Case study

Dorset County Council: an inclusive geography-wide approach

"The new arrangement across three councils is a good reflection of the collective will for broader joint working. For example, the three councils and the NHS locally have recently been successful in obtaining a £750,000 grant as part of the government initiative to transform the way health and social care services are delivered."

David Phillips, Director of Public Health

Key messages

- Three year agreement of all three authorities with pooled budgets.
- Critical mass of core staff to manage mandatory programmes and core functions.
- Alignment with other key organisational boundaries to support efficiencies in commissioning and delivery.
- Joint Health and Wellbeing Strategy structured for active consideration of both broader determinants of health and engagement of second tier authorities.

Context

Dorset has a population of 775,000 with population density varying widely across its districts, from 89 people per square kilometre in West Dorset to 4,000 per square kilometre in Bournemouth. The three top tier authorities have very differing demographic and health profiles, for example, Dorset County has one of the highest life expectancies in the country and some of the lowest premature mortality rates from heart disease and cancer and a population with an average age significantly above the national norm. Bournemouth by contrast has a much younger population with many students and tourists and has correspondingly different health indices; for example, it has the fifth highest premature death rate from liver disease in the country. The rapidly ageing population and the

effective prevention and management of the associated long term conditions are major challenges for all three local authorities.

Dorset now has a public health team covering three upper tier authorities: Dorset County Council and the borough councils of Poole and Bournemouth. The team is hosted by Dorset County Council on behalf of all three councils. This is a three-year arrangement, initially, with a commitment from all three councils to pool funds into a single budget on the understanding that it will be used for the benefit of all three.

The new arrangement is a good test bed for other joint working. Recently, for example, the county and borough councils and the local NHS successfully applied for a £750,000 grant as part of the government initiative to develop greater integration and new ways of working between health and social care. The public health team will play a key role in developing work on early intervention and prevention in this transformation project.

A further incentive to joint working across the three councils on public health issues is the fact that there is one Clinical Commissioning Group (CCG) covering the geography of the three authorities. Similarly there is one major community service provider and one local resilience forum, all of which helped make the decision to have one public health team much easier to make, with the potential for efficiency gains in future commissioning of services.

Furthermore, prior to the transfer to local government, there was already one public health team working across Bournemouth and Poole. Bringing this team together with the team for Dorset provides a critical mass which can deal effectively with the core public health functions as well as commissioning and delivering the mandatory programmes.

The new joint public health team has a director of public health, seven consultant-level staff and 35 other staff. Four of the consultant-level staff and four other senior staff have geographic as well as programme responsibilities. There are four assistant directors of public health, one for Bournemouth, one for Poole and two for Dorset, one of whom has special responsibility for the involvement of district councils. Feedback from the local authorities to this way of working has been positive so far.

Governance

There is a joint Public Health Board for all three partnership councils, but it was considered that one sole Health and Wellbeing Board would have been a “big ask”, so at the moment there are two – one for Bournemouth and Poole and one for Dorset. However, for reasons of economy of scale and consistency across the county, there is one commissioning intelligence group delivering a county-wide Joint Strategic Needs Assessment (JSNA). The Joint Health and Wellbeing Strategy (JHWS) for each of the two Health and Wellbeing Boards is developed on the basis of the single JSNA plus local intelligence. The JHWS have been approached first by aligning outcomes along the lifecourse and then by aligning actions for those outcomes in a holistic, cross-sectoral way and finally by looking at the contribution of particular organisations and services. This approach allows a focus on people and places, consistent with recent local government thinking, rather than on specific conditions, technical areas or ‘silos’. Initial feedback suggests that people have felt engaged and understand their roles better than was the case in local strategic partnerships.

To date, relations at the level of governance with the councils’ overview and scrutiny arrangements and the way in which ongoing audit of public health activities is to be carried out across the participating councils are evolving. Sorting these arrangements out at an earlier stage, could, the director of public health believes, have lead to an even smoother transition to the new partnership

but given the time frame would have been very difficult. However, he is pleased that the new arrangements have delivered a 'critical mass' of public health staff with pride in their ability to sustain a professional service for the population.

The chief executives and leaders of each of the partnership councils have contributed to the positive spirit of the transition by welcoming their new public health function and demonstrating mutual respect for the public health team.

Prioritising interventions and equity for rural areas

As in other counties where services must be provided both within large cities or towns and across more sparsely-populated rural areas, the Dorset-area public health team must meet the challenge of equitable service provision.

One example of how equity for rural areas is being tackled is in the way in which priorities are set for Dorset's JHWS. The initial stage is to test potential priorities against the following questions.

- Is the priority expressed as a health and wellbeing outcome?
- Is there evidence that Dorset residents see the outcome as a priority?
- Is there much difference/variation between localities or different social groups in Dorset?
- Is there evidence that the outcome adversely affects those identified as being particularly vulnerable?
- In measuring the outcome, does Dorset compare poorly with other equivalent areas, or when compared with England as a whole?

Potential priorities are then tested against a scoring matrix.

Absolute numbers of road traffic collisions that result in serious injury or death are few when compared with the data that relates to other outcome priorities for Dorset. However, the impact of road traffic collisions on people's health and wellbeing can be considerable. Overall, rates of road traffic collisions that cause death or injury are significantly higher in Dorset when compared to England as a whole. It is thought that this is largely due to the extensive rural road network in the county. Of all the collisions that result in death or injury, the majority occur on sing-track rural roads. This is why reducing harms caused by road traffic collisions is one of the priorities of the JHWS for Dorset. The approach set out in the JHWS involves a number of council departments, including environment (road design and speed restrictions), planning (infrastructure development), licensing (reducing drink driving) and partners (police, NHS, communities). Communication within and between councils is vital for a coordinated and effective strategy and this is facilitated by the public health team's place at the heart of the Dorset area partnership. For cross-sectoral activity such as is needed to tackle issues like road traffic collisions, the concept of partnership is particularly useful. In trying to address complex problems, a broad approach is needed to tackle the multi-factorial causal nexus.

Involvement with district councils

There are six district councils within the county's boundaries. The director of public health and colleagues have had longstanding positive relationships will all key stakeholders in the districts. One district council has its own health improvement statement as part of its corporate plan and the public health team is encouraging the other district councils to do the same. Public health issues which have found immediate support among district councils are workplace health, housing

and the role of regeneration and tourism in promoting health and wellbeing.

Each district council and relevant locality GP rep is represented on the Dorset County Health and Wellbeing Board. The JHWS are written so as to ensure that each of the organisations and agencies are clear as to their responsibilities for various aspects of the strategy. Because of the close relationships between all the councils involved, it has been possible to organise these responsibilities more on a logical basis than on an organisational one. The public health team has been influenced by the idea of an 'ecological approach' focusing on the linkages between underlying causes of ill-health, health outcomes and interventions. Central to this approach is the idea of interconnectedness across agencies and across determinants, which highlights the need to involve all layers of local government as well as civil society in any response to public health challenges.

For example, one of the Dorset JHWS priorities is increasing physical activity and tackling obesity with an emphasis, in the relevant areas, on activity in rural settings. The public health team has worked on a programme with one of the district councils, in which the role of the public health team is to support and evaluate the programme, Activate 1000, with the district council leading on implementation. It was decided that, rather than providing funding directly, the public health team would assist with design of the programme and would support the district council in making a bid for a major lottery grant, in which it was successful.

Future plans

The partner councils see the public health challenge as being to translate the deliberations of the Health and Wellbeing Boards into sustained action at a more local level, especially in areas where both county and districts need to be involved.

In one example, a multi-agency approach is being developed to two key issues of concern for the local population: one disease area, chronic obstructive pulmonary disease (COPD), and one related environmental factor, housing. Key inter-relationships and linkages which may drive health and wellbeing outcomes for each issue have been identified and various indicators developed. Simulations of different policies in housing and COPD will be developed and their impacts on long-term health tested. The focus will be on learning how and what actions in the present can trigger plausible reactions and change in outcomes over time. The intention is that this will assist in ranking different policy options in terms of their acceptability or effectiveness. For example in the case of COPD, is it best to invest all resources in better treatment for the symptoms of exacerbations of the disease, reducing exposure to smoking and second hand smoke or investing in improved home thermal insulation to prevent temperature extremes?

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