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Joint Public Health Board

Date:	Monday, 25 November 2019
Time:	10.00 am
Venue:	Committee Room 3, County Hall, Dorchester, DT1 1XJ

Membership: (Quorum 2)
Graham Carr-Jones, Laura Miller, Lesley Dedman and Sandra Moore

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Chief Executive: Matt Prosser, South Walks House, South Walks Road, Dorchester, Dorset DT1 1UZ (Sat Nav DT1 1EE)

For more information about this agenda please telephone Democratic Services on 01305 or David Northover 224175 david.northover@dorsetcouncil.gov.uk

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A G E N D A

Page No.

1 ELECTION OF CHAIRMAN

To elect a Chairman for the meeting from the host Authority.

2 APPOINTMENT OF VICE-CHAIRMAN

To appoint a Vice-Chairman for the meeting from the subsequent host Authority.

3 APOLOGIES

To receive any apologies for absence.

4 DECLARATIONS OF INTEREST

To receive any declarations of interest.

5 MINUTES 5 - 10

To confirm the minutes of the meeting held on 15 July 2019.

6 PUBLIC PARTICIPATION

To receive questions or statements on the business of the committee from town and parish councils and members of the public.

7 FORWARD PLAN 11 - 14

To receive the Forward Plan of the Board and to consider its content.

8 FUTURE OF THE JOINT PUBLIC HEALTH BOARD 15 - 36

To consider a report by the Director of Public Health.

9 NHS HEALTH CHECKS UPDATE 37 - 46

To consider a report by the Director of Public Health.

10 FINANCE UPDATE 47 - 54

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

11 CLINICAL SERVICES PERFORMANCE 55 - 72

To consider a report by the Director of Public Health on performance in respect of:-

- Substance Misuse
- Sexual Health
- Community Health Improvement Services (CHIS)

12 BUSINESS PLAN MONITORING 73 - 78

To consider a report by the Director of Public Health.

13 URGENT ITEMS

To consider any items of business which the Chairman has had prior notification and considers to be urgent pursuant to section 100B (4) b) of the Local Government Act 1972. The reason for the urgency shall be recorded in the minutes.

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Dorset Council

DORSET COUNCIL - JOINT PUBLIC HEALTH BOARD

MINUTES OF MEETING HELD ON MONDAY 15 JULY 2019

Present: Cllrs Graham Carr-Jones, Lesley Dedman and Sandra Moore

Apologies: Cllrs Laura Miller

Also present:

Officers present (for all or part of the meeting):
Dr Sam Crowe (Director of Public Health), Dr Nicky Cleave (Assistant Director of Public Health), Rachel Partridge (Assistant Director of Public Health), Sophia Callaghan (Assistant Director of Public Health), Jan Thurgood (Corporate Director, Adults, BCP Council), Mathew Kendall (Executive Director of People – Adults, Dorset Council), Dr Jane Horne (Consultant in Public Health), Vicki Fearne (Consultant), Sian White (Finance Manager), Clare White (Accountant), Kirsty Hillier (Public Health Communications Manager) and David Northover (Senior Democratic Services Officer).

1. **Election of Chairman**

Resolved
That Councillor Lesley Dedman be elected Chairman for the meeting.

2. **Appointment of Vice-Chairman**

Resolved
That Councillor Graham-Carr Jones be appointed Vice-Chairman for the meeting. On this basis he would assume the Chairmanship at the next meeting.

3. **Apologies**

An apology for absence was received from Councillor Laura Miller (Dorset Council).

4. **Declarations of Interest**

No declarations of disclosable pecuniary interests were made at the meeting.

5. **Public Participation**

There were no statements or questions from Town and Parish Councils at the meeting, nor public statements or questions.

6. **Welcome Presentation**

The Board had a presentation from the Director of Public Health introducing how the public health function was delivered across the two Councils; the role and purpose of the Joint Board, and identifying the areas of work most likely to be brought to the Board over the coming year.

This included the Prevention at Scale programme, and joint working with partners in the Integrated Care system, key commissioning activities for the next year and work with partners in the new Councils.

The Board requested further detail on the public health finaces and how the grant was allocated. This would be shared with the November Board. There was also a request to clarify voting rights of Board members, and to confirm that the Chairman would have a casting vote should the instance arise.

The Board were pleased to have had this opportunity to learn more about Public Health Dorset and in having a clearer understanding of the part they could play in bringing about improved public health outcomes.

7. **2019/20 Business Plan**

The report set out the 2019/20 Business Plan for Public Health Dorset and proposed a regular monitoring approach so that the Board could be assured of progress. The report highlighted the main priorities from the Business Plan, along with some of the risks and issues of delivery. The Board were satisfied with how this was to be managed, noted the Plan and agreed with the approach to monitoring in future meetings.

Resolved
1)That the Business Plan for 2019/20 be considered and approved
2)That the approach to monitoring be endorsed;
3)That the high level summary of the business plan for use with public and partners be noted.

8. **Finance Report**

Finance officers presented the budget monitoring report which presented the final outturn figures for 2018/19 and the opening budget for 2019/20.The Revenue Budget for Public Health Dorset in 2019/20 was £27.704M, based on an indicative Grant Allocation of £32.525M. The report explained how this would be managed in year. The report also included a final outturn figure for 2018/19, which showed a £45k underspend. Public health reserves were now at £1.784M, with £791k being committed to Prevention at Scale.

Board members enquired about the background to how the reserves had built up. Officers explained that this had largely accumulated as contracts had been reduced in value to make the national savings required in the Grant. The

Chairman was pragmatic in her view that if savings were being made, then an underspend appeared inevitable.

Board members were interested in how the cost increases associated with opiate substitution therapy were being managed and what the financial consequences might be of the increase. The Consultant in Public Health leading clinical treatment services explained that this was a national price rise and the services were working to limit the impact in price rises on service delivery. The Board were assured that ways in which this Service could be delivered more cost effectively were being sought as far as practical.

The Board was also interested in understanding how the Grant allocation was being used across both Councils, and whether this was providing value and meeting the needs of the respective populations. The Director of Public Health agreed to develop a presentation for the next Board meeting in November that would explain the finances in greater depth.

Members were largely satisfied with this and with he ways in which the finances were being run and the reasoning for this.

Resolved
The Board noted:
• the 2018/19 outturn;
• the provisional forecast for Public Health Dorset in 2019/20;
• the movement in reserves during 2018/19.

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

9. **Developing commissioning options for sexual health services in Dorset**

The Board was informed that Sexual Health Services in Dorset were currently provided by a consortium of NHS providers. As the two-year contract was due to expire in April 2020, the service required re-tendering under full, open competition in order to comply with Public Contract Regulations. The report summarised local consultation on a preferred model and the approach to be taken; reported on service transformation which had been conducted to date and the way this had been done; and recommended a preferred commissioning option – as set out in paragraph 4.6 of the report.

There was discussion by Board members about the recommendation to proceed with the tender for local authority commissioned elements first, with the option to further integrate NHS England and Dorset CCG commissioned elements of service at a break in the second year of the contract. The proposed contract length was discussed and officers agreed to supply a post meeting note giving the advice of the procurement team on contract length. The Board were satisfied with this approach and what was being proposed as a means to proceed.

Resolved
1) That the recommended option for re-tendering sexual health services - at paragraph 4.6 of the report - be supported and endorsed;
2) That the development of a procurement process and proceeding with an invitation to tender for a new contract, be approved;
3) That delegated authority be given to the Director of Public Health, after consultation with the two Portfolio Holders for Health, to award a contract to an appropriate provider on the best terms achievable and within the budget.

Reason for Decision
The preferred option allowed continued service development, aiming for full integration of the services current commissioned by Public Health Dorset on behalf of Councils. It also allowed for integration with NHS England commissioned sexual health services at a future break point in the proposed contract.

10. **Health Improvement Services Performance Monitoring**

The Board were provided with a report outlining current performance for health improvement services and children and young people's public health services. This included information and a better understanding on performance of LiveWell Dorset, smoking cessation, and what alternatives were available, weight management services, health checks and Children and Young People's Public Health Service (CYPPHS) key performance indicators. The Board acknowledged how improvements were being achieved and what this meant for public health outcomes.

The Board were pleased to see the progress being made with health improvements in these initiatives and saw encouraging signs that these could be maintained. Officers affirmed that Public Health Dorset would remain committed to achieving these improvements going forward.

Resolved
That the progress being made in the performance on health improvement services and children and young people's services be noted and acknowledged.

Reason for Decision
Close monitoring of performance will ensure that health improvement services deliver what is expected of them and that our budget is used to best effect.

11. **Forward Plan**

The Board's Forward Plan was received and discussed and additional items were proposed. This included reviewing the Health Checks programme; considering the future of the Public Health Partnership, based on the findings of the Task and Finish Group; the background to the Public Health Grant and how the Budget was allocated in the way it was and what successes were being derived; and updating on major tenders.

12. **Urgent items**

There were no urgent items for consideration.

13. **Questions from Council Members**

No questions were received from Council Members.

Duration of meeting: 10.00 - 11.40 am

Chairman

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Joint Public Health Board Forward Plan
For the period NOVEMBER 2019 to JULY 2020
(publication date – 25 OCTOBER 2019)

Explanatory Note:
This Forward Plan contains future items to be considered by the Joint Public Health Board. It is published 28 days before the next meeting of the Committee. The plan includes items for the meeting including key decisions. Each item shows if it is 'open' to the public or to be considered in a private part of the meeting.

Definition of Key Decisions
Key decisions are defined in Dorset Council's Constitution as decisions of the Joint Public Health Board which are likely to -

(a) to result in the relevant local authority incurring expenditure which is, or the making of savings which are, significant having regard to the relevant local authority's budget for the service or function to which the decision relates (***Thresholds - £500k***); or
(b) to be significant in terms of its effects on communities living or working in an area comprising two or more wards or electoral divisions in the area of the relevant local authority."

In determining the meaning of *"significant"* for these purposes the Council will have regard to any guidance issued by the Secretary of State in accordance with section 9Q of the Local Government Act 2000 Act. Officers will consult with lead members to determine significance and sensitivity.

Private/Exempt Items for Decision
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 shadow council 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.

Subject / Decision	Decision Maker	Decision Due Date	Consultation	Likely Exemption	Background documents	Member / Officer Contact
Future of Joint Public Health Board	Joint Public Health Board	25 November 2019	Officers and portfolio holders from each member local authority..	N/A	Board report	Sam Crowe
Health Checks Deep Dive	Joint Public Health Board	25 November 2019	Officers and portfolio holders from each member local authority..	N/A	Board report	Sophia Callaghan
Finance report (including return on investment)	Joint Public Health Board	25 November 2019	Officers and portfolio holders from each member local authority..	N/A	Board report & Presentation	Jane Horne, Sian White, Anna Fresolone
Clinical Services Performance Monitoring	Joint Public Health Board	25 November 2019	Officers and portfolio holders from each member local authority..	N/A	Board report	Nicky Cleave, Sophia Callaghan
Business Plan Monitoring	Joint Public Health Board	25 November 2019	Officers and portfolio holders for each member local authority	N/A	Board report	Sam Crowe
Finance report	Joint Public Health Board	3 February 2020	Officers and portfolio holders from each member local authority	N/A	Board report	Jane Horne, Sian White, Anna Fresolone

Subject / Decision	Decision Maker	Decision Due Date	Consultation	Likely Exemption	Background documents	Member / Officer Contact
Health Improvement Services Performance Monitoring	Joint Public Health Board	3 February 2020	Officers and portfolio holders from each member local authority..	N/A	Board report	Sophia Callaghan, Jo Wilson, Stuart Burley
Business Plan Monitoring	Joint Public Health Board	3 February 2020	Officers and portfolio holders for each member local authority	N/A	Board report	
Finance report	Joint Public Health Board	May 2020	Officers and portfolio holders from each member local authority	N/A	Board report	Jane Horne, Sian White, Anna Fresolone
Clinical Services Performance Monitoring	Joint Public Health Board	May 2020	Officers and portfolio holders from each member local authority..	N/A	Board report	Sophia Callaghan, Jo Wilson, Stuart Burley
Business Plan Monitoring	Joint Public Health Board	May 2020	Officers and portfolio holders for each member local authority	N/A	Board report	
Finance report	Joint Public Health Board	July 2020	Officers and portfolio holders from	N/A	Board report	Jane Horne, Sian White, Anna Fresolone

Subject / Decision	Decision Maker	Decision Due Date	Consultation	Likely Exemption	Background documents	Member / Officer Contact
			each member local authority			
Health Improvement Services Performance Monitoring	Joint Public Health Board	July 2020	Officers and portfolio holders from each member local authority..	N/A	Board report	Sophia Callaghan, Jo Wilson, Stuart Burley
Business Plan Monitoring	Joint Public Health Board	July 2020	Officers and portfolio holders for each member local authority	N/A	Board report	

Joint Public Health Board

Public Health Shared Service Model: Supporting Dorset and BCP Councils beyond 2019/20

Date of Meeting: 25 November 2019

Portfolio Holder: Cllr Laura Miller, Dorset Council
Cllr Lesley Dedman, BCP Council

Local Member(s): Cllr

Director: Sam Crowe, Director of Public Health

Executive Summary: This paper has two purposes. To update Members of the Joint Public Health Board on progress against the recommendations of the original task and finish group on the future of Public Health Dorset, to improve the shared service model for Dorset, Bournemouth and Poole, and to ask the Board to consider the future status of the partnership agreement for the shared service.
Equalities Impact Assessment: Not required as no significant change to policy or services
Budget: The Public Health revenue budget for 2019/20 within the partnership agreement is £27.7m.
Risk Assessment: Having considered the risks associated with this decision, the level of risk has been identified as: Current Risk: LOW Residual Risk: LOW
Climate implications: Not applicable
Other Implications: None

Recommendation:

Board members are asked to note the progress in meeting the recommendations made by the previous task and finish group to improve the shared service model.

The Board is asked to support the recommended timeline and process for renewing a decision on the partnership.

Reason for Recommendation:

During local government reorganisation the Public Health partnership was supported for a further minimum 12 months. This is due to expire in spring 2020. Continuing as a partnership will ensure we can provide the Public Health services to both unitary councils and the integrated care system in an efficient, effective and equitable way. To support both new councils in fulfilling their legal duty to improve health and reduce inequalities for their respective populations.

Appendices:

Appendix A – Progress against suggested development proposals from 2018 task and finish group

Appendix B – Task and finish group on future of Public Health Dorset – a shared service model for Dorset, Bournemouth and Poole – Findings from interviews with stakeholders

Background Papers:

Officer Contact:

Name: Sam Crowe
Tel: 01305 225891
Email: sam.crowe@dorsetcouncil.gov.uk

1. Introduction

1.1 Public health services have been provided to Councils under a shared service model ever since transition from the NHS in 2013. During the past 6 years, the service has successfully recommissioned most major public health services, developed an innovative integrated health behaviour change service, and provided systems leadership for prevention and population health management, working with Councils and the developing Integrated Care System.

1.2 Local government reorganisation provided an opportunity to review the partnership and shared service model, in preparation for the creation of 2 new unitary Councils. The Interim Director of Public Health commissioned depth interviews with Joint Public Health Board members to consider the strengths and weaknesses of the shared service model. This made recommendations for improving the service model to the Joint Public Health Board in February 2019.

1.3 Proposals for improvement were broadly in two categories:

- recommendations about how the Board functioned, including updating terms of reference to focus the Board's work more clearly on the shared service;
- developmental proposals designed to increase the effectiveness of integrated public health support to the 2 new unitary Councils and wider system.

1.4 This paper has two purposes. To update Members of the Joint Public Health Board on progress against the recommendations of the original task and finish group. And to ask the Board to consider the future status of the partnership agreement for the shared service.

1.5 During LGR the Board supported a recommendation in November 2018 to continue the shared service arrangement for a minimum of 12 months, in order that the shared service continue beyond the point of creation of the 2 new Unitary Councils in April 2019.

1.6 Since then, both Councils have successfully recruited a new substantive joint Director of Public Health for the shared service. The time now feels right to ask the Board to consider the future of the shared service model, including renewing the shared service agreement.

2. Progress with development proposals

2.1 Public Health Dorset has been working through the recommendations for improvement that were made in the original task and finish group report, as Dorset Council and BCP Council have been created. Table 1, page 3 summarises where progress has been made on these recommendations. The original task and finish group report is included at Appendix A for further background information.

2.2 The immediate recommendations around governance and terms of reference for the board have been completed. The longer-term development proposals relating to how the public health shared service works more effectively with both Councils is evolving, as the Councils evolve and take shape.

2.3 Both Councils recognise the need for a more integrated approach to considering how public health can support the development of new operating models and contribute to transformation in a way that is very different to previous directorate-based models. The Director of Public Health and senior team are involved in transformation work in both Councils – notably through supporting the development of new operating models, sponsoring the One Council service transformation programme, and contributing to work on prevention in reformed front doors for adult social care and children's services.

2.4 Longer term, there is a real opportunity for both Councils to consider how best to improve health and wellbeing through the development of the delivery plans supporting corporate plans. The Local Government Association is supporting Dorset Council in early 2020 with a workshop to look at what a health in all policies approach might mean for the new Council. In BCP Council, discussions are ongoing with Leader and portfolio holder about further support from the LGA.

3. Future of the partnership

3.1 At the July 2019 Board meeting (the first since the two new unitary councils were established), Members agreed to consider taking a decision on the future of the partnership, and it was put on the forward plan.

3.2 The following outline timeline and process is suggested as a way forward for Board members to consider a decision.

Date	Action	Comments
25 November – Joint Public Health Board	Review background and context to the shared service, and progress made against recommendations	Assume that Board wishes to continue the current model, with a chance to make additional recommendations
November / December	Meet with Monitoring officers to review and refresh a draft partnership agreement	Technical refresh of the legal agreement
3 February	Share draft partnership agreement, with recommendation to Board for a continuation of the partnership	Final decision by Joint Public Health Board to renew agreement, including timescales.

Table 2. Proposed process and timeline for refreshing the partnership agreement

4. Summary and recommendations

4.1 Board members are asked to note the progress in meeting the recommendations made by the previous task and finish group to improve the shared service model.

4.2 In addition, the Board is asked to support the recommended timeline and process for renewing a decision on the partnership, as set out in Table 2, page 9.

Sam Crowe

Director of Public Health

November 2019

Appendix A

Progress against suggested development proposals from 2018 task and finish group

Development area	Comments	Proposed actions	Update
Develop how PHD works with Elected Members	Report identified need to work with Members further in advance of Board meetings, and to ensure wider group of Members understand public health	• Continue briefings with Portfolio holders but ensure forward plan is considered and developed jointly • Develop new Member induction content on public health function of Councils	Joint briefings established with Cabinet Members Regular presentation on forward plan and business of the Board in advance of meetings Induction held with Dorset Council, planned for all Members in BCP via Health and Adult Social Care panel
Include assurance on Health Protection function and responsibilities via the JPHB	Should include brief update on issues from Health Protection Network and other strategic fora	• Include health protection on new Member induction, and offer a development session in 2019	Proposal to include Health Protection Network minutes on JPHB forward plan; include key issues in business plan monitoring report.
Greater engagement with schools	Head Teachers Alliance Starting Well work – links with communications actions	• Board paper on work with Schools on forward plan of JPHB – to be developed with Member input	Board to agree timescale for paper on forward plan
Setting the agenda, priorities and business plan, including options and priority setting	Opportunity to tell a clearer story that links finance, outcomes and choices	• Invite Members to join business planning session for 2019/20 – for February Joint Public Health Board	Completed February and July 2019 board meetings had presentations on business plan and year ahead
Improve communications and raise profile of public health work with Members and the public, to help them fulfil their leadership roles	We now have clearer resources for communications, and a strategy	• Refresh comms plan with Member input • Identify public health issues where joint work could improve public understanding and engagement (health checks, drug and alcohol services)	Clear communications plan in place; requires ongoing development with Portfolio holders

Raise profile of public health by participating in scrutiny committees	Needs more consistent approach in the new model across both Councils	• Schedule key public health topics on scrutiny committees of both Councils – minimum once per year	DPH attends both Health and Adult Social Care scrutiny committees and supports development of committee work
Improve integration of public health duty in new operating model for Councils including via a Health in all Policies approach	Need to understand how to do this effectively so that it is not just token, and does not lead to conflicting priorities	• Contact Local Government Association for support via the Sector Led Improvement programme to identify a development partner in a successful authority to work with	Workshop with LGA scheduled for February 2020 with Dorset Council; discussions ongoing with Leader and Corporate Director for Adults about suitable development for Members. DPH and team members involved in development of operating model in both Councils plus lead some transformation work.
Task and finish group recommendations for Governance (by March 2019)			
CCG to join Board as a key partner in the shared service (mandation to provide public health advice to NHS)	There has been irregular and unclear attendance on Joint Public Health Board – should be formalised because of mandated service	• Work with CCG to ensure regular attendance on Board (named director)	Completed February 2019 – named Director regularly attending Board
Clarity over DPH responsibilities and managerial relationships in new Unitaries – including corporate leadership role, line management and relationships with Cabinets	Need to understand how the evolving shared service model can provide clarity over the DPH role, while recognising that it can't work in exactly the same way as a single council service directorate	• Work with Members on a revised model for the partnership that ensures clear links between DPH and both top tier leadership teams and their Cabinets	Initial senior team structures and reporting lines established in both Councils with clear working pattern. Longer term to consider how best to use DPH influence effectively in both Councils
Clarify future operating model for the JPHB, to enable clear separation between strategic health and wellbeing work (Health and Wellbeing Boards) and assurance over public health delivery via the Public Health Grant (shared service model)	This should evolve as work on LGR progresses, and the place of Health and Wellbeing Boards within the governance for the ICS becomes clearer	• Task and finish group to consider different models – executive oversight as per Learning and Skills Board, vs continuing as a public meeting and shared executive	Completed July 2019

Explore making DPH position a joint appointment between 2 Unitaries and the CCG / ICS	In the past, DPH appointments were usually joint between NHS and Councils	• Acting Director to raise this with CCG	Incomplete – recruitment process meant felt personally conflicted in progressing this.

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

Findings from interviews with stakeholders

Miriam Maddison & Lyn Fisher
M Maddison Consulting Ltd
15th October 2018

Appendix B

Task and finish group on future of Public Health Dorset – a shared service model for Dorset, Bournemouth and Poole – Findings from interviews with stakeholders

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?	Functioning of the Joint Public Health Board, relations with portfolio holders and other Members

6. Could anything be improved in how we work with 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

Joint Public Health Board

NHS Health Check programme update

Date of Meeting: 25 November 2019

Portfolio Holder: Cllr Laura Miller, Lead Member for Adult Social Care and Health, Dorset Council
Cllr Lesley Dedman, Lead Member for Adult Social Care and Health, BCP Council

Director: Sam Crowe, Director of Public Health

Executive Summary: This report provides a high-level summary of performance for the NHS Health Checks programme – a nationally mandated public health service. Supporting Data is provided in appendix 1-5.
Equalities Impact Assessment: EQIA Assessments form part of commissioning for all public health services and are published in accordance with Dorset Council guidance.
Budget: Services considered within this paper are covered within the overall Public Health Dorset budget. The NHS Health Check service is commissioned through cost and volume type contractual arrangements under Any Qualified Provider Framework. The annual budget for the service is £0.6m, as agreed by the Joint Public Health Board. None of these contracts currently includes any element of incentive or outcome related payment.
Risk Assessment: Having considered the risks associated with this decision, the level of risk has been identified as: Current Risk: LOW Residual Risk LOW
Climate implications: No direct implications. However, acting on the advice given during an NHS Health Check to be more physically active, and eat a diet rich in fibre with less meat would be beneficial to reducing individual's carbon footprints, particularly if exercise was active travel.
Other Implications: N/A

Recommendation: That the Joint Public Health Board considers the information in this report and notes the improving performance on the NHS Health Check programme.
Reason for Recommendation: Close monitoring of performance will ensure that this programme delivers an important element of cardiovascular disease prevention, in line with national recommendations.
Appendices: Appendix A: Health Checks performance report
Background Papers: None
Officer Contact: Name: Sophia Callaghan — Susan McAdie Tel: 01305 225887 — 01305 224772 Email: Sophia.callaghan@dorsetcouncil.gov.uk — susan.t.mcadie@dorsetcouncil.gov.uk

1 Introduction

1.1 This report provides an overview of the past two quarters performance for the NHS Health Checks programme, a nationally mandated programme that all local authorities must provide.

1.2 The board will also receive regular updates against performance via the 2019/20 Business Plan to monitor progress and improvement.

1.3 This report provides data for the new unitary areas and sub unitary geographies, based on the public health locality geography.

2 Background

2.1 Local Authorities are mandated to provide the NHS Health Check programme under the 2012 Health and Social Care Act. One of the consequences of local authority commissioning of the programme is that the way in which NHS Health Checks are procured is subject to Public Contract Regulations 2015.

2.2 As reported to the Board previously (September 2018) performance for delivery of NHS Health Checks remains variable across Dorset. Performance in terms of number of checks delivered for 2018/19 across the former Council areas for Bournemouth, Poole and Dorset was among the lowest of all local authorities (141, 148 and 133th respectively of 152 Local Authorities).

2.3 In 2016/7 the programme (pan-Dorset) delivered 7,898 checks overall, and in 2017/8 delivered 7,407 checks. To put the numbers into perspective, Public Health England (PHE) had an expectation for the financial year 2016/17 for 46,456 people to be invited, and for 23,228 people to receive a check (similar invitations and checks expected for 2017/8).

2.4 The worsening performance in terms of checks delivered was due in part to the pharmacy providers of NHS Health Checks being unable to access individual level data held by GPs that was previously used to invite people to the programme.

2.5 In September 2018, the Board agreed a new procurement approach, which rolled out from April 2019. The total value of the NHS health check budget for 2019/20 was agreed at £600,000. This will enable up to 15,000 checks to be delivered each year, allowing for additional costs of invitations. While not meeting the national expectation of 23,000 checks delivered annually, achieving this number would be a significant improvement on the current position.

2.6 The procurement model agreed was the ‘Any Qualified Provider’ (AQP) framework, which enables Providers to register themselves for delivery of NHS Health Checks by checking they meet the key criteria as an easy sign up process. The model places the user at the centre of choosing where they wish to access the services-in this case through a website portal that identifies in postcode list form or on a map where Providers are located. The model also provides flexibility in allowing the Provider to come on and off the Framework at any time. New Providers can apply through the life of the contract.

2.7 The Public Health Dorset programme sponsor, GP Champion and locality link officers spent time with appropriate stakeholders (Local Medical Council, Local Pharmacy Council, GPs and CCG localities) during this period to ensure that they were fully informed and consulted through the pre procurement process. Existing Providers under the previous commissioned service were encouraged to re- apply under the new model and potential Providers were encouraged to apply to deliver NHS Health Checks.

2.8 There are currently 75 GP practices and 8 pharmacies signed up to deliver as NHS Health Check Providers across Dorset and a map of coverage is outlined in the appendix 5.

3 Performance for Quarter One and Two 2019/2020

3.1 The results for delivery in the past two quarters are encouraging, after comparing 2018/19 Q1 and Q2 with 2019/20 Q1 and Q2. Overall there has been an increase in uptake by 654 NHS Health Checks with a total of 4,579 reported checks delivered in the first two quarters. However, this remains off track for the annual forecast of 15,000 checks.

3.2 There has been a rise in delivery of checks in the new Bournemouth, Christchurch and Poole Council area compared to last year, with 722 additional NHS Health Checks delivered in this period compared with the previous period in 2018/19.

3.3 The main communication route where people hear about an NHS health check are via invitation letters from GPs with 4,031 people who received a check saying that they heard about it through that route (see Appendix 4).

3.4 There are some areas that are not delivering as many checks as expected, including Bournemouth Central, Bournemouth North, Poole Central and North Dorset. Appendix 3 shows the breakdown of checks delivered by locality.

3.5 Out of the 83 providers signed up to the framework, 49 providers across Dorset have submitted returns for NHS Health Checks delivered. At present, 32 providers (pharmacies) are registered but are not yet delivering any NHS Health Checks.

3.6 The main reasons given are that no people have presented for an NHS Health Check yet, issues with the terms and conditions raised by a large pharmacy chain, time constraints e.g. competing time required in flu season, equipment availability or expense or awaiting training.

3.7 18 of the 32 providers are actively being supported by the PHD Community Provider contract manager, who is working with them to resolve some of their underlying barriers to delivery of the checks.

4 Conclusion and Next Steps

4.1 The early signs are encouraging that under the new any qualified provider framework, we are starting to see consistent increases in the number of NHS Health Checks delivered. This will be supported by ongoing stakeholder engagement, especially in the areas where delivery is below expectations. A communications campaign will continue to raise public awareness of the programme and its benefits.

4.2 Public Health Dorset will keep an improvement focus on areas where delivery remains poor and challenges remain. This will be achieved through:

- More focused and targeted geographical communication and awareness campaigns.
- Effective website management and provider support to ensure all providers advertised are delivering NHS Health Checks.
- Proactively working with the CCG and Primary Care Networks to improve engagement at both strategic and operational levels.

- Further engaging the Dorset CCG Primary Care Commissioning Committee and the network Clinical Directors, encouraging the use of NHS Health Checks and subsequent referrals to LiveWell Dorset to improve positive behaviour change outcomes for users.

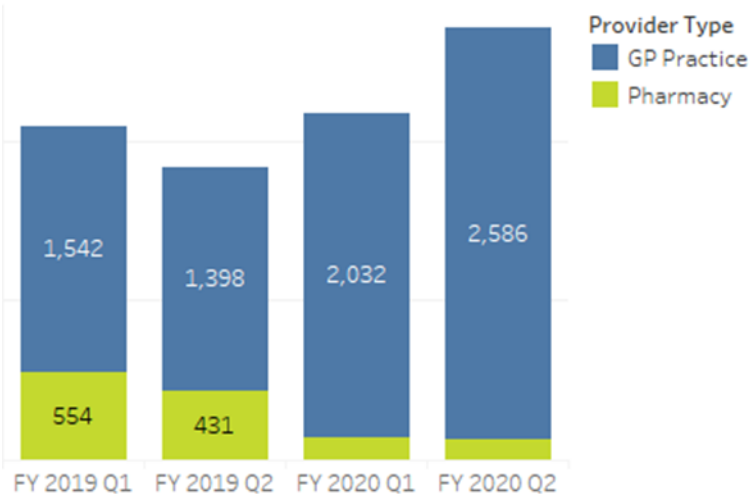
5 Conclusion and recommendation

5.1 The Board is asked to consider the information in this report and to note the improving performance on the NHS Health Check programme.

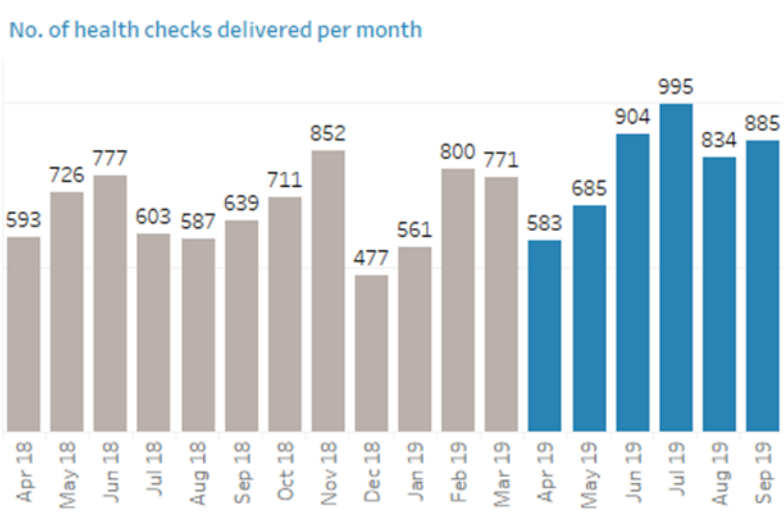
25th November 2019

Appendix One

1. NHS Health Checks Delivery Comparison to Last Year by Provider

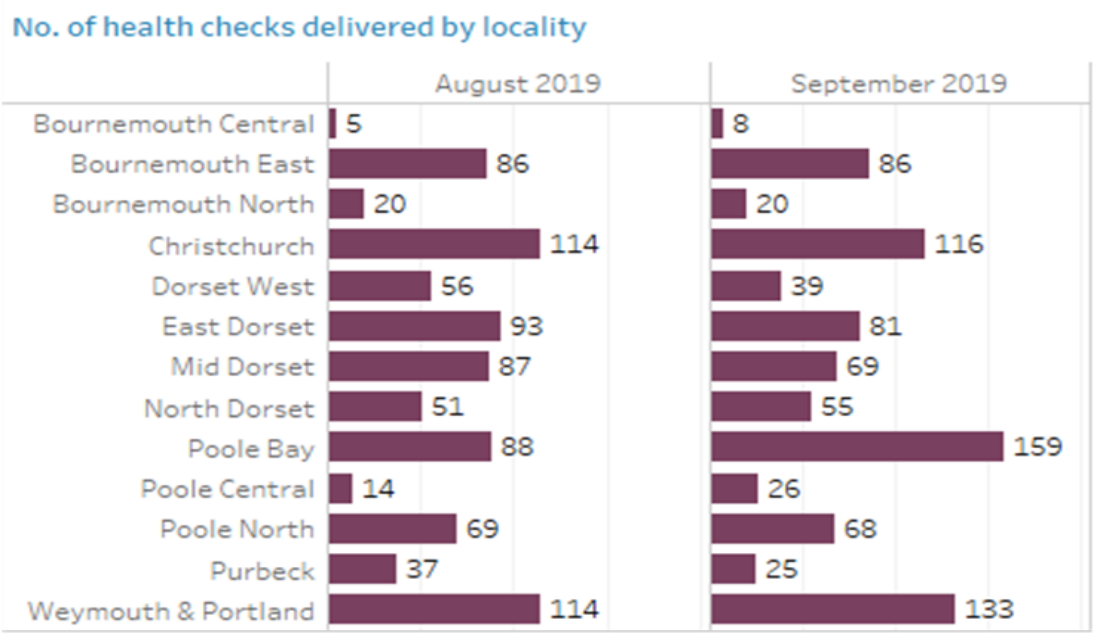


2. Total Number of NHS Health Checks Delivered Per Month

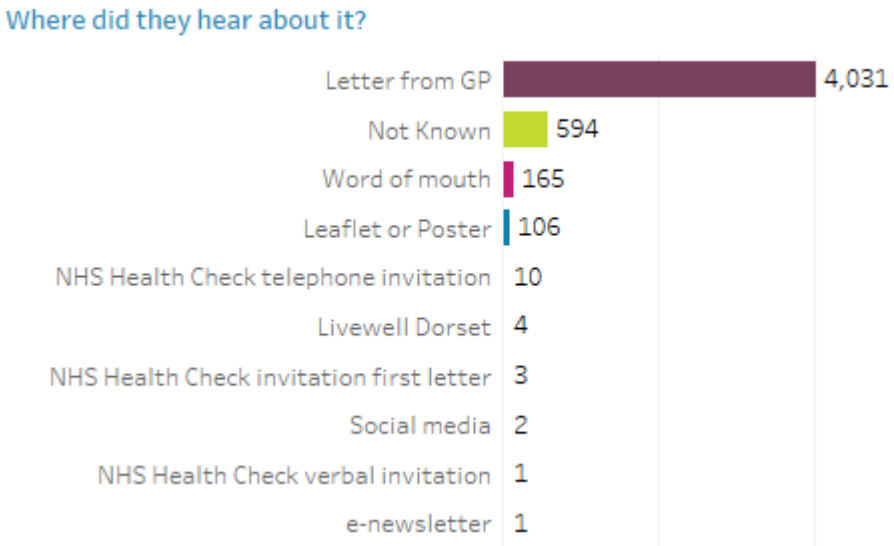


Appendix One

3. Total Number of NHS Health Checks Delivered by Locality

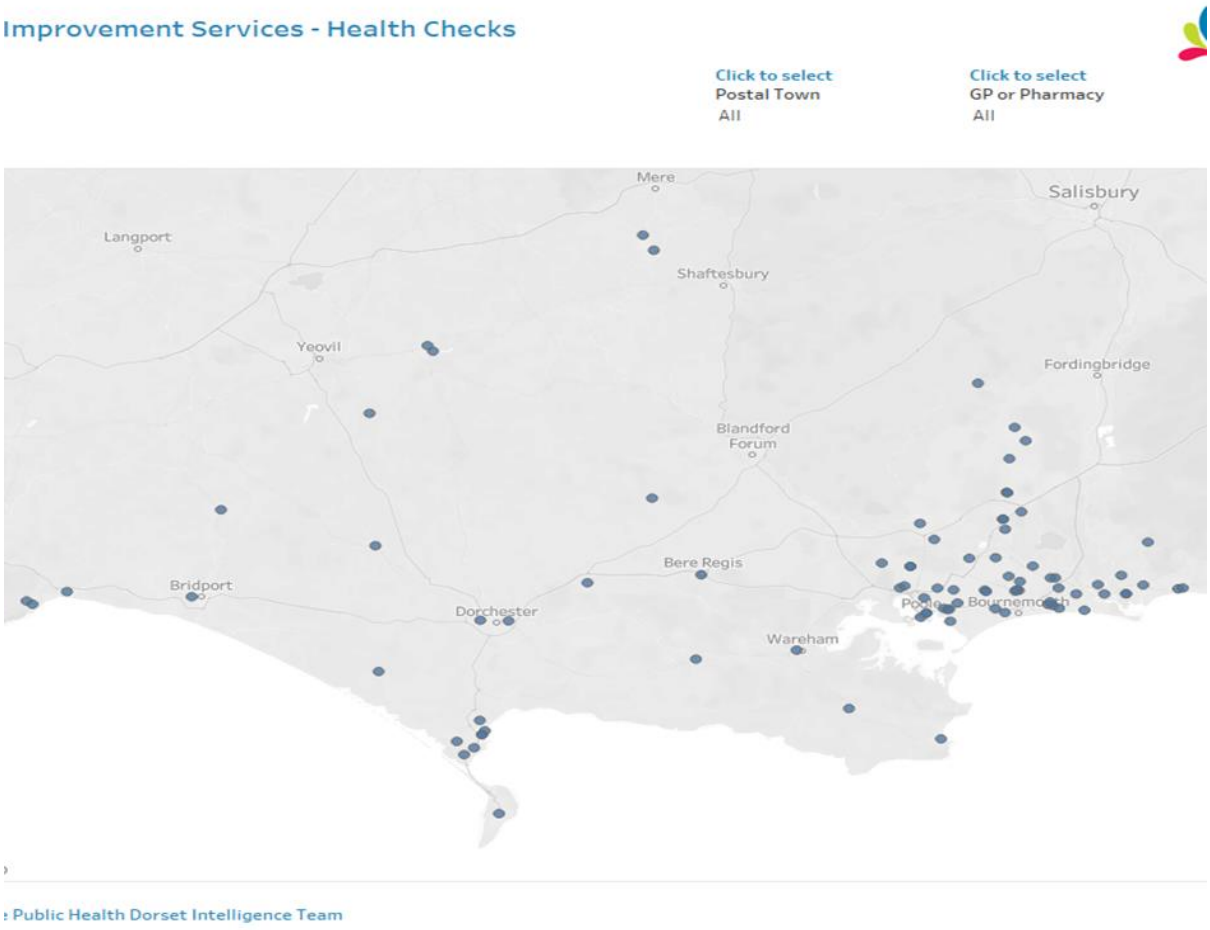


4. Awareness of the availability of the NHS Health Checks across the population of Dorset, Bournemouth, Christchurch and Poole



Appendix One

5. NHS Health Checks Coverage in Dorset, Bournemouth, Christchurch and Poole



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JOINT PUBLIC HEALTH BOARD

Financial Report

Date of Meeting: 25 November 2019

Portfolio Holder: Councillor Laura Miller, Lead Member for Adult Social Care and Health, Dorset Council,
Councillor Lesley Dedman, Lead Member for Adult Social Care and Health, BCP Council

Local Member(s):

Director: Chief Financial Officer and Director of Public Health

Executive Summary:
The revenue budget for Public Health Dorset in 2019/20 opened at £27.705M, based on an indicative Grant Allocation of £32.525M. There has been movement in from reserves and realignment of the retained elements giving a shared service budget of £27.716M.

The report includes forecast outturn for 2019/20, which shows a £351k underspend. Following agreement at last Joint Public Health Board information is also included on the retained elements of the ring-fenced grant.

The Spending Round 2019 announced a real terms increase for public health in 2020/21. It is unclear at this stage whether or how this will be distributed to local authorities. We anticipate further detail in late December/early January, but until then are working in the basis of the same grants and shared service budget as 19/20.

Equalities Impact Assessment:
This is a monitoring report therefore EqIA is not applicable.

Budget:
Failure to manage within the shared service budget would put future delivery by the shared service at risk. As the shared service budget is made up of contributions from each local authority from the public health grant, closely monitored by Public Health England, failure to manage the shared service budget and retained amounts in line with grant also impacts on reserves and general balances of the two local authorities, with knock-on effects for their Medium Term Financial Plans. This report therefore provides assurance as to current shared service budget position and use of elements retained by each local authority.

Risk Assessment: Having considered the risks associated with this decision, the level of risk has been identified as: Current Risk: MEDIUM Residual Risk LOW
Climate implications: None.
Other Implications: See report
Recommendation: The Joint Board is asked to consider the information in this report and to note: • the shared service 19/20 forecast outturn • use of retained elements in each local authority • update on 2020/21 grant allocation • Proposed use of reserves and or underspend in line with prevention at scale and other priorities.
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: Tables for finance report November 2019
Background Papers: Previous finance reports to Board
Officer Contact: Name: Sian White, Finance Manager Tel: 01305 225115 Email: sian.l.white@dorsetcouncil.gov.uk

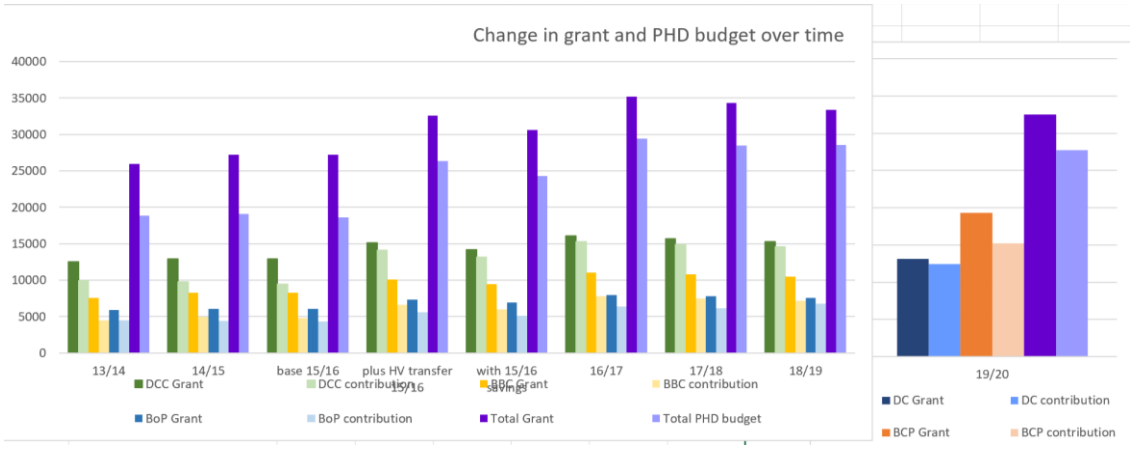
1. Background

1.1 Public Health Dorset (PHD) is a shared service across the two councils. Each council receives a ring-fenced grant for public health from the Department of Health and Social Care (DHSC), of which the majority is passed through to PHD. PHD have also returned significant savings to the previous councils, Borough of Poole, Bournemouth Borough Council, and Dorset County Council. The ring-fence grant conditions apply to the whole public health grant, including retained and returned elements. Retained elements were initially primarily for drug and alcohol services, and the Board previously agreed that returned savings should be used for early intervention and health protection interventions.

1.2 The shared services arrangement was set up in response to the Health and Social Care Act 2012, when significant responsibilities for public health were transferred to local councils from the NHS. Since 2013 PHD have also taken on responsibility for Health Visiting services, which moved to local authorities in October 2015, and additional responsibilities for commissioning drug and alcohol services from each local authority in 2015 and again in 2017.

2. PHD Budget and Forecast Outturn 2019/20

2.1 The opening revenue budget for Public Health Dorset in 2019/20 was £27,705k. This was based on a Grant Allocation of £32,525k, a further reduction in the grant allocation and anticipated retained amounts in line with previous years. The grant allocation, and shared service budget contributions have reduced each year since 2015/16, although this is masked by the changes in commissioning responsibility outlined in 1.2 above.



2.2 There has been movement into the budget (under health improvement) of £108k from Prevention at Scale reserves for a project to test ways to embed smoking cessation services within our drug and alcohol treatment services. This recognises that these patients are more likely to smoke than the general population, but that they may be less likely to engage with our usual services.

2.3 In 2018/19 PHD also gave back planned underspend. Together with the move to new authorities this created confusion in planning for 19/20 as BCP understood this to be part of their retained amount rather than a non-recurrent disbursement. Recognising commitments and cost pressures within the council there has been further discussion and realignment of how the retained element is used, agreement that part of the shared service contribution shortfall will be met through the BCP ring-fenced public health reserve, and the remaining shortfall either absorbed through underspend, or if required managed through PHD reserves for this year.

2.4 Together this means we now have a budget of £27.716M. Within the different budgets there has been a shift with the BCP shortfall being picked up on our team budget creating an apparent overspend here.

2.5 The current forecast shows a predicted underspend of £351k. Detail of the forecast is set out in Appendix 1, table 1. This is based on the following assumptions/issues:

- Health Checks forecast is based on Q1 data with small uplift each following quarter. Depending on Q2 figures and impact of communications campaign this could rise more significantly.
- For other health improvement cost and volume contracts forecasts have been modelled on a combination of Q1 data and previous year activity. We will continue to monitor whether the change to AQP has had significant impact as Q2 data is submitted.
- Change from voucher system to activity based payment in community weight management services that means better alignment of costs with activity.
- Changes in smoking models that have generated some savings.
- Inpatient detoxification activity is forecast to continue at current levels. We have seen significant volatility within this area in the last year, so this could change.
- Additional prescribing and dispensing costs within drug and alcohol treatment services are included in forecast. This relates to the cost of buprenorphine (used for opiate substitution therapy) which increased nine-fold during 2018/19, increased numbers of patients within the system, particularly in Bournemouth, and improved understanding of dispensing costs.
- Reduced prescribing costs of long-acting reversible contraception (LARC), following further shift in new models of supply.

3. Retained Bournemouth, Christchurch and Poole council grant

3.1 BCP council receives a ring-fenced public health grant of £19.353M. Most of this contributes to the shared service, however £4.355M will be retained for use within the council in 2019/20, compared to previously reported £4,203M. The public health conditions apply equally to the whole grant.

3.2 Within BCP council this is set against the following budget areas in the medium-term financial plan:

- Drugs and alcohol services for adults and children (£1.829M). This spend is predominantly within the previous Bournemouth Borough Council area, as PHD currently has responsibility for all of the Christchurch drugs and alcohol services and the majority of those in Poole. There are cost pressures within this area currently.
- Children's centres (£2.474M) and early intervention around 'adolescent risk' agenda (£20k). The Family Support and Early Help Strategy is due to be discussed at BCP Cabinet on 11 December, which will inform future plans in this area. Currently forecast to spend in full in 19/20.

- The Christchurch retained element of £32k is used for £20k Childrens' services and £12k Community Safety.

4. Retained Dorset Council ring-fenced grant.

4.1 Dorset Council receives a ring-fenced public health grant of £13.172M. Most of this contributes to the shared service, however £617k is retained for use within the council. The public health ring-fenced conditions apply equally to the whole grant.

4.2 Within Dorset Council this is set against the following budget areas:

- Community safety (£150k). This supports the Dorset Council Community Safety team, including some of the work that they deliver on behalf of both councils.
- Community development work (£353k). Previously the POPPs service, this supports community development workers across Dorset with building community capacity, but also has a specific focus on supporting vulnerable individuals who have suffered from or are at risk of financial scams.
- Children's early intervention (£114k). This includes work through HomeStart.

5. Reserve position and PAS plans

5.1 The current reserve included £791k committed to PAS as at 31 March 2019. Part of the 19/20 business planning was consideration of how we use this part of the reserve. These plans are already reflected within forecasts and movement out of the reserve. We therefore still have £617k committed to PAS within the reserve.

5.2 As we review the business plan and begin to look ahead to 20/21 the following principles for use of the PAS reserve are being considered:

- Ensuring completion/sustainability of current projects beyond non-recurrent funding
- Invest to save projects such as proposed investments in tobacco control for vulnerable groups, including e-cigarettes (£180k)
- Further enhancements to the digital LiveWell Dorset offer that can increase reach and the number supported – (£150k)
- Emerging priorities for public health support in both Councils in-year – for example, supporting the suicide prevention work – (£50k).

5.3 Good practice would suggest that the shared service maintains reserves for earmarked purposes (as per the PAS commitments), with £0.5M to provide in-year contingency to cover unforeseen costs if required, recognising that these are ring-fenced reserves. Use of the remaining uncommitted £437k in reserves should therefore also be considered.

6. 20/21 position

6.1 The Spending Round 2019 announced a real-terms increase to the Public Health Grant budget, which will ensure local authorities can continue to provide prevention and public health interventions.

6.2 No further details are available at this stage, and we expect that the general election on 12 December will mean further delay, with budget details unlikely before January.

6.3 Once detail is available, as part of planning for next year, there will be further discussion on the retained BCP element to ensure clarity at the start of the year.

7. Conclusion

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

- the shared service 19/20 forecast outturn
- use of retained elements in each local authority
- update on 2020/21 grant allocation.

4.2 The Joint Public Health Board is also asked to agree the proposed use of reserves allocated to Prevention at Scale under paragraph 5.2.

Appendix 1. Tables for finance report November 2019

Table 1. 19/20 Forecast Outturn

2018/19	Budget 2019-20	Outturn 2019-2020	Over/underspend 2019/20
Public Health Function			
Clinical Treatment Services	£11,208,000	£11,206,932	£1,068
Early Intervention 0-19	£11,104,000	£11,074,915	£29,085
Health Improvement	£2,771,000	£2,169,569	£601,431
Health Protection	£57,000	£23,380	£33,620
Public Health Intelligence	£147,800	£154,034	-£6,234
Resilience and Inequalities	£190,300	£415,488	-£225,188
Public Health Team	£2,238,200	£2,320,799	-£82,599
Total	**£27,716,300**	**£27,365,117**	**£351,183**

Table 2. 2019/20 partner contributions

	BCP	Dorset	Total
2019/20 Grant Allocation	£19,353,000	£13,172,000	£32,525,000
Less retained amounts	-£4,355,300	-£617,400	-£4,972,700
Use of BCP PH ring-fenced reserve	56,000		56,000
Joint Service Budget Partner Contributions	£15,053,700	£12,554,600	£27,608,300
Transfer from PHD reserve for PAS			£108,000
Provisional Budget 2019/20			**£27,716,300**

Table 3. Public Health reserve

Public Health Reserve	£
Opening balance 1/4/2019	1,784,000
PH Dorset commitment to STP/PAS costs	791,000
STP/PAS transfer from reserves – Healthy Homes	-66,000
STP/PAS transfer from reserves – Smoking transfer	-108,000
Balance of PH Dorset commitment to STP/PAS costs	617,000
Balance uncommitted in reserve	**993,000**

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JOINT PUBLIC HEALTH BOARD

Clinical Treatment Services Performance Monitoring

Date of Meeting: 25 November 2019

Portfolio Holder: Councillor Laura Miller, Lead Member for Adult Social Care and Health, Dorset Council,
Councillor Lesley Dedman, Lead Member for Adult Social Care and Health, BCP Council

Local Member(s):

Director: Director of Public Health

Executive Summary: This report provides a high-level summary of performance for drugs and alcohol and sexual health services, with supporting data in appendices. A report on clinical treatment services performance is considered every other meeting.
Equalities Impact Assessment: This is a performance report therefore EqIA is not applicable. Equality impact assessments are considered as part of the commissioning of our clinical treatment services.
Budget: Services considered within this paper are covered within the overall Public Health Dorset budget. Most of the Clinical Treatment Services are commissioned through block contract arrangements, with some elements commissioned on a cost and volume basis. None of these contracts currently includes any element of incentive or outcome related payment, however good performance will ensure that we achieve maximum value from these contracts.
Risk Assessment: Having considered the risks associated with this decision, the level of risk has been identified as: Current Risk: LOW Residual Risk LOW
Climate implications: There are no climate change implications arising directly as a result of this report.

Other Implications: See report
Recommendation: The Joint Board is asked to consider the information in this report and to note the performance in relation to drugs and alcohol, and sexual health.
Reason for Recommendation: Close monitoring of performance will ensure that clinical treatment services deliver what is expected of them and that our budget is used to best effect.
Appendix 1: Drug and Alcohol Performance Report Appendix 2: Sexual Health Scorecard Appendix 3: Community Health Improvement Services Report
Background Papers: Previous performance reports to Board
Officer Contact: Name: Nicky Cleave and Sophia Callaghan Tel: 01305 224400 Email: nicky.cleave@dorsetcouncil.gov.uk and sophia.callaghan@dorsetcouncil.gov.uk

1. Background

1.1 The Joint Public Health Board reviews performance of commissioned services on a six-monthly basis. This report focuses on our core treatment services for drugs and alcohol and for sexual health and associated services commissioned from pharmacies through.

1.2 Alongside this the Board also receives regular updates against the Public Health Dorset Business Plan to monitor progress against agreed deliverables.

2. Drugs and Alcohol

2.1 Many different organisations are responsible for commissioning and providing different elements of substance misuse services:

- Public Health Dorset commissions all services for adults and young people in Dorset Council. For Bournemouth, Christchurch and Poole, it commissions the prescribing service and all psychosocial services and services for young people other than in the former Bournemouth unitary area;

- BCP Council continues to commission the psychosocial service and services for young people in Bournemouth;
- Poole Hospital offers a well-developed alcohol liaison service and an assertive outreach service for those unwilling or unable to access mainstream community treatment, as part of their efforts to reduce unnecessary admissions/attendance at the hospital; our other hospitals are developing a similar approach;
- Other partners provide additional resources to support people who have less complex issues with alcohol or drugs locally, including primary care and LiveWell Dorset; or have related issues such as housing needs etc.

2.2 The recommissioning exercise undertaken during 2017 for community-based treatment services delivered a saving of £0.9M (from £5.8M to £4.98M) to the Public Health Dorset budget, as well as savings elsewhere in local authority budgets (e.g. social care). This, combined with previous savings delivered on the substance misuse budget, has increased pressures within the treatment system, some of which are now being seen in performance and budgets.

2.3 Detail on latest performance is available in appendix 1 and 3. This has identified some key issues:

- There has been a welcome increase in the number of people engaged in treatment. This has been a priority in the Bournemouth area where numbers engaged had been declining. However, the increased numbers have put additional pressure on services.
- Drug-related deaths (generally overdoses from opiates such as heroin) have been rising over the past seven years. Services have improved performance in the number of naloxone kits given to service users at risk.
- There is considerable fluctuation in successful completion rates. The latest performance within the new unitary council geographies shows rates that are comparable in Dorset and BCP for opiate clients, although this is slightly lower than the national average. For alcohol the rates in BCP are higher than those in Dorset and the national average.
- There was a sustained increase in supervised consumption activity in the first five months of 2019/20 although there are some signs that this is reaching a plateau. This increase is likely to reflect the new clients presenting for treatment for opiate dependence, leading to higher overall numbers in treatment, with those early in treatment more likely to require supervision. Activity is being carefully monitored by commissioners to assess impact on the budget.

2.4 In the last year there has been a focus on improving the wider health needs of those in treatment:

- Not all service users who could benefit from interventions to vaccinate against or treat blood borne viruses are receiving these. NHS England has made the elimination of hepatitis C a priority and commissioners are working closely with NHS services locally to increase access to treatment for hepatitis C positive clients;

- Service users in drug and alcohol treatment services are more likely to die of diseases not directly related to drugs including COPD – and much earlier than the general population. A smoking cessation offer has now been implemented as a pilot in the substance misuse service in Poole as part of a phased implementation across the county. Service providers are stocking supplies of nicotine replacement therapy and have been trained to provide this to service users alongside their normal treatment offer.

3. Sexual Health

3.1 Sexual health services are one of the programmes that local authorities are mandated to provide under the 2012 Health and Social Care Act. Public Health Dorset Commissions sexual health and reproductive services on behalf of Dorset and BCP Councils, which includes:

- Contraceptive services (including prescribing costs);
- Young people's sexual health;
- HIV prevention, sexual health promotion, services in educational settings and pharmacies;
- Sexually transmitted infections (STI) testing and treatment at Genitourinary medicine (GUM) clinics;
- Chlamydia screening and HIV testing.

3.2 Following support from the Board in 2018 progress with service integration continues with ongoing joint working and integrated service development over the last six months. The current service contract is due to end in March 2020 and a procurement process is in development to invite providers to bid via open competitive tender. This is now scheduled for mid-December following purdah.

3.3 The agreed contract envelope has reduced from £6M in 17/18 to £5.6M in 19/20 and a further reduction to £4.8M in 2020/21.

3.4 Detail on latest performance for sexual health is included in Appendices 1 and 3 and has identified some key findings.

3.5 All new sexually transmitted infections (excluding Chlamydia) per 100,000 population aged 15 to 64 years are lower than England average in Bournemouth, Christchurch and Poole, and lower in Dorset. A longer-term trend shows a peak during 2014/5 in Bournemouth, Christchurch and Poole and a fall during 2016 but relatively static overall since 2012.

3.6 However, rates of infection with gonorrhoea have increased since 2016 in the BCP Council area, and also Dorset, but remain lower than the England average.

3.7 Nationally rates of syphilis diagnoses have been steadily rising. Rates in BCP Council have risen from 2017 (following a decline since 2014) and are now

above the rate for England. There has been a recent syphilis outbreak across the South West, which is being managed by Public Health England.

3.8 The prevalence rate for HIV in BCP Council is higher than the rate for England. This is related to a higher prevalence of the infection in some core groups such as men who have sex with men (MSMs), injecting drug users, and sex workers.

3.9 Nationally conception rates have fallen over time in the BCP Council area, remaining slightly above the rate for England, while the rate in Dorset Council is below the England rate.

3.10 There has been an increase in access to Emergency Hormonal Contraception (EHC) with 120 sites delivering the service. There have been a relatively consistent number of monthly consultations, largely in areas of higher need such as in Bournemouth, Poole and Weymouth and Portland.

3.11 Long—acting reversible contraception access is similar to last year and also shows delivery in areas of higher need.

3.12 One key contract management issue that has emerged this year are a high number of people turned away from same-day appointments. The challenge with a complex appointment system with people of varying needs is that there are only so many appointments per day, which quickly become booked up. Many people turned away successfully access services within 48 hours.

3.13 The challenge with this system is to ensure that vulnerable people are seen the same day. Further investigation into some of the mitigating actions the provider has put into place will help to ensure same day appointments are offered to those most in need. The following steps are being re-inforced with providers:

- Ensuring referral pathways are in place for vulnerable patients at high risk – teenage pregnancies, paediatric inpatients, psychiatric inpatients, sexual assault;
- Prioritising appointments for people referred by outreach services i.e. Dorset Working Women's Project, Sexual Assault Referral Centre, social services, people with learning disability;
- The new online booking system with triage will identify under 18s and MSMs and allocate a suitable appointment for them;
- A one stop shop is being developed for under 18s in the east, as is available in the west of the county.
- Where vulnerable people are assisted by relevant agencies, same day access is improved, so having strong partner links and clear, accessible website information is important.
- Once someone is identified as vulnerable either in person or via the phone, they will not be turned away without an appropriate appointment.

3.14 In the last year there has been a focus on improving the wider health needs as part of contract management and case study submissions show more in-depth accounts of services working with health and social care, safeguarding or housing services to support vulnerable people.

4. Conclusion

4.1 This paper provides a high-level summary in narrative form. Appendices include supporting data and information, with more in-depth information available on request.

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

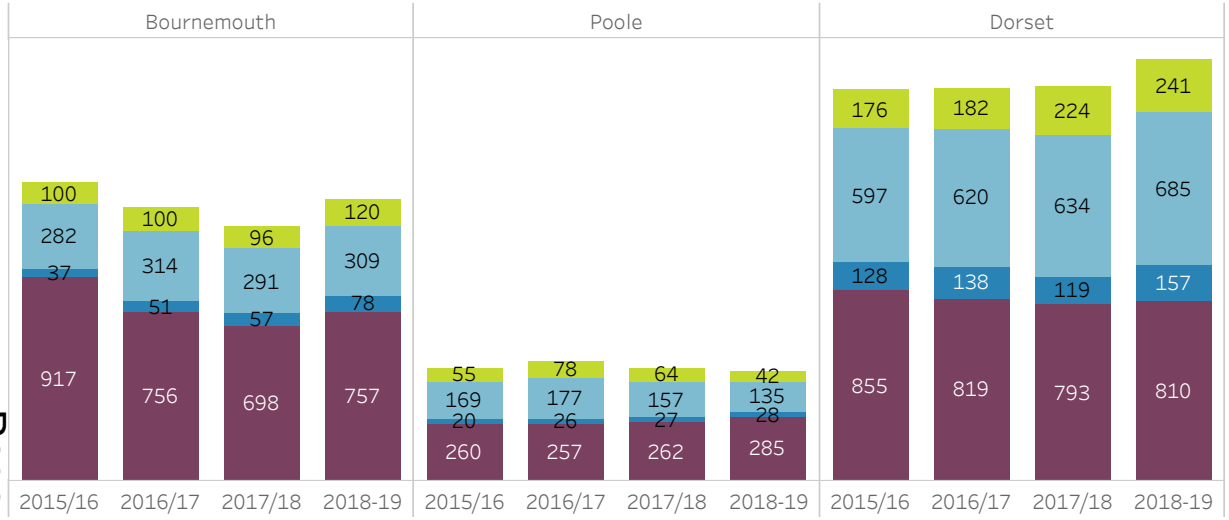
- Note performance in relation to drugs and alcohol; and
- Note performance in relation to sexual health.

Sam Crowe
Director of Public Health
November 2019

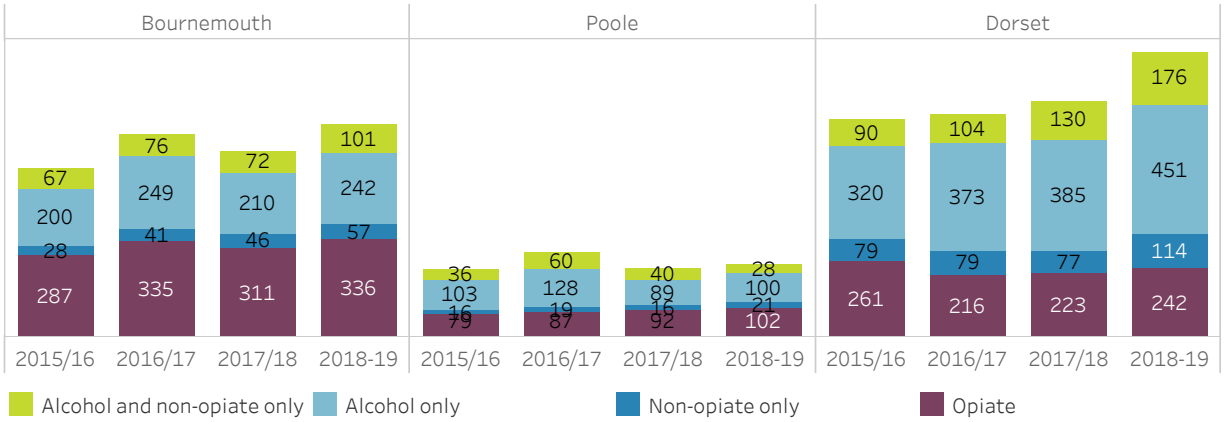
JOINT PUBLIC HEALTH BOARD PAN-DORSET SUBSTANCE MISUSE REPORT

NOVEMBER 2019

Number of Clients in Structured Treatment

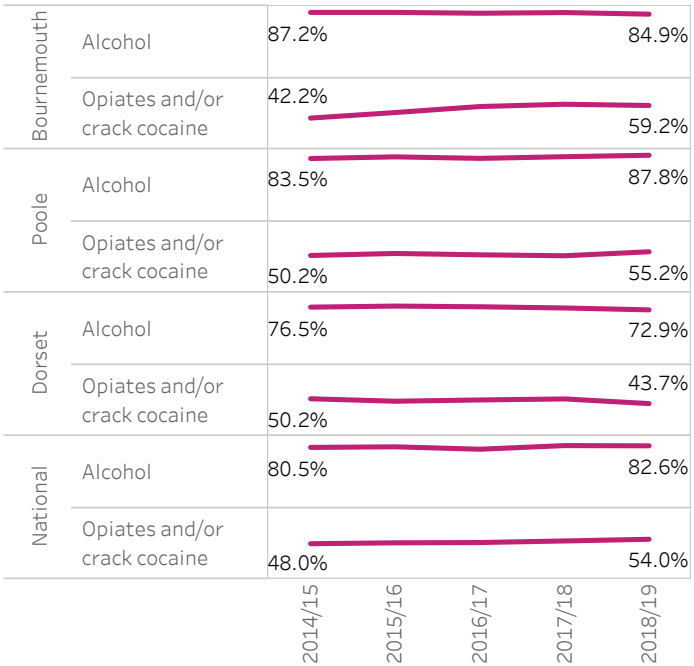


Number of New Presentations to Structured Treatment



Estimates of Unmet Need

The estimated proportion of people in each area who are dependent on opiates and/or crack cocaine or alcohol not in the treatment system



In 2018-19 we saw an increase in the total number of clients engaged across all three local authorities. This is a positive development as it shows that more people are accessing the support they need. Increasing the number of opiate users engaged in treatment in Bournemouth had been a specific priority for commissioners. However these increased numbers have put services under pressure, prompting a review of the design and delivery of the specialist prescribing service in BCP.

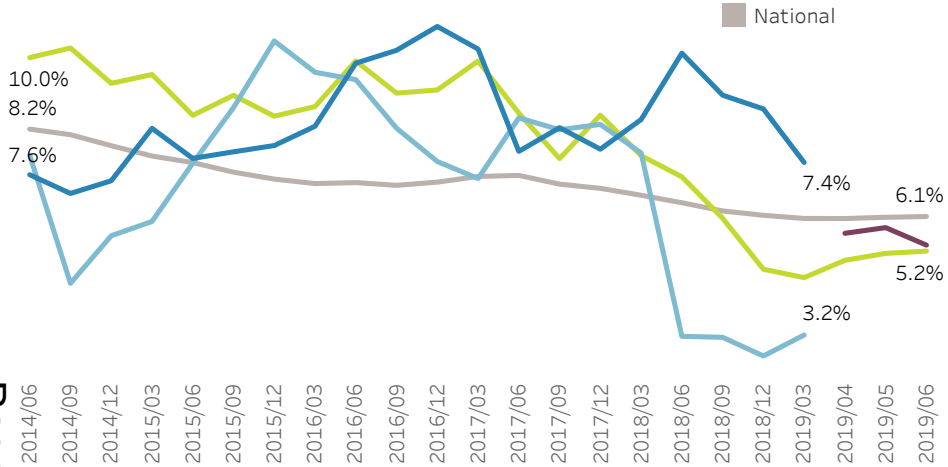
Created and maintained by the Public Health Dorset Intelligence Team.
Data Source: NDTMS DOMES & Adult Activity Report

JOINT PUBLIC HEALTH BOARD PAN-DORSET SUBSTANCE MISUSE REPORT

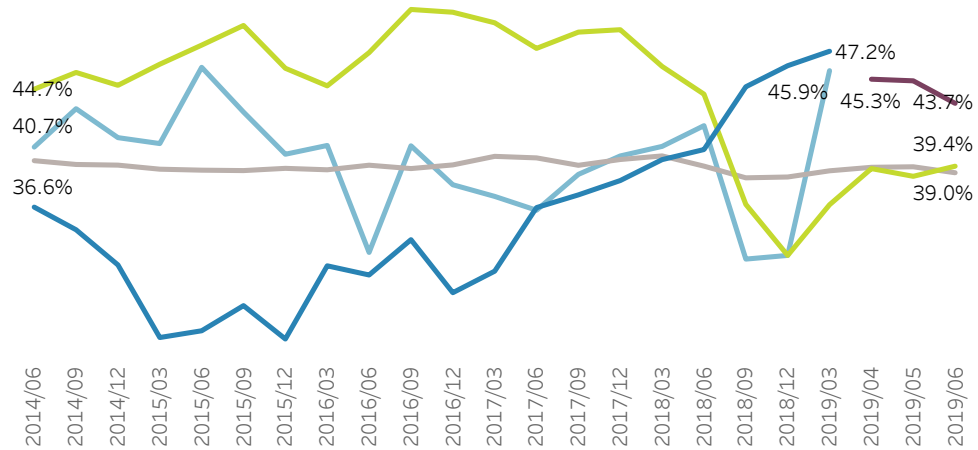
Successful completions as a proportion of all in treatment

Bournemouth
Poole
BCP
Dorset
National

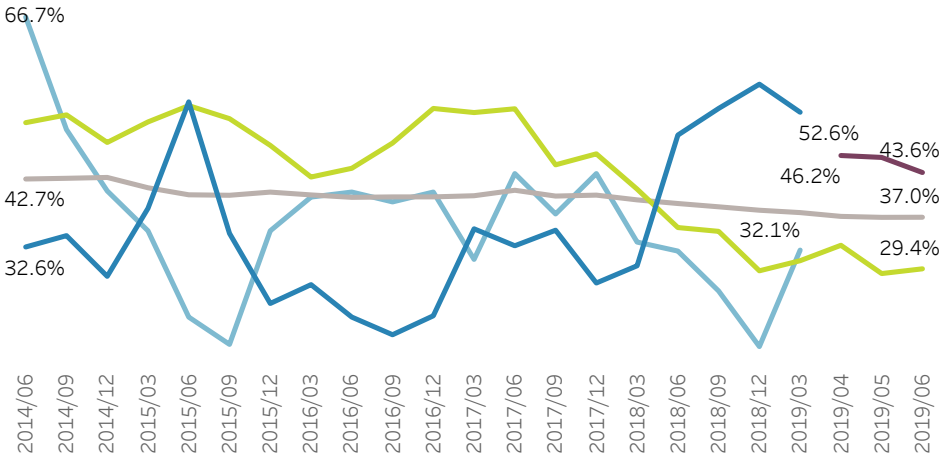
Opiate Successful Completions



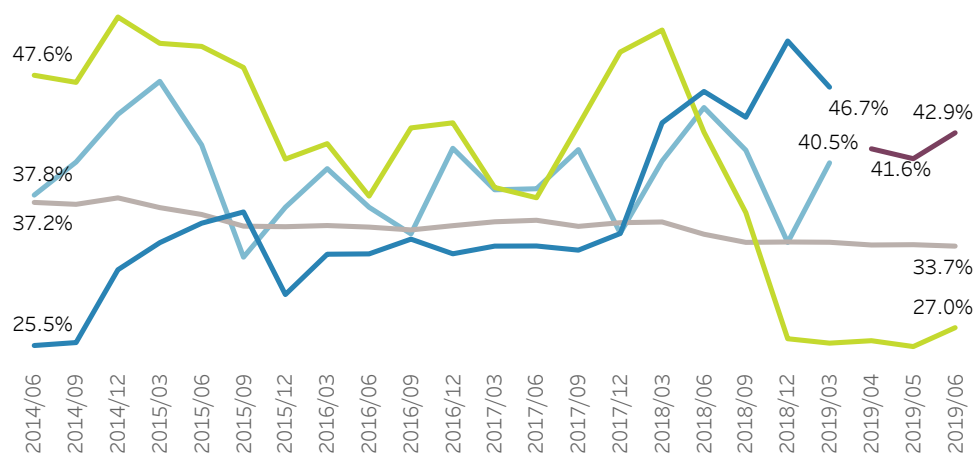
Alcohol Successful Completions



Non-Opiate Successful Completions



Alcohol & Non-Opiate Successful Completions



Completion rates for opiate users across the area are stable but slightly below the national average, reflecting the pressures prescribing services are under. For other substances BCP completion rates are above the national average, while Dorset's are slightly below but again are stable. Although this is not an area of concern, a review of alcohol treatment is being conducted across the area which it is hoped will improve service outcomes for service users who do not use opiates.

Created and maintained by the Public Health Dorset Intelligence Team
Data Source: NDTMS Successful Completions Report

JOINT PUBLIC HEALTH BOARD PAN-DORSET SUBSTANCE MISUSE REPORT

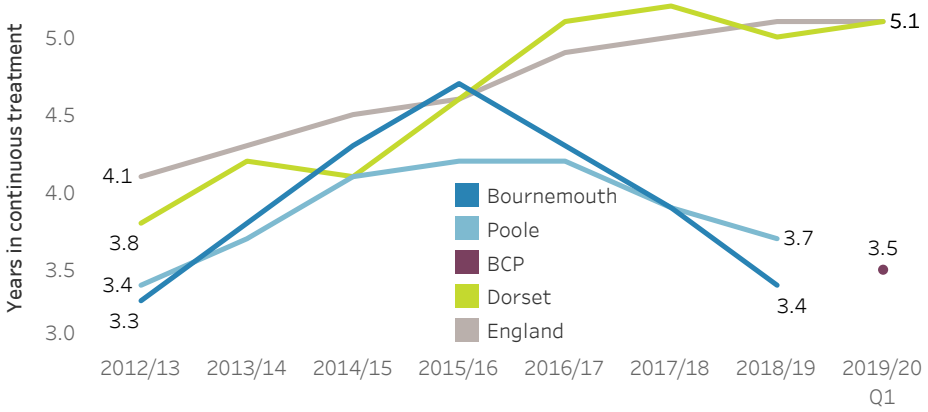
Time in treatment & alcohol related hospital admissions

Opiate Clients in treatment for 6 years or more

Number of clients in treatment for stated time period / all clients in treatment at the end of the period

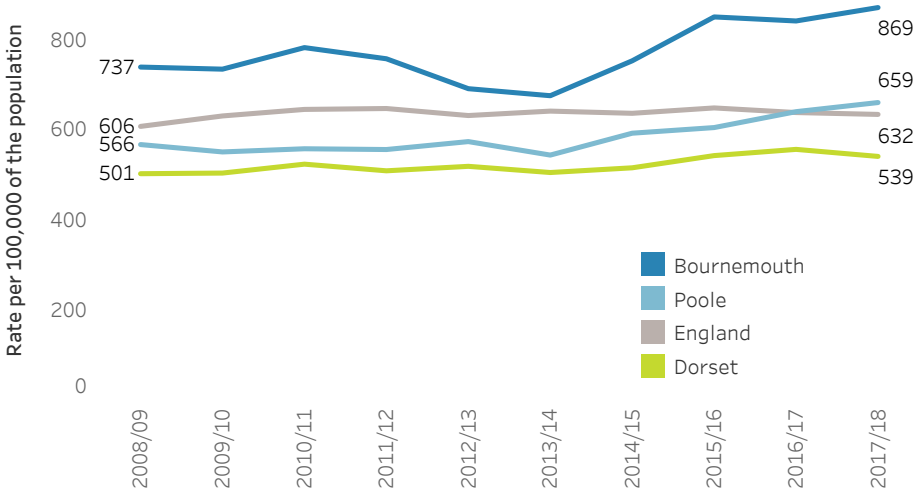
Area	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20 Q1
Bournemouth	14.6%	23.1%	29.4%	37.4%	32.9%	27.4%	21.7%	
Poole	21.4%	28.9%	32.8%	33.3%	32.2%	26.7%	22.6%	
BCP								21.3%
Dorset	25.2%	30.8%	31.0%	32.9%	35.0%	34.6%	30.5%	34.0%
National	25.9%	28.7%	31.3%	31.7%	32.6%	32.3%	31.8%	31.8%

Opiate Clients - Average Time in Continuous Treatment (in years)



Alcohol Related Hospital Admissions

Rate per 100,000 of the population all ages - Narrow (Local Alcohol Profiles for England Indicator 10.01)
Where an alcohol-related illness was the main reason for admission or identified as an external cause



Reflecting the challenges faced in Bournemouth regarding engagement and retention in treatment of opiate clients, the length of time spent in treatment and the proportion of clients who have been in treatment for six years or more has fallen significantly. The figure in Dorset continues to rise in line with the national average, while Poole has seen a slight drop in the past year leaving it comparable to Bournemouth.

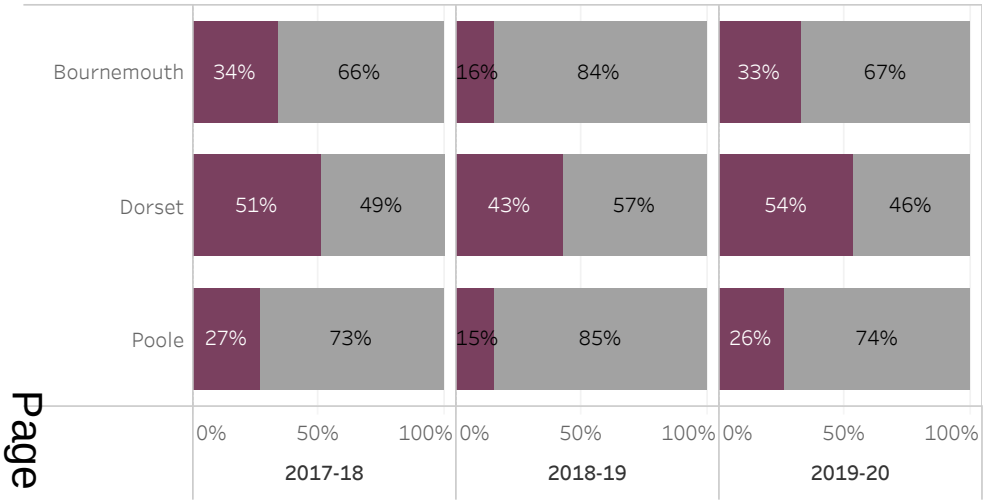
Alcohol related hospital admissions are higher than the national average and rising in both Bournemouth and Poole while the figure for Dorset is relatively stable. This may have implications for how the acute trusts and other partners address alcohol related issues.

Created and maintained by the Public Health Dorset Intelligence Team
Data Source: NDTMS DOMES and Local Alcohol Profiles for England (LAPE)

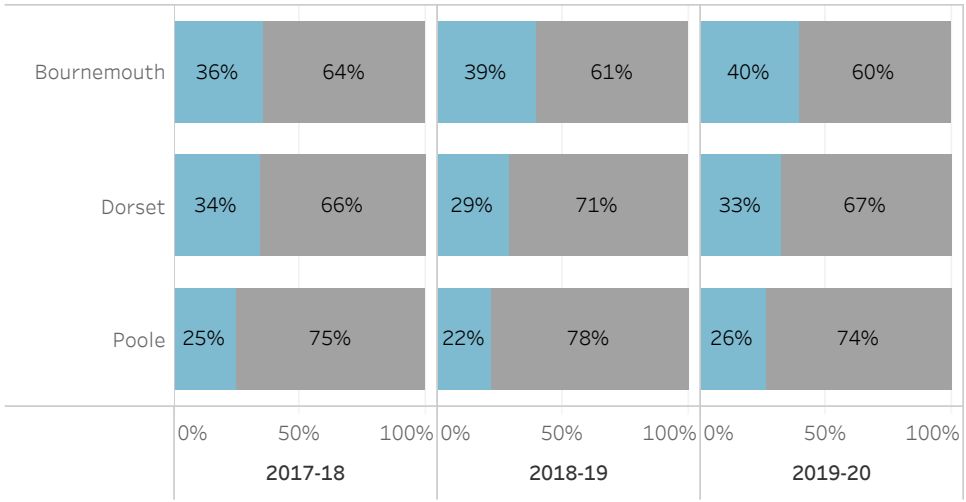
JOINT PUBLIC HEALTH BOARD PAN-DORSET SUBSTANCE MISUSE REPORT

Blood Borne Viruses

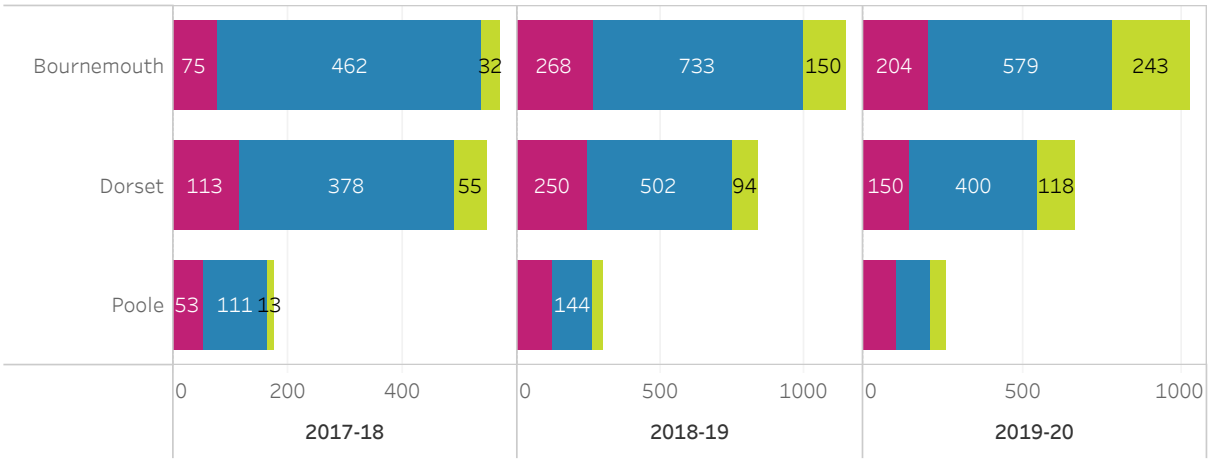
Percentage of Clients in treatment who accepted Hep B immunisation



Percentage of clients in treatment who have completed Hep B course



Hep C latest test date for clients who currently or have previously injected (for clients in treatment during each year)



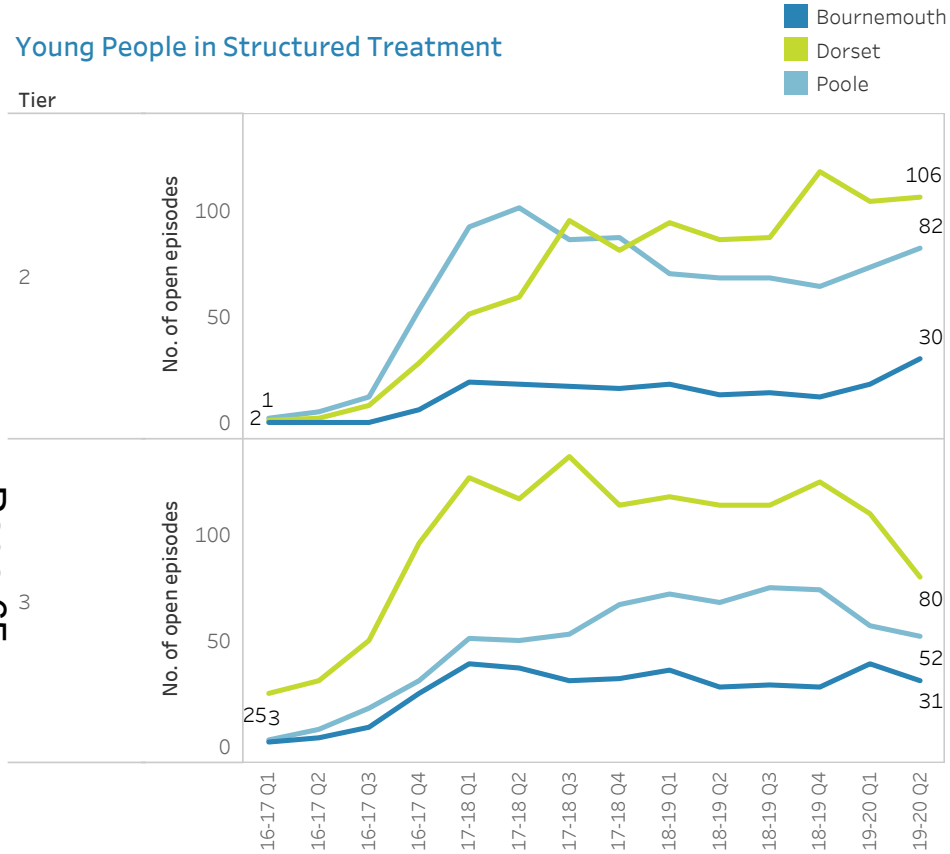
Bournemouth shows good and improving performance in relation to delivering blood borne virus interventions, particularly in relation to hep C tests. This is likely to be due to specific targeted work to engage more people in new treatments. Learning from this will be explored to see if similar actions can improve performance in Poole and Dorset.

Created and maintained by the Public Health Dorset Intelligence Team
Data Source: Halo Substance Misuse Case Management System

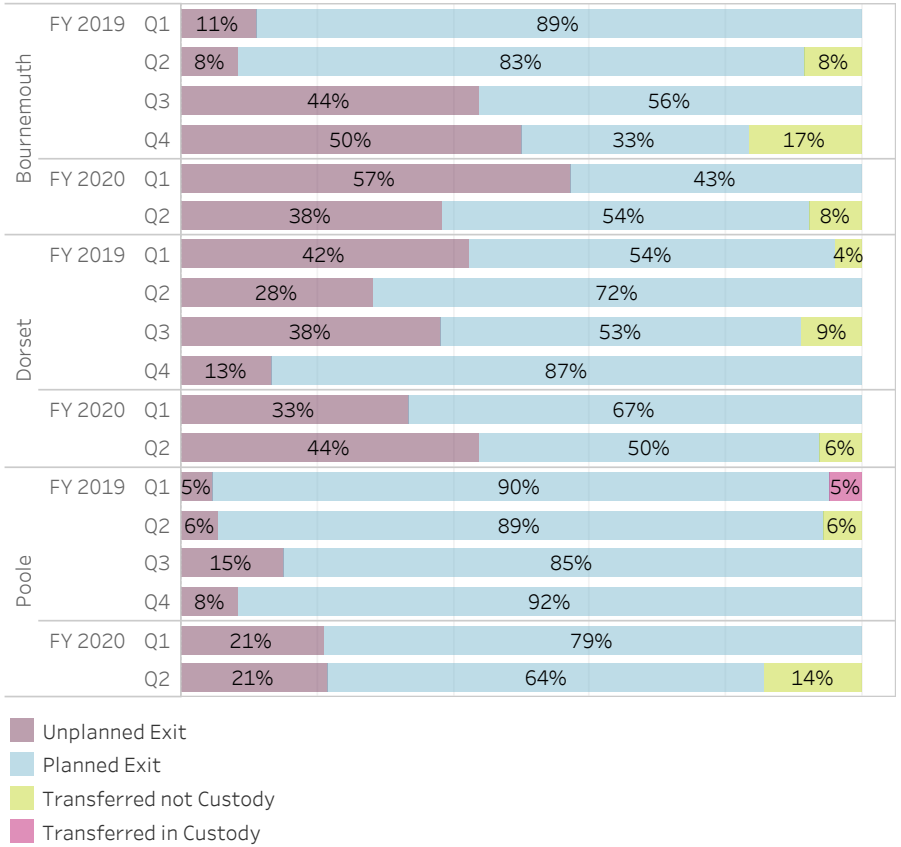
JOINT PUBLIC HEALTH BOARD PAN-DORSET SUBSTANCE MISUSE REPORT

Young people in treatment

Young People in Structured Treatment



Young People - Closures



As noted in previous reports a higher number of young people are engaged in Dorset due to the approach taken locally and this is reflected in the levels of vulnerability.

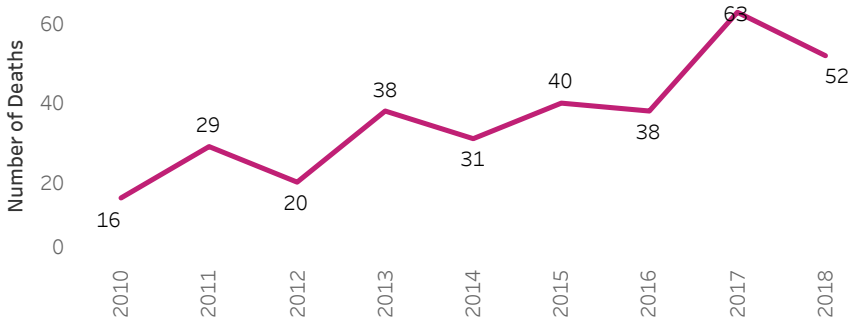
The number of tier 3 clients has dropped as they are being recorded more accurately as tier 2.

Created and maintained by the Public Health Dorset Intelligence Team
Data Source: NDTMS and Halo Substance Misuse Case Management System

JOINT PUBLIC HEALTH BOARD PAN-DORSET SUBSTANCE MISUSE REPORT

Drug related deaths and Naloxone provision

Drug Related Deaths Pan-Dorset



Drug Related Deaths Locations

	2010	2011	2012	2013	2014	2015	2016	2017
Bournemouth	9	12	14	20	21	19	19	27
Weymouth and Portland	3	3	3	8	4	8	3	12
Poole	2	6	1	6	5	3	7	7
West Dorset		4	2	3	1	2	3	4
North Dorset	1	1		1		3	3	6
Purbeck	1	2				2		2
Christchurch						2	2	4
East Dorset		1				1	1	1
Grand Total	16	29	20	38	31	40	38	63

Believed Suicide	2010	2011	2012	2013	2014	2015	2016	2017
No	14	29	20	33	28	39	34	57
Yes	2			5	3	1	4	6

Drug related deaths continue to be a priority locally, and while figures for the distribution of naloxone continue to improve there is still work to do to maximise coverage of this valuable intervention, particularly for clients in treatment in Bournemouth.

Created and maintained by the Public Health Dorset Intelligence Team
Data Source: Dorset Police DRD Coordinator and Halo

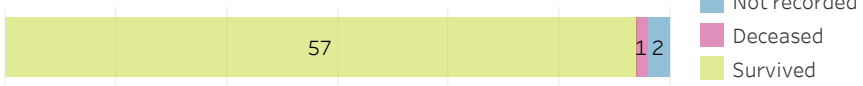
Number of kits issued to date

	Bournemouth	Dorset	Poole
Client	393	496	238
People not in treatment	136	130	177
Worker	41	17	13

Naloxone kits used since start of project

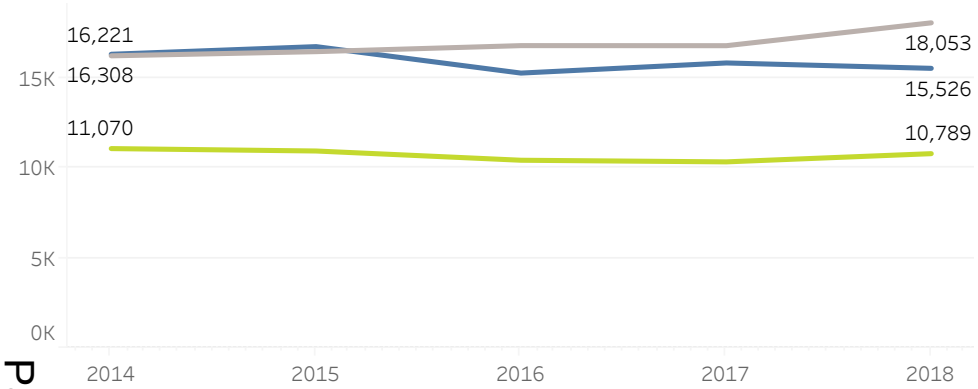
By people in drug treatment	12	16	17
By people not in drug treatment	3	2	8
By drug workers	1		1

Outcome of usage

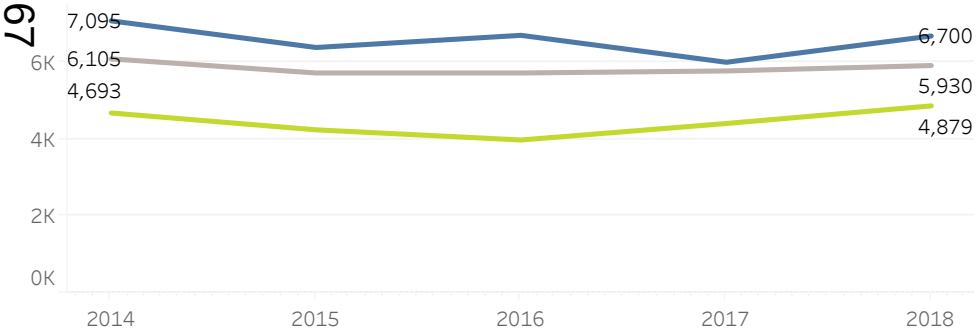


JOINT PUBLIC HEALTH BOARD SEXUAL HEALTH PERFORMANCE REPORT

1. New sexually transmitted infections diagnoses in under 25 year olds per 100,000 population



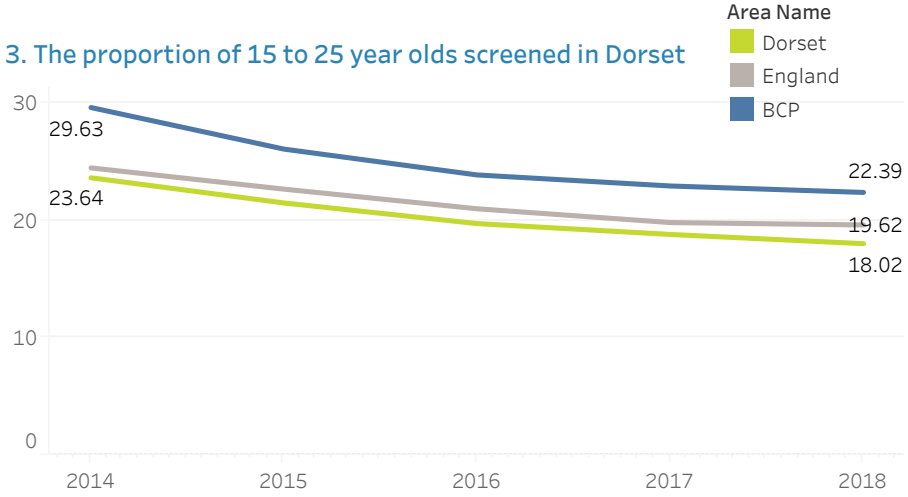
2. Rate of Chlamydia diagnoses for age 15-25 years



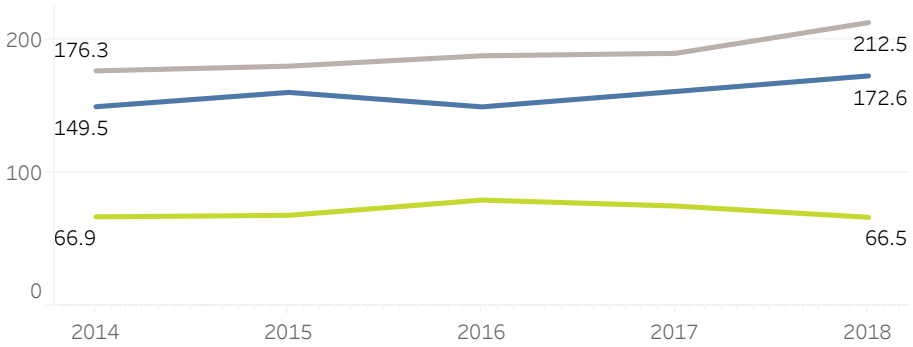
All new STIs (excluding Chlamydia in under 25s) per 100,000 aged 15 to 64 years showed that in 2018 infection diagnoses are lower than England average in Bournemouth, Christchurch and Poole combined and lower in Dorset. A longer term trend shows a peak for 2014/5 in Bournemouth, Christchurch and Poole and a fall 2016 but relatively static overall since 2012. More recent local data emerging suggests activity with some STIs in some areas is starting to rise, especially when compared to regional South West Data.

Created and maintained by the Public Health Dorset Intelligence Team
Data Source: PHE Fingertips

3. The proportion of 15 to 25 year olds screened in Dorset



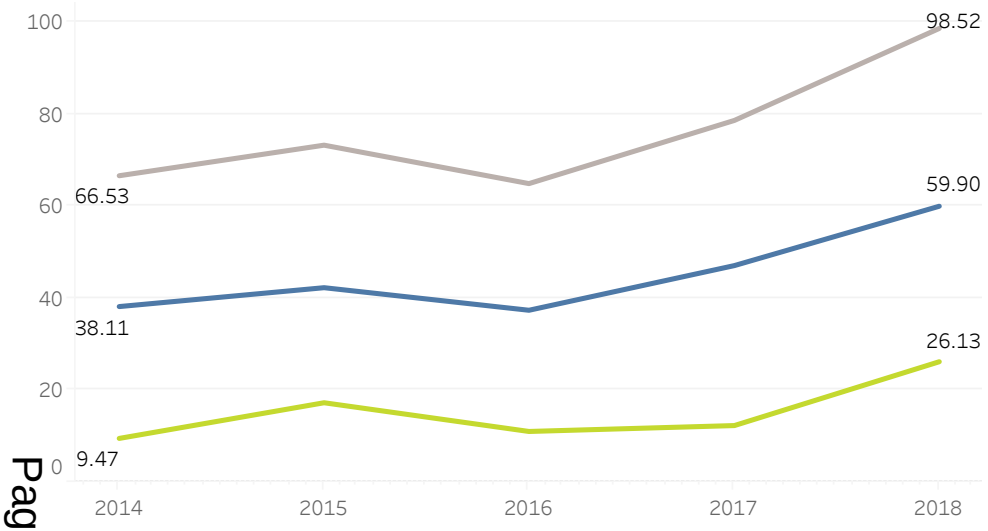
4.Rate of Chlamydia diagnoses for age 25 years and over



For chlamydia screening Sexual Health Services in Dorset have adopted a more targeted focus in directing screening to areas of greater need to increase positivity rates and subsequent treatment. The numbers screened aged between 15-25 in Bournemouth, Christchurch and Poole combined are shown as higher than England average and just lower in Dorset. When looking at positivity rates Bournemouth, Christchurch and Poole are just below average and follow the national trend of a slight increase and positivity rates in Dorset remain low.

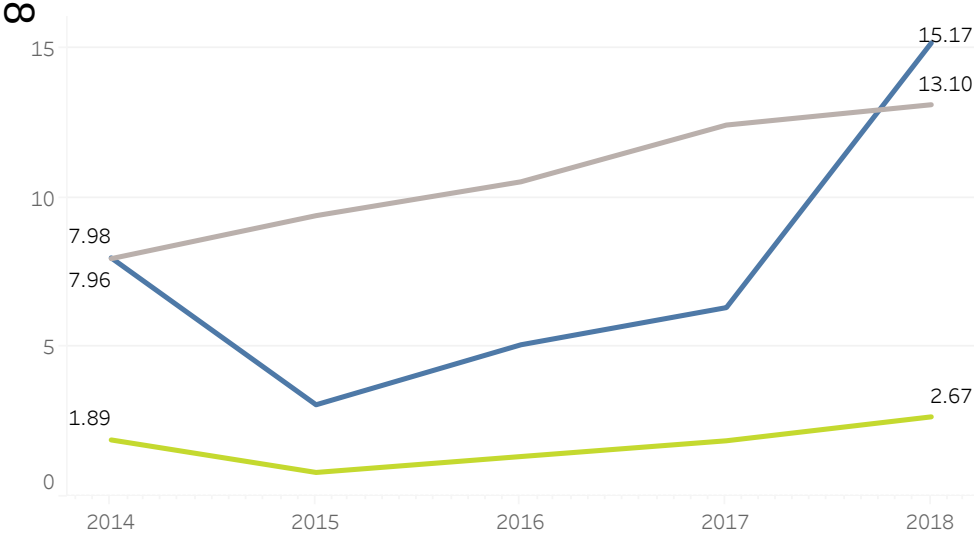
JOINT PUBLIC HEALTH BOARD SEXUAL HEALTH PERFORMANCE REPORT

5.The rate of Gonorrhoea diagnoses per 100,000 population



The rate of Gonorrhoea has increased since 2016 in Bournemouth, Christchurch and Poole and Dorset but remain lower than the England average with figures of 59.60 and 26.13 per 100,000 population respectively.

6.Rate of syphilis diagnoses per 100,000 population

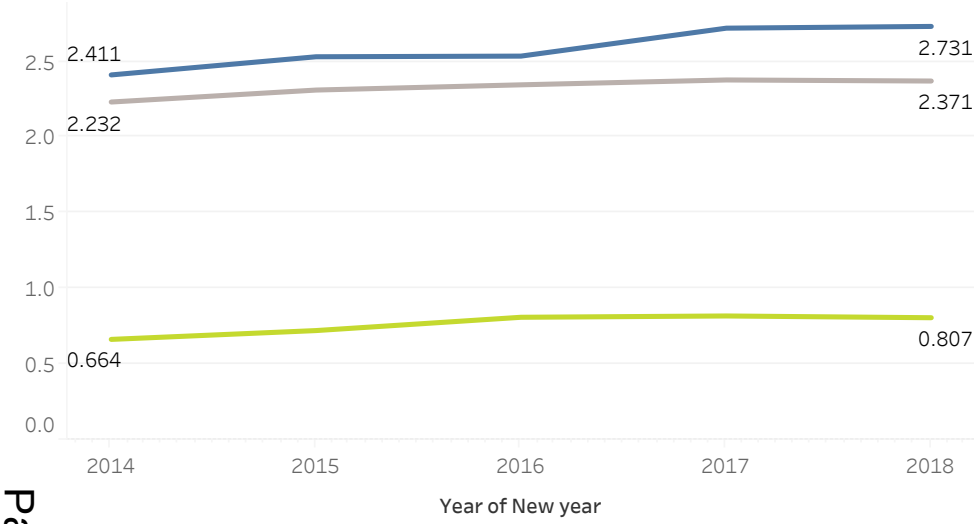


Nationally rates of syphilis diagnoses have been steadily rising, rates in Bournemouth, Christchurch and Poole have peaked again from 2017 following a decline since 2014 and are now above England average (15.17 and 13.10 respectively). There has been a recent outbreak across the South West, which is being managed by PHE.

Created and maintained by the Public Health Dorset Intelligence Team
Data Source: PHE Fingertips

JOINT PUBLIC HEALTH BOARD SEXUAL HEALTH PERFORMANCE REPORT

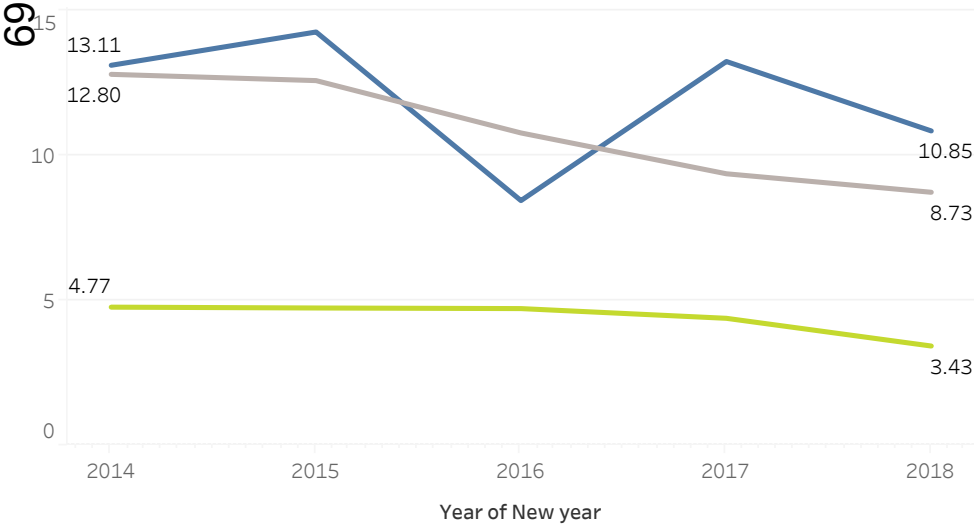
7.HIV Diagnosed prevalence 15 -59



The prevalence rate for HIV is 2.731 per 1000 population in Bournemouth, Christchurch and Poole, which is higher than the England average (2.371). Trends have remained higher, which is largely due to vulnerable groups residing in the area. This gives an amber ranking against the PHE goal of less than 2 per 1000 population. Rates for Dorset (0.80) are below average and ranked green.

Area Name
Dorset
England
BCP

8.HIV new diagnosis rate per 100,000 15 plus years.



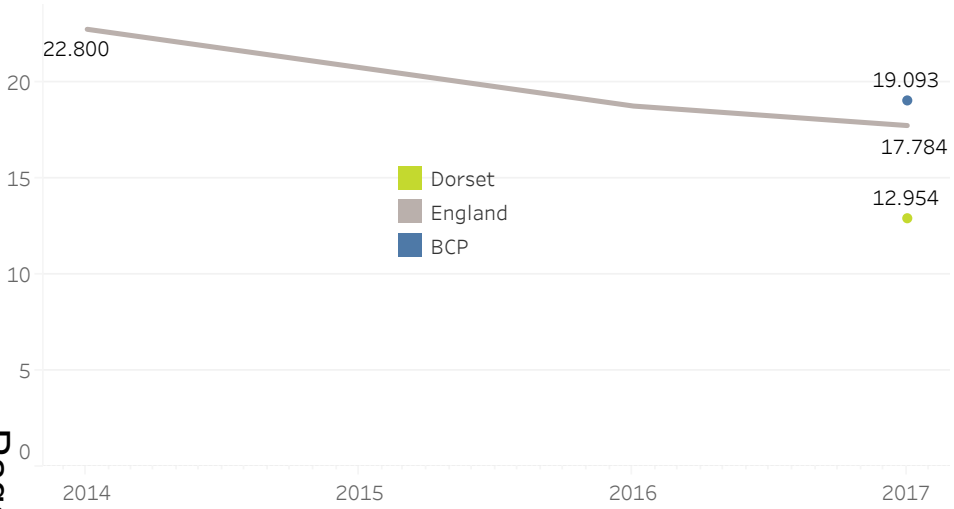
New HIV new diagnosis rates have fallen overall, but not significantly and remain above England average in Bournemouth, Christchurch and Poole, (8.73 and 10.85 respectively). Dorset remain low (3.43) and are decreasing. Late diagnosis for HIV has improved since 2011 as people are presenting and getting tested earlier and awareness of clinical indicators for HIV among care professionals has improved.

Created and maintained by the Public Health Dorset Intelligence Team
Data Source: PHE Fingertips

JOINT PUBLIC HEALTH BOARD SEXUAL HEALTH PERFORMANCE REPORT

9. Under 18 conception rates per 1000 population in females 15-17 years

Note: only 2017 figures provided for new LA areas



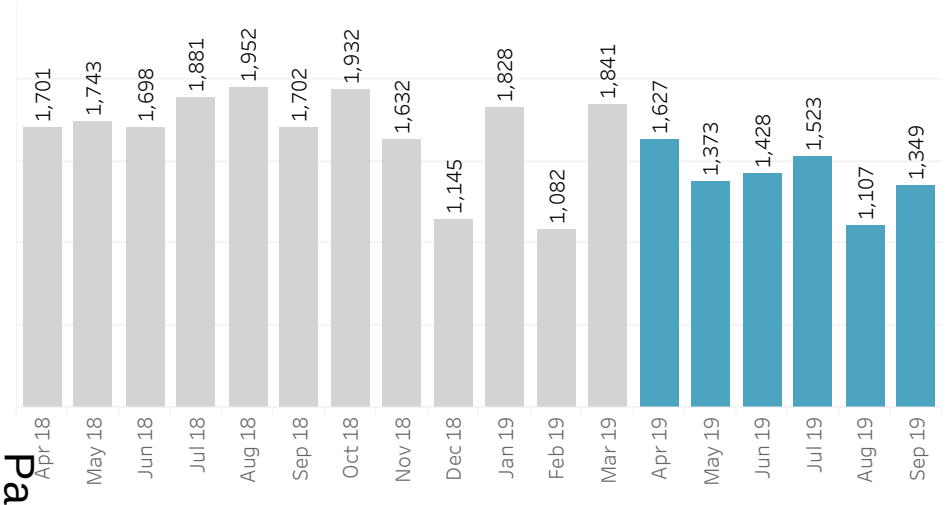
Nationally conception rates have fallen over time from 22.8 to 17.7 Bournemouth, Christchurch and Poole are slightly above England average (19.09) and Dorset remain below average.

Created and maintained by the Public Health Dorset Intelligence Team
Data Source: PHE Fingertips & LARC Data

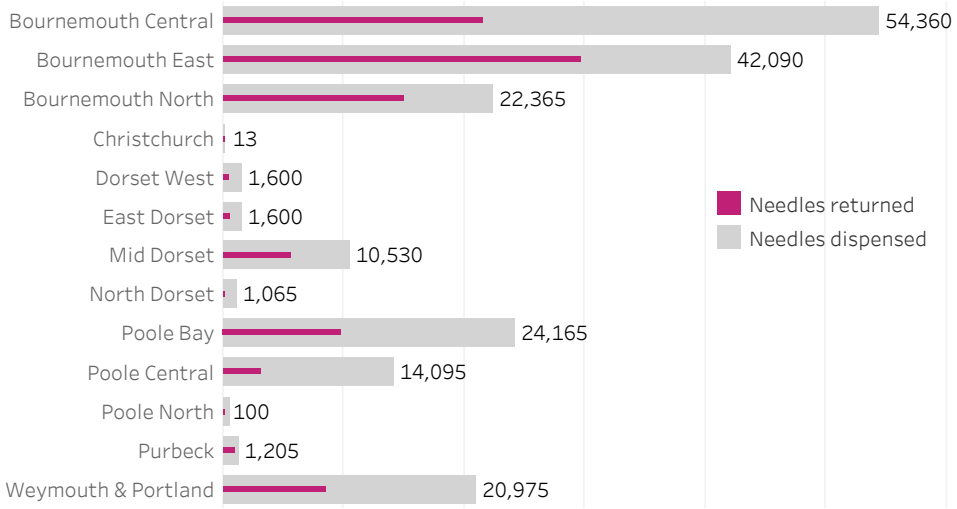
JOINT PUBLIC HEALTH BOARD COMMUNITY HEALTH IMPROVEMENT SERVICES

November 2019

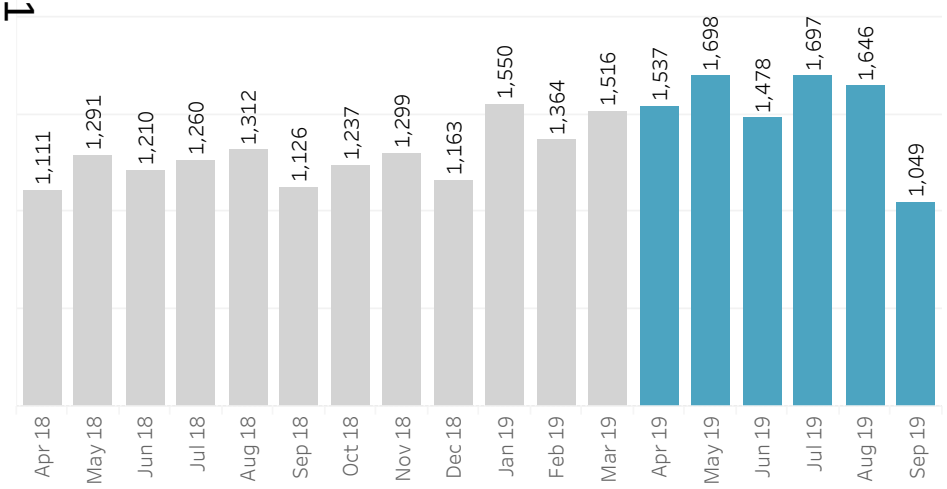
Needle Exchange Interactions by month



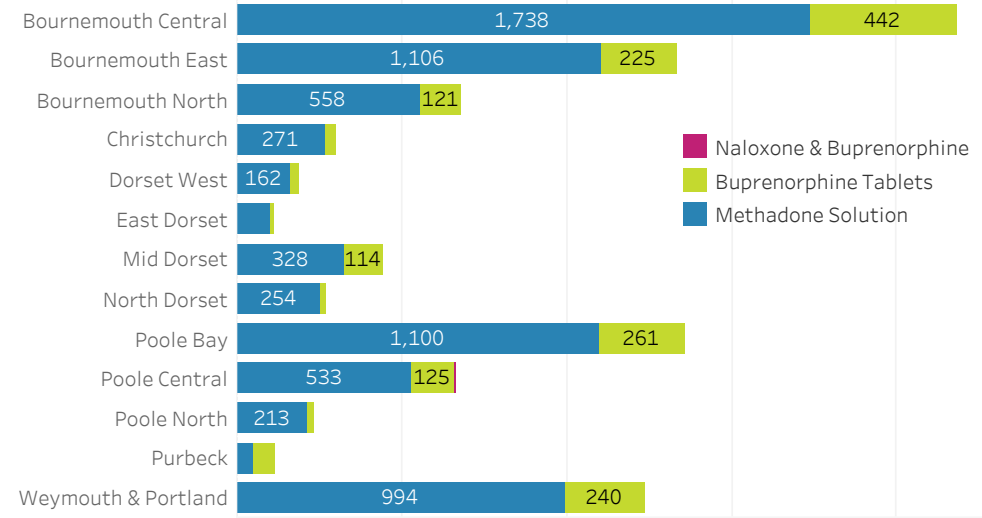
Needles dispensed and returned by Locality 2019-20



Supervised Consumption Interactions by month



Supervisions and drug type by Locality 2019-20



Created and maintained by the Public Health Dorset Intelligence Team
Data Source: Community Health Improvement Services (PharmOutcomes)

www.publichealthdorset.org.uk
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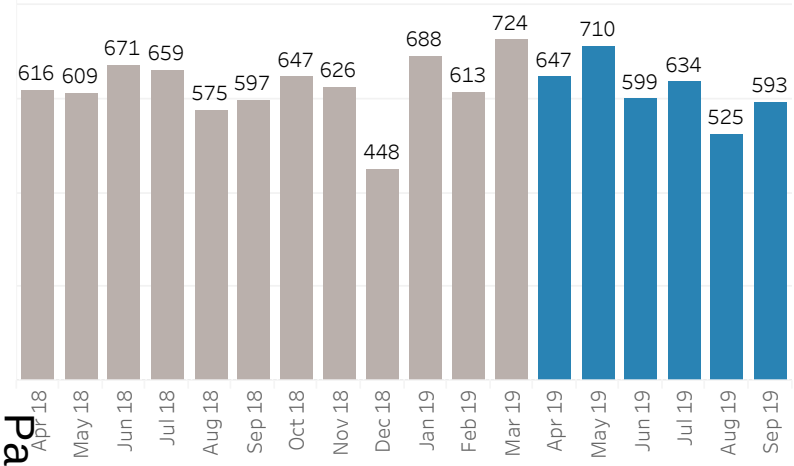
@publichealthdorset

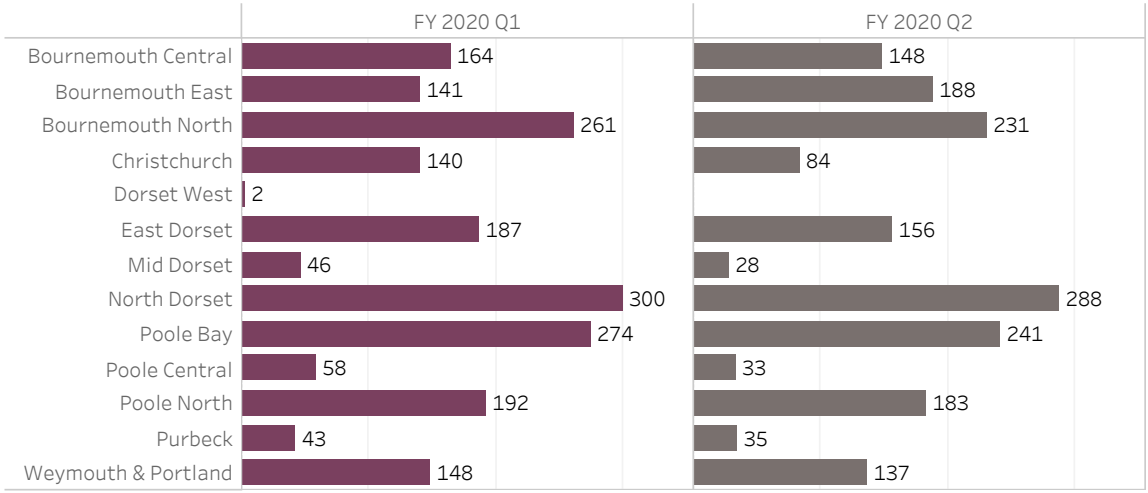
JOINT PUBLIC HEALTH BOARD COMMUNITY HEALTH IMPROVEMENT SERVICES

November 2019

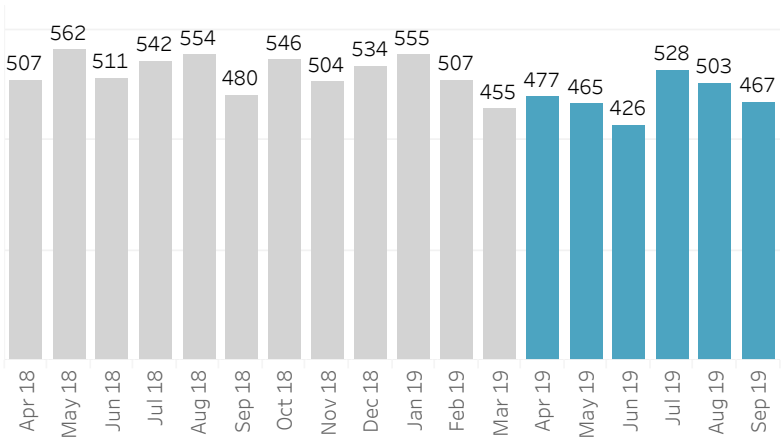
No. of LARC procedures per month



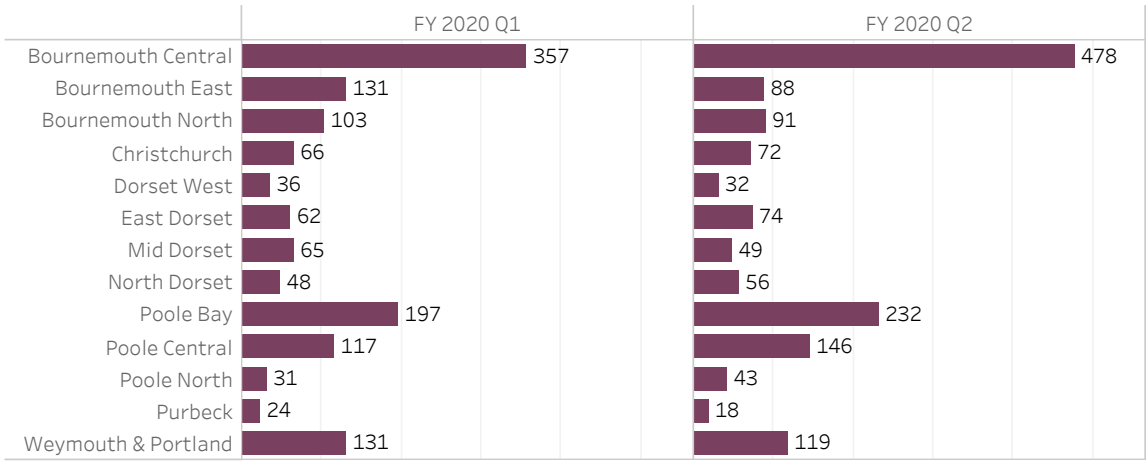
No. of LARC procedures delivered by locality



No. of EHC consultations per month



No. of EHC consultations by locality 2019-20



Created and maintained by the Public Health Dorset Intelligence Team

Data Source: Community Health Improvement Services (PharmOutcomes)

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Joint Public Health Board

Business plan monitoring report

Date of Meeting: 25 November 2019

Portfolio Holder: Cllr Laura Miller, Lead Member for Adult Social Care and Health, Dorset Council
Cllr Lesley Dedman, Lead Member for Adult Social Care and Health, BCP Council

Director: Sam Crowe, Director of Public Health

Executive Summary: This report provides a quarterly summary of progress in delivering the agreed outputs from the Public Health Dorset business plan for 2019/20. The approach to monitoring delivery is to RAG rate progress against project milestones, with a simple narrative update. A separate report on performance with major commissioned services provides more detailed performance information on a twice-yearly basis.
Equalities Impact Assessment: EQIA assessments form part of commissioning for all public health services and are published in accordance with Dorset Council guidance.
Budget: Services and projects considered within this paper are provided from the overall Public Health Dorset budget of £27.7M. The new Children and Young Persons Public Health Service contract contains elements that are outcome-based. This is being agreed in detail with the provider and will be reported on more fully in the next 6-monthly performance report.
Risk Assessment: Having considered the risks associated with this decision, the level of risk has been identified as: Current Risk: LOW Residual Risk LOW
Climate implications: No direct implications. However, some of the public health interventions and projects within the business plan will positively reduce carbon emissions at individual and organisation level if implemented at scale, particularly active travel.
Other Implications: N/A

Recommendations:
The Joint Public Health Board is asked to consider the information in this report and note the overall progress on our major projects and deliverables for 2019/20. The Board is asked to note the deteriorating position in the substance misuse prescribing service provided by AWP affecting the BCP Council area. Board members are asked to support the following recommendations:

i) Give delegated authority to the Director of Public Health in consultation with the chair and vice-chair to agree a mitigation plan, and additional resource for the service via a contract extension;

ii) Include in future business plan monitoring reports a summary of the main public health services commissioned from NHS England under Section 7A of the Health and Social Care Act (mainly screening and immunisation programmes).

Reason for Recommendation:
Close monitoring of the delivery of projects in the business plan is important to enable both Councils and the Integrated Care System achieve Prevention at Scale ambitions in the local health and care system. It also assures the Board that spend through the ring-fenced Public Health Grant is effective and efficient, and complies with the national Grant criteria.

Appendices:
Appendix A: Business plan monitoring report

Background Papers:
None

Officer Contact:
Name: Sam Crowe
Tel: 01305 225881
Email: sam.crowe@dorsetcouncil.gov.uk

Appendix One

1 Introduction

1.1 The Joint Public Health Board exists to provide oversight, assurance and governance around the effectiveness of the delivery of the public health function for Dorset and BCP Councils.

1.2 An important part of this role is understanding how the Public Health Grant allocation is used to commission effective public health services, and whether those services are providing value for money, and equitable delivery for our populations.

1.3 This monitoring report sets out a summary of progress against the Public Health Dorset business plan for 2019/20. The plan includes commissioned service deliverables, as well as a number of projects being delivered as part of the Dorset ICS Prevention at Scale plans.

2 Current position

2.1 The monitoring report (Appendix A) shows that midway through the financial year most projects are on track for delivery this year. However, there are two service areas experiencing ongoing challenges with delivery. The first is the NHS Health Checks programme, which is the subject of a separate deep dive report (see separate agenda item).

2.2 The second area is a new risk around the delivery of effective substance misuse prescribing services to clients in the BCP Council area. This is due in part to staffing shortages following a restructure in the provider. However, the service in BCP Council is also engaging many more people in treatment compared with two years ago (from around 600 to around 900 people). This is putting additional strain on the service, particularly the need to ensure regular and ongoing review while in treatment.

2.3 A mitigation plan is being developed with the provider to ensure adequate capacity within the service. The service may need additional resources above the contract value in order to provide a safe, effective and sustainable service. This is being worked through and will be formally negotiated as part of a contract variation when finalised. Board members should note that the contract value for this service has reduced significantly during the past three years (circa £0.9M), in line with the nationally imposed reductions to the public health Grant.

2.4 There is also a requirement for the Director of Public Health to provide assurance over the delivery and effectiveness of public health services commissioned by NHS England – known as Section 7A services. These include the major cancer screening programmes, and immunisation programmes offered to the local population.

2.5 Previously the Joint Public Health Board has not been sighted on this assurance process, as it is carried out via the local Health Protection Network. Following the recommendations of the task and finish group on the future model for public health, it is proposed to begin capturing the main assurance issues in future business plans, for monitoring by this board.

2.6 The public health support to these programmes is delivered by Public Health England colleagues who work across the region. Currently they have highlighted the following issues with local screening programmes:

- Dorset Breast Screening Service – 2 serious incidents and 2 screening safety incidents have been identified. A PHE consultant Julie Yates is leading the serious incident management meetings on these. Pathology errors and trust processes appear to be the common factor;

- Dorset Cervical Screening – concerns with staffing issues at Dorset County Hospital are affecting colposcopy referral times. This may be exacerbated with the planned change to HPV screening, which takes effect on 25th November as it could lead to a further increase in colposcopy referrals. Concerns over how this department are going to meet tis demand. Poole lab will cease processing new cytology samples for the cervical screening programme on 25 November.

- Dorset Bowel Screening – some endoscopy clinics have been cancelled due to staffing issues. However, the service has a recovery plan in place and are working with PHE to ensure a return to usual waiting times.

3 Conclusion and recommendations

3.1 This monitoring report shows that Public Health Dorset is making good progress in delivering against its business plan in this financial year.

3.2 Board members are asked to note the progress, and to support the following recommendations:

iii) Note the risks around the substance misuse prescribing service in the BCP Council area, and to support giving delegated authority to the Director of Public Health in consultation with the chair and vice-chair to agree a mitigation plan, and additional resource for the service via a contract extension;

iv) Include in future business plan monitoring reports a summary of the main public health services commissioned from NHS England under Section 7A of the Health and Social Care Act (mainly screening and immunisation programmes).

Sam Crowe
Director of Public Health
25th November 2019

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