A4

THE ROYAL BOROUGH OF KENSINGTON AND CHELSEA

HEALTH SCRUTINY COMMITTEE –8 JULY 2009

REPORT OF THE EXECUTIVE DIRECTOR OF HOUSING, HEALTH AND ADULT SOCIAL CARE, THE EXECUTIVE DIRECTOR OF FAMILIES AND CHILDRENS SERVICES AND THE DIRECTOR OF PUBLIC HEALTH FOR NHS KENSINGTON AND CHELSEA.

JOINT STRATEGIC NEEDS ASSESSMENT – THE WAY FORWARD

The first Joint Strategic Needs Assessment (JSNA) was published in May. A launch seminar with key commissioners and voluntary sector organisations was held and delegates were asked to identify joint commissioning opportunities and priorities for future JSNAs. This paper summarises the feedback from this event and highlights themes that have been identified for further investigation.

FOR INFORMATION/DISCUSSION

1 INTRODUCTION

1.1 The JSNA is a statutory on-going process by which the Council and NHS Kensington and Chelsea continue to identify the current and future health and social care needs of the borough's population as a basis for joint commissioning.

1.2 The first JSNA has just been completed. It has three products; the published summary document, the detailed analysis chapters (available on the internet) and the data fact sheets, also internet based.

1.3 The products were launched on 21 May in the Small Hall. Seventy delegates from the Council, NHS Kensington and Chelsea and selected BME and voluntary organisations attended.

1.4 This paper only refers to the feed back received during the launch event and further work to both plug gaps in knowledge and refine the data. The Commissioners themselves will develop ways of working with this new tool to change the way services are commissioned.

2 CHALLENGES TO THE STATUS QUO

2.1 The following paragraphs contain the headlines from the launch that the Commissioners agreed they need to consider as they use the JSNA.

2.2 There was an overwhelming acknowledgement from staff of all organisations that we need to better join up the way we deliver services and understand people. People are complex, often with a range of needs. Services need to be delivered in a way that responds to this and joint commissioning is key. In some cases, outreach may be more suitable than premises based services

2.3 Diet and nutrition was an area discussed. It was suggested that we should develop an approach for dealing with obesity that crossed all age groups. It was pointed out that Families and Children's Business Group had spent a considerable amount of time getting school meals right and the experience gained here could be used in commissioning services for older people in day care centres or those requiring meals on wheels.

2.4 It was thought that oral hygiene should be tackled at a younger age and more work could be done to involve parents. The links between dentistry, nutrition (malnutrition in some older people), obesity and physical activity could be better exploited though joint commissioning.

2.5 When children move into young adulthood aged (16-18) stronger joint commissioning is needed to ensure that their transition between adult and children's services is smooth and effective.

2.6 The potential role of Health Visitors was raised by many. There are opportunities to provide them with more training on health promotion so that they can explore where clients wish to make changes and then signpost people to specific local services on areas like nutrition, exercise and smoking cessation which meet individuals' needs.

2.7 Better information sharing between the Council and NHS Kensington and Chelsea is required. Departments may be undertaking pieces of work that the other knows nothing about. The JSNA Co-ordinator should be informed about all pieces of research or consultation being undertaken so duplication can be avoided. The progress with and the results of such work can then be shared.

2.8 The clarity of desired outcome for clients and patients is important to enable the Council, NHS and other partners to bring together all

the necessary ingredients to design and reconfigure their services to meet the changing agenda.

3 FUTURE JSNA PRIORITIES

3.1 There were several themes that cut across several chapters where commissioners expressed their concerns about a lack of information on. Eight of these are listed below:

- Carers – a robust needs assessment is required. Being a carer is not a steady career. Young carers and carers with a disability are a particular concern.
- Self-funders – there is a concern that self-funders only present themselves to services in a crisis. Commissioners would like to know more about what they choose to spend their money on.
- Users of private services - there is little information available about those using private health and social care services, as an alternative or to complement public provision. For example, about half of resident children go to private school – this means, among other things, that there is a lack of data on BMI and obesity. In addition, where screening rates are low it could also be because people are going private.
- Transition (young person to adult) – more is needed to win people's confidence and changing expectations on what can be achieved. There is also a change from being given prescribed services to suddenly having a choice of services, and with the personalisation agenda, how they are delivered. Further work is needed on understanding family needs of children and adults with disabilities rather than separating them into adults and children.
- Prevention - Need to identify key prevention areas (such as those for obesity). We should review the preventative services we commission and older people use/the uptake. There are large unidentified groups of people. Work on mental health should start in schools. For the invisible population, middle class and affluent; there are concerns particularly in relation to drug and alcohol use or those ashamed of mental illness. These groups are only likely to present themselves in a crisis.
- Harder to reach groups - There is a need for more information on the needs of BME older people and whether or not services are equally accessible and appropriate to them. There is also difficulty in reaching relatively affluent residents who may not use local authority social care or NHS health care services until there is a crisis, as mentioned above.
- Housing/built environment – living in inappropriate accommodation can be disabling and lead to further social isolation and possibly depression. The design of a house needs to be enabling to improve

someone's quality of life and use of resources. It was suggested that the housing allocation policy should be reviewed and that we should also consider moving older people into more suitable accommodation that isn't several floors above ground. It was pointed out that a high proportion of older people are renting from private landlords – this also brings challenges.

- Inequalities –the question was posed as to whether it is worse to be deprived when living in an area of affluence. A comparison study could be undertaken to compare us with similar boroughs.

4 OTHER COMMENTS

4.1 It was acknowledged that the voluntary sector must now be more engaged and contribute to the JSNA process. They will be invaluable in helping us to understanding who our community really are.

4.2 It is clear that there needs to be a stronger link between the JSNA and the personalisation agenda as there are some common aims, specifically around making it easy for anyone in the borough to find out about the services and facilities available locally and what they are entitled to.

4.3 Future JSNAs should include more qualitative data around the community and patient experience. We need to ask residents what they think their health care needs are. 'Softer' information from existing consultations should be pulled together and made available in the JSNA – this might identify areas where further consultation is required.

4.4 There were several comments about the way the JSNA has been arranged to suit existing ways of working. However, it could be organised differently in future according to a 'life journey' approach.

4.5 As the JSNA is used by commissioners, the next update document will have to show outcomes and success stories demonstrating how things have changed as a result of the JSNA.

5 NEXT STEPS

5.1 A JSNA co-ordinator will be recruited after the summer period. This person will take forward a JSNA action plan which will be based on the information presented in this paper and the gaps already identified in the JSNA (which can be found at the end of each of the detailed chapters). This action plan will be approved by the JSNA Project Board in October.

5.2 The co-ordinator will meet with key commissioners from each of the subject areas to discuss the action plan and the work needed to fill each of the aims. By then, a reasonable length of time will have passed since the launch of the JSNA and they will be able to find out how they are commissioners are using the JSNA and the impact it is having on their services.

5.3 The JSNA co-ordinator will review our existing knowledge of residents' priorities, particularly with our BME communities, and arrange further work as required to plug gaps.

5.4 Further work is required to make information 'come alive' on the Council's website. The data presented is quite static. Interactive mapping, where commissioners can pick the parameters they would like to find out more about, would be hugely beneficial.

5.5 It is acknowledged by all that generally a more holistic joint commissioning approach is needed across the Council, NHS and voluntary sector. At the moment, existing Council and NHS strategies and individual needs assessments are driving the JSNA, but as the process evolves, it should be the JSNA driving the strategies and commissioning decisions.

5.6 The more difficult task of how the JSNA will shape future commissioning decisions is still in a state of evolution. Input will be needed from a wide range of commissioners from the Council, NHS and voluntary sector, all of whom will be working to different commissioning cycles and timetables. It is not yet clear how the Scrutiny Committee will work with the newly formed Joint Commissioning Board.

5.7 Consultation is being undertaken with all of the JSNA duty holders to establish how the JSNA will shape future commissioning. A report on this will be brought to a future Health Scrutiny Committee.

6. FOR DISCUSSION

6.1 Members are invited to comment on the priorities identified in the report and JSNA and suggest any additional areas that may not be currently reflected in either. These will then be incorporated into the JSNA action plan.

Paul Morse
Director for Environmental Health and Trading Standards

Jean Daintith
Executive Director of Housing Health and Adult Social Care

Background papers:
JSNA summary document and internet based detailed chapters found at http://www.rbkc.gov.uk/partnerships/healthwellbeing/default.asp

Contact officer: Ann Ramage, Head of Environmental Quality and Public Health **Tel:** 020 7341 5612 **E-mail:** ann.ramage@rbkc.gov.uk