the way services are delivered? What factors have influenced your rating? 4. Is enough information given in our board papers to help you judge this?	Level of understanding as to whether the public health function is addressing the right priorities, and amount of scrutiny this receives.
5. How well do you feel the current model has enabled Elected Members to be informed and involved in decision making for public health? 6. Could anything be improved in how we work with Members?	Functioning of the Joint Public Health Board, relations with portfolio holders and other Members
7. How effective do you feel Public Health Dorset has been in providing public health leadership across the system e.g. how we support Councils & NHS partners in various boards, programmes & strategic meetings?	Effectiveness in getting prevention more recognised and embedded in the wider system
9. Is there anything you would like to highlight as particularly successful about the current model of public health delivery?	
10. Is there anything you would like to highlight as requiring improvement about the current model of public health delivery?	
11. How do you think Public Health Dorset can most effectively support the future delivery of the Public health function and services to the two new Unitary Authorities in the future? What could be improved, thinking about the future as we move to two new Unitary Councils?	Thoughts on future leadership in the new Councils, particularly delivering a more visible presence

Sam Crowe

Acting Director of Public Health

August 2018