By:	Graham Gibbens, Cabinet Member for Adult Social Care and Public Andrew Scott-Clark, Director of Public Health
To:	Kent Health and Wellbeing Board
Date:	16th September 2015
Subject:	JSNA recommendations report
Classification:	Unrestricted

Summary:
This paper outlines key recommendations from the Kent JSNA and related needs assessments that may be considered by CCGs and other commissioners represented on the Board for their next commissioning plans in 2016/17. The recommendations follow a life course approach and summarises some of the key findings from the latest JSNA exception report which was noted at the May 2015 Kent Health & Wellbeing Board.

Recommendations:
Kent Health & Wellbeing Board members are asked to:

1. Consider how areas identified in this report reflect the priorities of the Health and Wellbeing Strategy

2. Consider the focus that these areas should have in the commissioning plans

3. Ask local health and wellbeing boards to develop their priorities based on the discussion at this Health and Wellbeing Board

1.1. The purpose of this paper is to ensure that annual CCG commissioning plans reflect important changes in population need. Therefore, in addition to the annual JSNA exception report tabled earlier this year, a short report listing key recommendations, at a Kent level, could be considered before the commencement of the next CCG commissioning round, starting in March 2016.

1.2. The recommendations have been broadly listed using a life course approach, focusing on key programme areas. An additional section has been written particularly around the infrastructural requirements around the better use of

information and intelligence affecting the success of future health and care service planning by commissioners.

2. Early Years

The following key points should be included in commissioning plans:-

2.1. A Kent-wide maternity service specification to include the ***Healthy Child Programme***, particularly the universal delivery of full conception to first week of birth element, and reflect all relevant NICE Guidelines for maternity care.

2.2. Commissioners need to oversee the delivery of ***NHS England Stillbirth Care Bundle*** (which includes reducing smoking in pregnancy) to reduce stillbirth and early neonatal death. Reducing deaths in babies and young children; specifically neonatal mortality and still births is a key NHS indicator in the NHS Outcomes Framework.

2.3. There is a need to improve capacity and with ***Unaccompanied Asylum Seeking Children*** to cope with the considerable increase in demand. There is also a need to improve data about the health needs of children in care.

2.4. ***The commissioning of speech, language and communication services*** should be less fragmented across the county resulting in an inconsistency of approach and risks inequity. A detailed assessment of need and provision using a nationally validated method needs to be undertaken. This should allow a service specification to be developed which can inform a joint commissioning strategy going forward.

2.5. There is a need to have a greater impact on families suffering from ***the toxic trio (domestic abuse, mental health and substance misuse).***

2.6. It is important to ***increase breastfeeding rates*** in Kent, particularly in areas of deprivation. Health and social care professionals and the third sector should evidence they are working collaboratively to provide women with a fully integrated service in line with the national breastfeeding pathway.

2.7. ***Increase childhood vaccination rates*** via closer working between the immunisation and vaccination coordination service and GP practices, utilising a targeted approach to those practices and vulnerable population groups where uptake is lowest. Social marketing campaigns and improved monitoring systems need to be used.

3. Improving lifestyles

Sexual Health

3.1. ***Termination of pregnancy services*** need to be commissioned as per the guidelines which offer and undertake testing for HIV, syphilis, gonorrhoea and chlamydia with all clients and provide contraception; signpost to sexual health services for discussion and implementation of long acting methods of contraception and give clear advice on how information about positive Sexual Transmitted Infections (STI) tests and treatment will be communicated.

3.2. Commissioners need to incorporate ***HIV testing*** as a routine test for all patients discharged from active services in the forces, all patients with TB, Hepatitis C, Hepatitis B, all new registrants, all patients who present with HIV clinical indicators.

3.3. Commissioners commit to undertake to promote and offer ***chlamydia screens*** to all contacts aged 15-24.

3.4. Clinicians in primary care to offer a full range of contraception including ***Long Acting Reversible Contraception (LARC).***

Smoking

3.5. ***Carbon Monoxide (CO) screening*** should be part of routine care. CCGs should include a requirement in service specifications that midwives discuss smoking status at booking with all women and that all women are screened for CO. Midwives should give very brief advice on cessation to identified smokers and promptly refer a minimum of 90% of those with CO score of 4 or higher to local stop smoking services.

3.6. Commissioners should include requirements to ***reduce smoking*** within Key Performance Indicators (KPIs) in contracts with secondary care. The KPIs should include:

- Identifying and coding all smokers on admission and referring to stop smoking services
- Mandatory training for all front line staff so confident/competent in raising the issue and signpost/make referrals
- Nicotine Replacement Therapy readily available and seven day 24 hour service
- An electronic referral system in place
- Services available to provide support as and when needed

3.7. Every Kent clinician including ***GPs knows the smoking status of each patient*** they care for and has the competence and the commitment to encourage and support that patient to quit through direct action and referral.

3.8. ***Future commissioning plans should include Quit smoking interventions*** delivered by GPs and pharmacies building on the current success of 4-week quit stop smoking services in GP surgeries and pharmacies. New models of commissioning will be designed in line with NICE guidance and consultation with Public Health and CCGs.

Physical Activity

3.9 The Kent population is becoming less active over time. Almost 3 in 10 adults fail to achieve at least 30mins of physical activity over the course of a week and over 4 in 10 adults do not currently meet the recommended levels of 150mins of physical activity per week.

3.10 Primary and secondary care practitioners are well placed to identify and signpost individuals who will benefit by increasing their physical activity. C should use commissioning opportunities to influence behaviour change through service providers by contractually implementing programmes such as ***Making Every Contact Count***. CCGs to also work with Public Health who are currently developing programmes to improve physical activity based on current guidance from NICE and Department of Health on local programme design and commissioning.

Healthy Weight

3.11 ***Education and training*** as part of on-going Continuous Professional Development (CPD) is required to a range of professional and non-professional staff including developing confidence in raising the issue of weight, offering brief advice and more intensive training including motivational interviewing and nutrition to identified staff who will be local champions.

3.12 Further work is required to ensure that both adult and children ***weight management pathways have adequate capacity*** to meet specialist dietetic and weight management services.

4 Long Term Conditions – Early Diagnosis and Treatment

Health Checks

4.1 Inequity patterns exist across key Long Term Conditions particularly linked with deprivation on indicators such as recorded and expected prevalence, hospital admission rates, premature mortality rates and vascular health checks.

4.2 ***Estimated volumes of undetected disease prevalence should be monitored alongside health check performance*** and in the wider context of avoidable admissions, profiling for cardio-vascular admissions considered amenable to health check intervention.

4.3 Patients identified at risk of cardio-vascular disease through the health check programme should be supported with the ***appropriate range of adjunct primary and secondary prevention interventions.***

Cancer

4.4 A recent cancer equity report highlighted marked outcomes inequalities by gender, deprivation and emergency presentation rates. Variation across CCGs exist for early stage diagnosis, one year survival and urgent GP referral rates. Additionally, lung cancer mortality rates are increasing quickest amongst the most deprived groups.

4.5 Action is required to ***target health promotion/prevention and cancer risk awareness messaging among the male population and deprived areas.*** Consideration should also be given to ensuring that such action is delivered in ways that are likely to be effective among at risk male groups.

4.6 ***Reinforce the importance of early diagnosis and urgent referrals in primary care*** towards achieving improved survival rates, particularly in Swale and Thanet.

Stroke

4.7 Commissioners need to ***map out and understand in detail the care journey of stroke patients*** in order to identify potential areas for improvement, where resources can be utilized more efficiently.

4.8 Further improvements are required in the ***management of key risk factors*** for stroke in primary care, ***targeting particular groups ie. Black African and***

Caribbean in North Kent region. This should be part of the wider prevention agenda by Public Health to promote healthy lifestyles and reduce poor diet, obesity, smoking, physical inactivity and excessive alcohol consumption.

4.9 ***The Stroke Review Programme Board should consider the above factors towards the commissioning of hyperacute and subacute stroke beds.***

Mental Health

4.10 National reports and local needs assessments as well as the JSNA exception report already highlight the growing burden and importance of tackling mental ill health both in children and adults, particularly domestic violence, self-harm and suicides.

4.11 Commissioners should contribute to the current pathway to ***improve outcomes to issues such as self-harm (particularly in relationship to liaison psychiatry)*** to reduce hospital admissions and consider how to improve equity to psychological therapy in particular risk groups eg. new mothers, Lesbian Gay Bisexual & Transexual, and isolated men and some BME communities (regarding suicide risk).

4.12 ***Further audit, evaluation and needs analyses*** is required in a number of areas such as a 'serious incidents / lessons learnt process' for patient suicides, benzodiazepines and opiate prescribing, treatment of high risk groups such as veterans and offenders and services such as Community Mental Health Teams.

4.13 ***Further integration and service transformation work is required*** in joining up pathways for treatment pathways for personality disorder, dual diagnosis (consider use of incentives such as 'CQUINS'), screening (both physical and mental health) and brief interventions for alcohol misuse, and a multiagency partnership approach towards domestic abuse.

4.14 A ***Kent-wide perinatal mental health pathway*** with equitable access to perinatal mental health support at all levels of need, including prevention services, for pregnant women across Kent. The pathway should be developed with reference to the national maternal mental health pathway.

Learning Disabilities

4.15 With respect to ***annual health check assessments*** for persons with learning disabilities, commissioners need to work with local GPs to improve the measures need to be taken to ***improve uptake rates*** for the same. To address variation in health outcomes of people with learning disability attention should also be given to the quality of health checks. This can be done through service audits in primary care.

4.16 With regards to national screening programmes commissioners need to ***work collaboratively to improve quality of data recording*** particularly for identification of those eligible for various national screening programmes. Attention should be paid to improving the uptake of cancer screening amongst people with Learning Disabilities.

5 Shifting care out of hospital

5.1 Based on forecasts by the Office of National Statistics, the older population (65 years and over) in Kent is expected to increase by another 30,000 (10%) to 330,000 by the year 2020. This will have considerable impact on health care services caused by higher old age dependency, chronic disease management particularly multiple morbidities and increased care needs.

5.2 Work is required to understand how to bring key programmes for older people's health together for ***service integration and transformation***, particularly in three areas – ***dementia, falls prevention and end of life care (EoLC).***

5.3 Further work is still required to ***improve the completeness of dementia prevalence*** registers in primary care to meet national targets, and review impact of the referrals for dementia identification and assessment particularly from care and nursing homes. Commissioners may need to consider how they wish to take part in local Dementia Action Alliance and their role in the population approach to raising awareness about dementia and voluntary services and other organisation that are part of Dementia Friendly Communities.

5.4 Kent overall appears to be on target for consistent reduction in falls related hospital admissions, however in West Kent and Swale CCGs, the rate of decrease is currently lower than their respective targets. Commissioners should ***continue their efforts in falls prevention, integrate services in the community for rehab and postural stability for maintaining***

independence.

5.5 Alongside this, commissioners need to consider ***the impact of sensory impairment services*** such as eye health treatment provided by primary care optometrists eg. management of Acute Macular Degeneration, Glaucoma and Cataract. There is a universal requirement for the availability of communication support for the deaf, blind and deafblind people in all health settings.

5.6 ***In EoLC, completeness of palliative care registers need to be improved*** with a view to find the missing 'one per cent'. Adequate training of frontline staff and raising awareness to minimise access to EoLC services between cancer and non-cancer patients.

5.7 As part of the ***Kent Pioneer and Vanguard work***, commissioners should continue their respective efforts in service integration, multi-disciplinary team approach to chronic disease management, evaluate the use of technology to support direct care such telehealth and telecare, as well as sharing of medical records and care plans.

6 Embedding Sustainability

6.1 There is a clear interdependency between public health, health and social care, sustainability and wellbeing. Workplaces impact significantly on population health, and good quality employment has been shown to increase wellbeing, whilst at the same time reducing conditions such as anxiety and depression. ***CCGs should develop plans to promote their staff health and wellbeing.***

6.2 CCGs also have responsibility for promoting environmental sustainability and should develop programmes to promote sustainable practices in their procurement processes.

7 Improving the access to and use of informatics for planning health and care services

7.1 National policy shift emphasizes the need for redesigning payment contracting mechanisms to incentivize service integration and integrated care. However, the evidence based approach for whole system transformation within current financial resources is still not yet determined, owing to a lack of suitably designed information and intelligence systems that can deliver this.

7.2 Commissioners must appreciate the urgent need for the ***right infrastructure and resources required in the development and design of whole population person level linked datasets*** and work with Public Health to design a whole system strategy on the use of health and care informatics for planning purposes.

7.3 Commissioners need to be adequately aware of the benefits and uses of linked datasets particularly around ***capitated funding model development, predictive modelling and 'system modelling', and accurately estimate future service demand and costs.***

7.4 A key example would be linked datasets that can effectively plan Child and Adolescent Mental Health and disability services, particularly understanding impact on vulnerable groups such as Children in Care comparing to the rest of the population.

8 Recommendations

Kent Health & Wellbeing Board members are asked to:

1. Consider how areas identified in this report reflect the priorities of the Health and Wellbeing Strategy
2. Consider the focus that these areas should have in the commissioning plans
3. Ask local health and wellbeing boards to develop their priorities based on the discussion at this Health and Wellbeing Board

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