

REPORT TO EXECUTIVE COMMISSIONING TEAM

Public response to consultation on the Joint Strategic Needs Assessment

Reference No:	
Purpose / Action Required:	Briefing Paper for Review
Strategic Aim / Goal and/or Healthcare Standard:	Health and well being improvement and reducing health inequalities.
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Consultation and/or Involvement Process:	The work was led by the JSNA steering group with representatives from the PCT and North Lincolnshire Council Adult Services.
Freedom of Information Status:	Public document

1. INTRODUCTION/PURPOSE

The Local Government and Public Involvement in Health Act 2007, makes Joint Strategic Needs Assessment, (JSNA), a statutory duty for PCTs and local authorities, to be undertaken jointly by the Director of Public Health, the Director of Adult Services and Director of Children's Services. Government Guidance describes the JSNA as a tool to identify the health and wellbeing needs and inequalities of a local population and recommends that the findings be used to:

- Inform more effective and targeted service provision
- Determine shared targets to meet these needs, through the Local Strategic Partnership and Local Area Agreement
- Identify priorities for commissioning

The Guidance also makes it clear that each JSNA should be unique to an area, reflect local circumstances and be informed by the views of local people, with a particular focus on the views of vulnerable groups.

The Director of Public Health, Director of Adult Services and Director of Children's Services published a consultation JSNA document, 'Finding the Future Together', in May 2008. This focused on the needs of older people and people with long term conditions and posed a number of questions about the future shape of health and social care services in North Lincolnshire. This consultation document was made available in a variety of formats and the findings were disseminated to local stakeholders, community groups and the public. A series of presentations and consultation events took place during July and August 2008, focussing on the Acorns area of Scunthorpe, an area with significantly high levels of poverty, poor health, and social deprivation, but extending out to rural communities and other vulnerable populations across North Lincolnshire.

This report describes the process of consultation and summarises the key findings. More detail can be found in the attached reports.

Consultation process

The JSNA consultation document and draft priorities were placed on the Council's, the PCT's and NLaG websites. These were presented for discussion at the PCT Board, the LSP Board, the Council's Cabinet Committee, the Who Cares Management Board, the Council's Overview and Scrutiny Committee and the Acorns' Management Board.

Leaflets were distributed to the public via community newsletters and by colleagues working within Freshstart, the Acorns team, 'Who Cares' and Voluntary Action North Lincolnshire. These were also made available at Local Links offices, libraries and GP practices. A 'Talking Book' summary was also produced and an interpreter employed to enable those with a sensory impairment to participate in the process.

In addition, staff members of the Acorns Neighbourhood Team, 'Who Cares' and Adult Social Services consulted directly with 19 community groups, disability and/or carers' support networks as well as with more than 80 individual members of the public. A total of 360 people took part in these consultation events over the course of 4 weeks. The fact that so many people were willing to contribute at such short notice reflects the level of public interest in the issues raised, as well as the enthusiasm, skills and commitment of the facilitators, who volunteered to run these groups alongside other work commitments, as well as in their own time. It also reflects the priority that partner agencies attached to this work. Needless to say none of this would have been possible without their support.

More details on the process and outcome of this consultation work can be found in the attached reports. A formal joint response from PCT provider services is also attached for information. Readers should note that the views expressed in these reports may not be representative of the public at large, although they do reflect the opinions of those people who attended these groups. Inevitably, when asked to consider priorities, people tend to focus on the negative rather than positive aspects of services. However we did receive some very positive and supportive written comments from a few people about the health and social care services they had received. In retrospect, perhaps we could have encouraged respondents to explore both their positive as well as negative experiences in these groups

2. ASSESSMENT OF STRATEGIC LDP RISKS AND BENEFITS

2.1 Public Health

The JSNA is a key tool for identifying the health and social needs and inequalities of our local population and consulting with local communities on strategic priorities.

2.2 Quality and Performance

Both the JSNA and the public's response have informed the development of North Lincolnshire PCT's (draft) Strategic Plan and the strategic priorities of the LSP for improving health and well being in North Lincolnshire over the next 3-5 years. The results of this process will add to the existing evidence base on the health and well being of our local population, and will inform the development of the Local Community Strategy.

2.3 Finance

No immediate financial implications.

2.4 Equality / Diversity Assurance

The public consultation process focussed initially on the most deprived areas of North Lincolnshire, and was undertaken by people who work within these communities. It also extended out to other parts of North Lincolnshire, including our more rural communities, and encompassed the voice of disability and carers' support groups in these areas. Representatives from local faith groups and BME communities contributed to the process

via a special meeting of the 'Who Cares' health and social care local involvement network, (LINKS).

3. ANALYSIS, OPTIONS AND CONCLUSIONS

What follows is a brief summary of responses to the key questions and priorities in the JSNA. (These questions were modified and reworded for use with different groups). More detailed responses are available in the attached reports.

Question 1: Have we identified the major factors affecting the future provision of health and social care for people living with long term conditions and older people?

The general view was that the JSNA document identified most of the major factors, but that mental health was not covered as well as it could be. There was considerable support for the inclusion of mental health in the shortlist of commissioning priorities for the next 3-5 years. In particular, reference was made to the likely increase in the prevalence of mental ill health amongst our future older population, and the need to strengthen prevention, early identification, treatment and support services, especially for people with dementia and their carers.

Question 2: Have we got the balance right between providing health and social care services and investing in programmes to keep people healthy for longer?

Most people felt that preventive services needed strengthening and that intervening early to prevent the need for expensive health and social care services in the longer term was a sound investment. Some carer groups felt that resources would be better spent on improving the quality of existing health and social care services for older people now, rather than investing in new preventive programmes for the future. However, virtually everyone supported the need for earlier intervention and treatment, to enable people to live healthier for longer.

Question 3: What more could be done to help these (pen portrait) families live healthier lifestyles?

A consistent theme arising from the Acorns consultation, and particularly from direct interviews with the public, was the need to tackle the root causes of ill health. Many cited stress as the main cause of unhealthy lifestyle behaviours, caused by the pressure of living on a low income and the everyday challenges of modern life. Many felt the connection between social inequalities, physical and mental ill health was overlooked by services, who tended to respond separately to these issues. The Acorns Management Board recommended a coordinated approach, and asked for this be reflected in the PCT's Strategic Plan and in the LSP's priorities.

Respondents also highlighted the need for more practical, community based support to help them make positive lifestyle changes. It was recognised that GPs and other health professionals were not the most appropriate or accessible source of lifestyle advice and support. When asked, more than a quarter said they would not know where to turn for help with lifestyle changes. Just under half said they would look to family and friends for support.

There was a lot of support for the Health Trainer model in the Acorns area, as well as for more targeted lifestyle support. Targeting whole families rather than individuals was felt to be the way forward.

Other suggestions included free access to swimming and other leisure activities, for people on low incomes; and more social activities for families and older people.

Question 4: Self care will be an important part of care for all these families – what needs to happen to enable them to do this well?

A recurring theme was the need for consistent information about how and where to access services, preferably provided in a single place, but with access to face to face advice if required. As one lady put it, 'Being landed with a whole pile of leaflets from different services is no help at all'. Others complained about being given the wrong information about how services could be accessed.

There was a general feeling that people were being deliberately denied appropriate information and so were missing out on services to which they were entitled. As one person commented, 'Anyone would think Social Services was an international State Secret.' 'If people don't know what is available, they will make do with what they have.' A few said they had disengaged from services due to poor access, poor communication or poor quality of services received.

People with hearing loss complained that services were often inappropriate or inaccessible. An example given by one person was the experience of sitting in hospital outpatients all afternoon and then missing the appointment because they had not heard their name being shouted out. When asked if staff could write their name down when it was their turn to be seen, they were told this was in breach of data protection and patient confidentiality.

A common complaint was the length of time people waited for aids and adaptations to be fitted. Some people said they were so worn down by the process or by having to repeat their stories over and over again to different people, they had withdrawn from services.

Another recurring theme was the need for better continuity of care between hospital, primary care and community health and social services. Patients and carers spoke with frustration about the lack of communication between service providers and inconsistency of care. This often resulted in delays in access to treatment and support services, or no access to services at all.

Older carers said they would welcome a single point of contact – a named worker who understood their needs. Not necessarily available 24/7, just someone who could provide reassurance, point them in the right direction of services and potentially intervene before a crisis developed. Many felt that carers needed more support to help them take better care of their own health.

Question 5: What's the right balance between remote access, central facilities and local services? How can we ensure that families access the services when they need them?

The general view was that services must be accessible to those most in need, preferably community based, walk in and provided in both clinical and non clinical settings; tailored to the needs of local people. It was felt that health and social care services were more likely to be sensitive to local needs if they were commissioned to work together within the same geographic areas.

There was considerable interest in the potential of new technologies, including remote access to support and advice through the internet and TV. However more information was needed to reassure people about the quality and safety of these new services. People were concerned that these might replace personal services, simply because they were considered to be a cheaper option. The same quality and safety issues applied to the direct purchase of support services through direct payments and individualised budgets.

Question 6: What services should we prioritise to help these (pen portrait) families stay in their own homes for as long as possible?

Without doubt the service that people most commonly requested was a single point of access to high quality information about local services. This was followed by targeted preventive support to help those most in need plan for their future and look after their health. Better access to welfare benefits advice to enable older people to maximise their incomes, improve their quality of life and engage in the wider community, was also mentioned.

Many of the older people who were consulted said that belonging to support groups and attending social activities like Freshstart had made a real difference to their quality of life. Many older people wanted to see more services like this.

Public response to the draft priorities

- Priority 1 *Most smokers say they want to quit. We need to provide the best quality services for everyone, especially those who find it hardest to quit.*

Most people recognised the difficulties that smokers faced in giving up and there was little support for denying services to those who continued to smoke. It was recognised that for many, smoking was a coping strategy for dealing with difficult social and personal circumstances. Stop smoking services were essential. But they had to be pitched within local communities, accessible and affordable. The reasons why people took up smoking and continued to smoke had to be tackled too, especially in our poorest communities.

- Priority 2 *Other programmes need to be developed too, to help people stay physically active, eat healthily, achieve a healthy body weight and drink sensibly.*

Whilst many people agreed with this statement, they were often at a loss to know how services might tackle this. When asked, most people said they could live more healthily, exercise more and eat and drink less. Many respondents were regular smokers too. However, behaviour change was hard. People had to be given positive reasons for doing this as well as being supported to take more control of their lives. Some discussed the idea of 'personal contracts' with services. Others liked the idea of health 'trainers' and community health champions.

- Priority 3 *To reduce the coronary heart disease mortality in North Lincolnshire's most deprived wards a systematic programme of 'heart health' needs to be developed targeted at people in their 50s and 60s.*

Most people supported the idea of health checks for those at risk of heart disease – but felt that the GP surgery was not necessarily the best place for this. Men were often reluctant to go to the doctors – so other ways of reaching people would have to be explored. Those on the Acorns felt that people living in more deprived areas should be targeted sooner, in their 40s rather than 50s.

- Priority 4 *Services for people living with long term conditions need to be further developed to enable them to be sustainable giving growing demand. Self care needs to be a major element. Programmes targeted at people living with chronic obstructive airways disease, heart failure and diabetes are likely to be important.*

There was general agreement with this statement – and people supported the idea of intervening early to prevent these conditions becoming a problem later on. However this needed to be resourced properly. People were concerned about the adequacy of

existing services to support self care, as well as the poor continuity of care between providers. 'Self care' should not mean 'care on the cheap'.

If people were to be encouraged to self care in the community, then information and support services had to be in place.

- Priority 5 *People clearly want a say in how health and social care in North Lincolnshire are developed. We need to find ways of systematically engaging local people in how these and other services are commissioned.*

Many focus group participants said they had been 'consulted' with many times over the last few years, with little evidence of change. Understandably they were cynical about the capacity or willingness of local agencies to act on their views. If agencies were serious about consultation 'it was time to put words into action'. Those who had participated, expected feedback on how such consultation exercises had influenced local commissioning decisions. They also wanted agencies to move away from traditional methods of consultation, such as publications and public meetings, towards more direct and accessible methods of communication with local residents.

4. RECOMMENDATIONS

The Executive Team is asked to:

- Note the findings of this report and the attached documents.
- Refer this to PCT Board members for information

Background papers attached for reference

1. 'Finding the Future Together – A report on consultation with local residents. Acorns Neighbourhood Team. September 2008
2. Report of a Special Meeting to consult on the JSNA, 18th July 2008. Greg Gough - 'Who Cares', the local health and social care involvement network for North Lincolnshire.
3. Response to the JSNA from the Healthier Communities and Older People Scrutiny Panel. June 2008
3. Response to the JSNA consultation document from PCT provider services. August 2008.