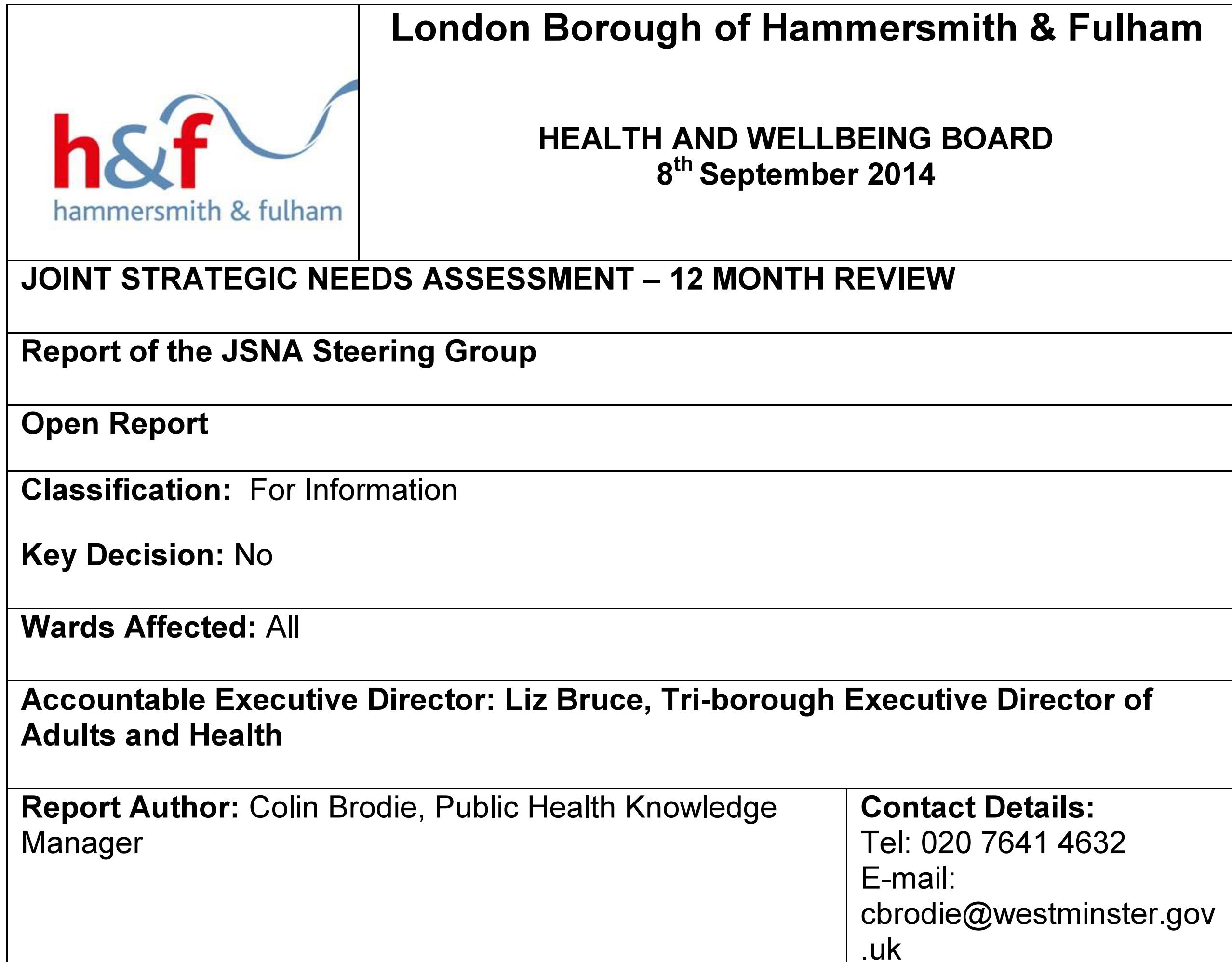

| | London Borough of Hammersmith & Fulham<br><br>**HEALTH AND WELLBEING BOARD**<br>**8th September 2014** |
|---|---|
| **JOINT STRATEGIC NEEDS ASSESSMENT – 12 MONTH REVIEW** | |
| **Report of the JSNA Steering Group** | |
| **Open Report** | |
| **Classification:** For Information<br><br>**Key Decision:** No | |
| **Wards Affected:** All | |
| **Accountable Executive Director: Liz Bruce, Tri-borough Executive Director of Adults and Health** | |
| **Report Author:** Colin Brodie, Public Health Knowledge Manager | **Contact Details:**<br>Tel: 020 7641 4632<br>E-mail:<br>cbrodie@westminster.gov.uk |

## 1. EXECUTIVE SUMMARY

1.1. This report sets our progress being made against evidence set out in deep dive JSNAs published in early 2013.

## 2. RECOMMENDATIONS

2.1. The London Borough of Hammersmith and Fulham Health and Wellbeing Board are asked to note the report attached at Appendix 1 which provides a 12 month update on Joint Strategy Needs Assessment Deep Dive projects undertaken in 2013.

## 3. REASONS FOR DECISION

3.1. This is for information only

## 4. INTRODUCTION AND BACKGROUND

4.1. Joint Strategic Needs Assessments provide a detailed picture of the health needs of the local population, usually focusing on a specific topic. They are developed jointly by local health and care partners and identify actions that local agencies will need to take to improve the well-being of individuals and communities. Local authorities and Clinical Commissioning Groups (CCGs), through the Health and Wellbeing Board, are responsible for the production of JSNAs. Many other partners are also involved in the process, including service providers, voluntary organisations and bodies representing patients and service users.

4.2. The London Borough of Hammersmith and Fulham Health and Wellbeing Board has delegated the day-to-day management of the Joint Strategic Needs Assessment programme to a sub-group of the Health and Wellbeing Board, “the JSNA Steering Group”.

4.3. The report attached at Appendix 1 has been provided by the JSNA Steering Group and provides a summary of progress on the deep dive JSNAs published a year ago. These were Suicide Prevention; Rough Sleepers; Carers; Child and Adolescent Mental Health (CAMHS); Sexual Health; Tobacco Control and Prison Healthcare. The report includes an evaluation on progress made against the recommendations (where this is relevant)

4.4. The JSNA programme team are currently developing a framework to ensure there is a robust process in place for future reviews on the impact of JSNA deep dives, primarily focussing on the recommendations which are now included in the deep dive JSNAs.

## 5. PROPOSAL AND ISSUES

5.1. Please see attached report at Appendix 1.

## 6. OPTIONS AND ANALYSIS OF OPTIONS

6.1. N/A

## 7. CONSULTATION

7.1. N/A

## 8. EQUALITY IMPLICATIONS

8.1. N/A

## 9. LEGAL IMPLICATIONS

9.1. N/A

## 10. FINANCIAL AND RESOURCES IMPLICATIONS

10.1. N/A

## 11. RISK MANAGEMENT

11.1. N/A

## 12. PROCUREMENT AND IT STRATEGY IMPLICATIONS

12.1. N/A

**LOCAL GOVERNMENT ACT 2000**
**LIST OF BACKGROUND PAPERS USED IN PREPARING THIS REPORT**

| No. | Description of Background Papers | Name/Ext of holder of file/copy | Department/ Location |
|---|---|---|---|
| 1. | None | | |

**LIST OF APPENDICES:**

Appendix 1: Joint Strategic Needs Assessments 2013 – 12 month progress report

## Appendix A: JSNA Deep Dive Update and Progress Review July 2014

**COMPLETED JSNA DEEP DIVES PRODUCTS 2012/13 – Update on Progress**

The following deep-dive JSNAs were completed and published in 2012/13. Below is a reminder of the summary of the key findings for each JSNA and an update on progress since they were published.

<table>
<tr><th colspan="2">Suicide Prevention JSNA</th></tr>
<tr><td>Summary</td><td>Rates of deaths by suicide in Inner North West London are higher than in most London Boroughs.<br><br>Suicides are most prevalent in men aged 40-49 years old and the majority of all people completing suicide are born in the UK.<br><br>There is strong evidence that the following interventions help prevent suicides:-<br>• For the general population<br>  o Restricting access to means of suicide<br>  o Policies to reduce harmful use of alcohol<br>  o Responsible reporting of suicide in the media<br>• For at risk groups<br>  o Gatekeeper training for family and community members and health and social care professionals to recognise those at risk<br>  o Mobilising communities<br>  o Postvention for suicide survivors<br>• For individuals<br>  o Identification and treatment of mental disorders<br>  o Management of persons who have attempted suicide or identified as at risk<br><br>There needs to be improved access to local data relative to suicide from coroners.<br>Feedback from local service providers and families of people who have completed suicides indicate that there is an urgent need to:<br>• Strengthen and co-ordinate postvention for the friends and family bereaved by suicide<br>• More joined up working between services, including information sharing<br>• Increased gatekeeper training for family and community members as well as health and social care professionals to help recognise those</td></tr>
</table>

| | |
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| | that might be at risk, question them openly, persuade them to seek help and refer them to appropriate health professionals.<br>• Improve the knowledge about mental illness and the risk of suicide for family members |
| Purpose | To inform the development of a Triborough suicide prevention strategy |
| Recommendations | No |
| Lead responsibility | Triborough Suicide Prevention Working Group |
| Progress to date | A tri-borough suicide prevention strategy was developed based on the findings of the JSNA and which sets out five priorities:<br>• Timely communication and information sharing between agencies on identification of at risk individuals and care pathways.<br>• Public education and awareness on suicide and/or mental health promotion – through community outreach, anti-stigma campaigns, etc.<br>• Promotion of existing suicide prevention resources, interventions or support services (e.g. Maytree respite or telephone help-lines like Samaritans/CALM).<br>• Training for frontline workers (GPs, A&E, and concerned others) through programmes like mental health first aid training or applied suicide intervention skills training.<br>• Targeted interventions for at risk groups (bereaved families, people from BME background, people with mental health issues, people known to mental health services, etc.<br><br>One issue highlighted in the JSNA was improved access to coroner's files and data. Permission was received from Fulham coroners to access case files. An audit of the coroner's files was recently completed and this information is now being analysed.<br><br>In response to feedback from local providers and families of people who have completed suicide the following action has been taken:<br>• A resource pack for families bereaved by suicide has been developed. This has information to help people navigate the bereavement process from death notification, coroner's inquest and afterwards.<br>• A multi-agency suicide prevention working group continues to meet quarterly. Membership is drawn from a range of agencies in operating in the area that have a strategic interest in promoting mental wellbeing. These include local mental health trusts, London underground, acute trusts, local authority, public health, police (British transport and metropolitan), clinical commissioning groups, academic institutions, community providers and service users. The group seeks to promote effective inter-agency working in communicating, managing and preventing suicide incidents in the tri-borough area. One of the key themes the group is exploring is developing an information sharing protocol.<br>• A business case for suicide prevention training for gatekeepers is currently being developed |
| Future delivery | As above |

| Risks and issues | None identified |
|---|---|
| Actions for Health and Wellbeing Board | • Ensuring that suicide prevention and mental health promotion receives equal priority to other health and wellbeing issues.<br>• To nominate a named board member as a lead for mental health. This person can be trained as a mental health champion.<br>• Explore opportunities for investment in prevention, promotion and early intervention |

| **Rough Sleepers: health and healthcare** | |
|---|---|
| Summary | In 2012 INWL PCT was given funding by NHS London to undertake a review of the health needs and healthcare costs of rough sleepers in the London Boroughs of Hammersmith and Fulham, Kensington and Chelsea and Westminster.<br><br>The INWL Boroughs were chosen because they have amongst the highest rough sleeper populations in London. This work consisted of a literature review, a qualitative piece of research talking to current and ex rough sleepers and service providers and a quantitative piece of research to identify the secondary care health costs of rough sleepers across the three boroughs. The quantitative data analysis has never been done in London before and provides very useful healthcare usage and costing data of rough sleepers and shows that rough sleepers use emergency health care significantly more than the general resident populations and therefore cost more per head than the general population.<br><br>**Key findings from the report are:**<br>• **Rough sleepers use more secondary health services, and therefore cost more.** National estimates show that the homeless population consumes about four times more acute hospital services than the general population, costing at least £85m per year. The 933 rough sleepers analysed in inner North West London used secondary care at a cost of £2.4 million. Rough sleepers access A&E seven times more than the general population, and are more likely to be admitted to hospital as emergencies, who cost four times more than elective inpatients.<br>• **Rough sleepers have more health needs.** When rough sleepers attend hospital, they average seven A&E attendances per patient, nearly 10 appointments per patient for outpatients, and nearly three inpatient admissions per patient. They also present with more co-morbidity – one in five who had contact with hospitals had three or more diseases.<br>• **There are specific barriers to accessing services for rough sleepers.** Rough sleepers face a number of attitudinal and structural barriers to accessing healthcare. These include discrimination by health professionals, not being allowed to register with a GP, a lack of knowledge of services, a lack of continuity of care, and cost. Fear of stigmatisation and health as a low priority are also significant |

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| | barriers.<br>• **But there are things that can be done.** Interventions and models of care have been developed, and are being used, to provide a better system of care for rough sleepers. |
| Purpose | To inform future decision-making by contributing to the evidence base for rough sleepers in inner London. The JSNA describes rough sleepers health needs and usage, evaluates the cost of healthcare, identifies existing models of service delivery, and summarises the evidence for interventions targeting rough sleepers. |
| Recommendations | No |
| Lead responsibility | Peter Beard; Senior Commissioning Officer Learning Disabilities and Carers; North West London Commissioning Support Unit; Tri-borough Joint Commissioning Team Adults |
| Progress to date | In response to the findings from the JSNA the following information has been provided<br><br>**Rough sleepers use more secondary health services, and therefore cost more.**<br>• A peripatetic nurse role has been established in West London and funded by WL CCG<br><br>**Rough sleepers have more health needs.**<br>• There is an identified clinical lead for Homeless Health which includes rough sleepers<br>• A Homeless Health Local Enhanced Service<br><br>**There are specific barriers to accessing services for rough sleepers.**<br>• Homeless health peer advocacy service provided by Groundswell which has been shown to reduce Did Not Attend (DNA) rates among rough sleepers<br>• A workshop was held on 21st May bringing together CCGs, health providers and patients to develop a pathway to ensure that the health services for rough sleepers and the homeless are based on need and not location<br>• A pathway has been developed. This will now be formally agreed during June and the impact on commissioning determined by the CCG |
| Future delivery | As above |
| Risks and issues | None identified |
| Actions for Health and Wellbeing Board | None identified |

| Carers Evidence Pack for Hammersmith and Fulham | |
|---|---|
| Summary | This evidence pack was designed to provide the analytical underpinning that justifies why the Borough Carers Action Plan gives priority to the areas chosen. It used data and evidence from a range of national and local sources. In some cases, available data was relatively old. Early in 2013, new data will be made available from the 2011 Census and National Carers Survey, which will add to the existing knowledge base around carers' needs and inform future action plans.<br><br>**Key points from the evidence pack**<br><br>• The way information is recorded and shared could be improved and new data from the 2011 Census and National Carers Survey could alter understanding of the pattern of caring locally,<br>• There is a need to work closely and in a coordinated way with a wide range of stakeholders to improve identification of carers, particularly new carers<br>• The drop in numbers of carers known to the council in 2010/11 needs to be addressed (although recent data shows a rise).<br>• The expected rise in those needing care may result in more carers and hence more support needed for them in their caring role.<br>• Although the numbers taking up carers' assessments and receiving direct payments are high compared to elsewhere, there is scope to improve this uptake.<br>• There has been a drop in numbers receiving information and advice compared to previous years<br>• More information and advice is needed for carers, not only in a range of formats but also a range of settings, including GP practices, pharmacies, libraries and job centres.<br>• Involvement of carers in decisions about care appears to be slightly better in the borough than nationally, but with scope for further improvement, particularly in hospital settings (e.g. through link workers and hospital discharge planning)<br>• A range of interventions that help reinforce and build well-being may tackle issues of low well-being and low life satisfaction reported among some carers locally.<br>• There needs to be increased awareness of the factors that increase the risk of carers being involved in harm.<br>• Although the borough is relatively successful at identifying young carers compared to elsewhere, there is still likely to be significant unmet need.<br>• There is a recognised 'gap' for carers who have reached the age of 18 , and are therefore too old for the young carers service, but too young for the range of services offered to predominantly older adult carers. |
| Purpose | Provide the evidence base to inform the Carers Action Plan |

| Recommendations | No |
|---|---|
| Lead responsibility | Peter Beard, Senior Commissioning Officer Learning Disabilities and Carers; North West London Commissioning Support Unit; Tri-borough Joint Commissioning Team Adults |
| Progress to date | The following is an update against specific findings of the JSNA:<br><br>**Need to work closely and in a coordinated way with a range of stakeholders to improve identification of carers, particularly new carers**<br>• Carer Primary Care Navigator project initiated with practices<br>• GP practices better connected to the local carer support service<br>• GP practices better connected to the young carers service<br><br>**The drop in numbers of carers known to the council in 2010/11 needs to be addressed (although recent data shows a rise).**<br>• There has been an increase in number of carers identified by GP practices involved in the carer primary care navigator service; following data cleanse of their carer register:<br><br>**The expected rise in those needing care may result in more carers and hence more support needed for them in their caring role**.<br>• Current carer support services Funded by CCGs are establishing level of need and developing exit strategies that are sustainable and efficient in supporting existing carers and new carers<br><br>**Although the numbers taking up carers' assessments and receiving direct payments are high, there is scope to improve this.**<br>• There is a focus on increasing the number of carers personal budgets via improved identification<br><br>**There has been a drop in numbers receiving information and advice compared to previous years.**<br><br>**More information and advice is needed for carers, not only in a range of formats but also a range of settings, including GP practices, pharmacies, libraries and job centres**.<br>• We have seen an increase in the numbers of carers identified and referred to the local carers support service through primary care services<br>• No work has yet started in relation to pharmacies, however the local carer support service have run information points within other community based locations including libraries and churches |

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| | **Involvement of carers in decisions about care appears to be slightly better in the borough than nationally, but with scope for further improvement, particularly in hospital settings (e.g. through link workers and hospital discharge planning)**<br>• There is a Tri-Borough carer hospital discharge project in place covering Imperial and CWFT<br>• This is provided by a local third sector carers organisation working with key senior managers in the relevant hospital sites and frontline staff and carers<br><br>**Interventions that reinforce and build well-being may tackle issues of low well-being / life satisfaction among carers locally.**<br>• There has been ongoing funding and management support provided by the CCG to Third Sector organisations to promote and further develop the wellbeing services for carers<br><br>**There needs to be increased awareness of the factors that increase the risk of carers being involved in harm.**<br>• Carers e-learning package procured through CCG funding Due to launch in July/August<br>• This will be rolled out to staff in Social care, Housing, Universal services, Primary and acute care etc<br><br>**Although the borough is relatively successful at identifying young carers, there is still likely to be significant unmet need.**<br>**There is a recognised 'gap' for carers who have reached the age of 18 , and are therefore too old for the young carers service, but too young for the range of services offered to predominantly older adult carers.**<br>• Work is required in this area<br>• Transition pathway needs to be established<br>• Detailed needs analysis to be completed<br>• Identification of where there are specific gaps |
| Future delivery | • Implementation and launch of Carer roadmap in partnership with CCGs and RCGP, modelled on Dementia roadmap<br>• Further practices to be engaged through the carer primary care navigator project<br>• Further extension to the Carer primary Care Navigator service for a further 12 months; working with 24 more practices<br>• Commencement of procurement of a young carer family support service commissioned by CLCCG |
| Risks and issues | Lack of procurement capacity in Local Authority procurement team could result in services not being delivered as planned through S.75 |
| Actions for Health and Wellbeing Board | Assist in increasing capacity to procure services already agreed in Section 75 for 2014/15 |

| Child and Adolescent Mental Health (CAMHS) | |
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| Summary | **Main findings** |

**Main findings**

It is estimated that the prevalence of mental health disorders for children and young people across the tri-borough are as follows:

| | Boys | | Girls | | Estimated total number across the tri-borough |
|---|---|---|---|---|---|
| | **5-10** | **11-15** | **5-10** | **11-15** | |
| Conduct Disorder | 3.75% | 4.8% | 1.75% | 2.1% | **Between 1281-1764** |
| Hyperkinetic Disorder | 1.0% | 0.4% | 0.1% | 0.1% | Between 175-229 |
| Emotional Disorder | 2.2% | 3.5% | 2.8% | 5.2% | Between 1336-1736 |
| Co-Morbid Disorder | 2.1% | 2.9% | 0.6% | 1.3% | Between 714-963 |
| Neurotic Disorders (16-19 year olds) | | | | | 2688 |
| Autistic Spectrum Disorder | | | | | 406 |

Based on population projections the number of children presenting with mental health conditions will increase as a total number and as a percentage of the population for the next 15 years.

Children and Young People who are particularly vulnerable to mental health conditions are:

- BAME children
- Looked After Children
- Care Leavers
- Young Offenders
- Children with learning Disabilities
- Unaccompanied Asylum Seekers
- Homeless young people
- Those who self harm and are at risk of Suicide

The number of children and young people who may experience mental health problems appropriate to a response from CAMHS at Tiers 1, 2, 3 and 4 have been estimated using national research. The following table shows the estimates for the population aged 17 and under across the tri-borough area:-

| | Tier 1 | Tier 2 | Tier 3 | Tier 4 |
|---|---|---|---|---|
| Hammersmith & Fulham | 4926 | 2299 | 608 | 25 |
| Kensington & Chelsea | 4080 | 1904 | 503 | 20 |
| Westminster | 5550 | 2590 | 685 | 28 |

**Main issues**

- The service data collected from across the tri-borough is not consistent across all the services and there is a wide variation in the data and information that they can provide. This means that it is difficult to know if the services that provide the different tiers of service are doing so effectively.
- Currently prevalence of mental health conditions in children and young people is an estimation based on national research. It is not possible to get local prevalence data currently as the data is not consistently collected across the services.

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| Purpose | On 1st April 2012 the Children's Joint Commissioning Team became responsible for commissioning Council and CCG funded CAMH Services for Hammersmith and Fulham, Kensington and Chelsea and Westminster.<br><br>The team requested a JSNA to inform their review of funding and provision across the three boroughs. This was to ensure that a comprehensive range of accessible services from universal to highly specialist that;<br>a. are commissioned and delivered in line with best practice guidance<br>b. effectively meet the needs of patients, families and stakeholders<br>c. are high quality<br>d. represent good value for money |
| Recommendations | No |
| Lead responsibility | Jacqui Wilson; Commissioning Manager ; Children's Joint Commissioning Team<br>North West London Commissioning Support Unit |
| Progress to date | Progress update provided by lead commissioner<br><br>• Service specifications and reporting systems have been tightened up in the last contract round. This will help us to better understand demand and supply for CAMHS services.<br>• Work is underway across the Triborough to think about how services for Looked After Children (LAC), including those with mental health issues, are best managed |

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| | • A CAMHS network has been established. These meetings provide a forum for services working with children and young people to thir about how services function, and ensure consultation opportunities around service changes. This is also an opportunity for those working with children and young people to raise issues and think about how they can work together to resolve them.<br>• Commissioners are engaged in Early Help work to again ensure joined up working |
| Future delivery | As above |
| Risks and issues | None identified by Commissioner |
| Actions for Health and Wellbeing Board | None identified |

| **Sexual Health JSNA** | |
|---|---|
| Summary | The consequences of poor sexual health can be serious. Many sexual infections have long-term impacts on health such as:<br>• Pelvic inflammatory disease (which can cause ectopic pregnancies and infertility);<br>• Cervical and other genital cancers;<br>• Hepatitis, chronic liver disease and liver cancer;<br>• Recurrent genital herpes;<br>• Bacterial vaginosis and premature delivery;<br>• Psychological consequences of sexual coercion and abuse;<br>• Poor educational, social and economic opportunities for teenage mothers;<br>• Requirement for lifelong adherence to Highly Active Anti-Retroviral Therapy (HAART) for HIV;<br>• Earlier onset of conditions normally seen in older age amongst people living with HIV.<br><br>**Limitations and potential data requirements**<br><br>• Estimates indicate a significant Lesbian, Gay, Bisexual and Transgender people who live, work and visit the tri-borough. However, accurate population size remains unknown. In addition, more understanding is required of the needs of these communities to ensure that accessible and appropriate services are available.<br>• Estimates indicate a significant number of sex workers living or working in the tri-borough area. Work is required to understand the |

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| | size and demographics of this population. Further understanding of the complex needs of this population needs to be gained over time. |
| Purpose of JSNA | The purpose of the sexual health needs assessment was to inform the development of the Tri-borough Sexual Health and HIV Strategy, ensuring continuity and integrity of sexual health commissioning following NHS reforms. It describes the picture of sexual health across the Triborough, service provision, identifies gaps in services, and key prevention groups |
| Recommendations | No |
| Lead responsibility | Ewan Jenkins, Sexual Health Commissioner, Triborough Public Health Service<br>The CCGs also have responsibility for commissioning certain sexual health services, NHS England commission all HIV treatment |
| Progress to date | A draft Sexual Health Strategy and Action Plan has been presented to stakeholders. Feedback indicates that further work is required to ensure that the strategy will coherently drive improved sexual health outcomes.<br><br>The following progress has been made:<br>• Work is underway to identify how we can improve prevention work across tri-borough<br>• A review of Sexual and Reproductive Health services delivered in the community has been initiated. This will recommend ways to improve the uptake of contraception including in Primary Care settings. New services are scheduled to be in place from 1 April 2015<br>• A review of HIV services (including prevention, testing and psychosocial support) has been initiated. New services are scheduled to be in place from 1 April 2015. |
| Future delivery | Prevention is key to reducing the high rates of acute sexually transmitted infections across Westminster. Significantly increasing the number of people practising 'safe sex' has the potential to reduce suffering and reduce costs. This will require joint working between the local authority and CCGs.<br><br>To better understand the needs of the Lesbian, Gay, Bisexual and Transgender (LGBT) people Public Health are scoping out an application for a deep-dive JSNA on this community which is likely to involve an element of primary research. |
| Risks and issues | None identified |
| Actions for Health and Wellbeing Board | None |

| Tobacco Control | |
|---|---|
| Summary | Smoking is the biggest single preventable cause of disease and premature death in the UK and across the tri-borough.Generally, smoking attributable mortality is low in Westminster and Kensington and Chelsea. However, smoking attributable deaths are significantly high in Hammersmith and Fulham compared with other two boroughs and higher than London and England. For Westminster and Kensington and Chelsea, average smoking attributable mortality masks the high mortality rates in the more deprived parts of the boroughs. Deaths due to lung cancer and COPD are significantly higher in H&F compared with Westminster and K&C. Hospital admissions due to smoking were also observed to be high in Hammersmith and Fulham compared with other two Inner North West London boroughs.<br><br>Health costs due to smoking across the tri-borough are £25.8 million per year with similar amounts for loss of productivity due to smoking.<br><br>High prevalence of smoking in the most deprived parts of Inner North West London. These areas have a high proportion of social housing, ethnic minority groups and routine and manual workers. These deprived parts of Inner North West London have the highest rates of premature mortality including cardiovascular diseases and cancer.<br><br>National evidence suggests that over the last 60 years, male smoking prevalence is decreasing faster than female smoking prevalence and as of 2010 male smoking prevalence is slightly higher than females.<br><br>Certain ethnic groups including Black African and Caribbean males and any other ethnic group (Middle Eastern community) groups, Irish men and Eastern Europeans and Bangladeshi men have high prevalence of smoking compared with other ethnic groups.<br><br>Routine and manual groups in Westminster and Kensington and Chelsea have high rates of smoking prevalence, while routine and manual groups living in Hammersmith and Fulham have low rates those compared with their respective general population.<br><br>All Inner North West London boroughs have low rates of current smokers who are pregnant compared with England and London.<br><br>Generally, rates of quitting smoking across the tri-boroughs are either similar of better compared with London and England. The highest rates of smoking quitters were observed in Hammersmith and Fulham compared with other two boroughs. |

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| | Low rates of smoking quitters in certain deprived parts of the tri-borough<br><br>According to a recent self assessment looking at current performance with regards Tobacco Control with stakeholders and an additional review of the functioning of the Inner North West London Tobacco Control Alliance across the tri-borough:-<br>• There is good work with young people in Hammersmith and Fulham<br>• Communication is largely reactive with no communications strategy.<br>• No strong leadership<br>• Attendance and membership of the alliance is patchy and unequal<br>• No lead for Tobacco Control<br>• No local Tobacco Control Strategy or vision<br>• Commissioning of services is not joined up with wider strategic plans<br>• There are no governance or reporting arrangements in place.<br><br>**Data Limitations**<br><br>There are limitations in terms of data availability for this needs assessment. For example, data on the prevalence of other tobacco products such as shisha is unknown in Inner North West London. There are a high proportion of shisha bars and Middle Eastern community groups smoke shisha in these bars. Furthermore, data availability is limited for Paan use amongst certain ethnic community groups such as Bangladeshi groups.<br><br>An additional gap in information is for second-hand smoking for those residents in tri-boroughs. |
| Purpose | The aim of this report was to describe the size of the smoking problem in the three Inner North West London Boroughs (Hammersmith and Fulham, Kensington and Chelsea and Westminster), to analyse the public health impact and disease burden due to smoking and to analyse the local stop smoking services to date. The JSNA has informed the re-commissioning of Stop Smoking Services |
| Recommendations | No |
| Lead responsibility | Andrew Burnett, Deputy Director for Public Health, Triborough Public Health Service<br>Christine Mead, Behaviour Change Commissioner, Triborough Public Health Service |
| Progress to date | Progress to date:<br>• An ineffective Stop Smoking service was decommissioned and a new service commissioned on a Triborough basis, using the |

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|  | evidence from the JSNA to develop the service specification.<br>• The new service is incentivised with targets to deliver in areas of highest smoking prevalence, both geographically and amongst communities with higher prevalence eg mental health service users and certain ethnic communities<br>• A draft Triborough Smokefree strategy has been developed<br>• Three local campaigns and local implementation of the three national campaigns have been commissioned to improve communication. The three local campaigns include Busting the Myths about Smoking and Stopping Smoking; a shisha campaign/CntrlZ launch focusing on students; and a campaign on preventing young people from starting smoking.<br>• Work has been commissioned to take the message not to start smoking in schools, using Operation Smokestorm game<br>• Questions were added to the schools survey to collect information on the prevalence of smoking amongst 15 yr olds, as well as information about where young people get their cigarettes from..<br>• The Smokefree Alliance (formerly Tobacco Control Alliance) has supported innovation projects in mental health hospitals, Chelsea and Westminster Hospital, trading standards testing of shisha, trading standards using sniffer dogs to find illicit tobacco sellers together with HMRC, a paan chewing research project amongst Bangladeshi communities, and hospital referral systems to stop smoking services.<br>• The Smokefree Alliance reviews KPIs of the stop smoking services, trading standards and environmental health on tobacco control elements<br>• The Smokefree Alliance has received briefings from HMRC, ASH, and the Fire Brigade on tobacco control evidence and best practice to link local work with wider strategic working. |
| Risks and issues | None identified |
| Actions for Health and Wellbeing Board | None identified |

| Prison JSNA – HMP Wormwood Scrubs | |
|---|---|
| Summary | This document highlights the current range of services that are available for prisoners in HMP Wormwood Scrubs. These include primary and secondary care services for physical health, mental health and substance misuse.<br>Local data accessed indicates that the actual numbers of prisoners diagnosed with specific health conditions (including Asthma, Diabetes, Epilepsy and Learning Disabilities) is above that of the local population in the adjacent areas in the local community.<br><br>However, the rates picked up are below estimated prevalence figures highlighted in national research projects. This may indicate that health conditions are not being picked up at reception and may lead to health and health concerns worsening while in prison.<br><br>In addition, there are higher levels of mental health disorder, smoking, and worse dental health than in the general population. |
| Purpose | This JSNA was produced to identify the health needs of prisoners in HMP Wormwood Scrubs so that appropriate and effective services can be commissioned for the prison population. |
| Recommendations | The following findings and recommendations were made in the JSNA<br>**Overarching principle for healthcare delivery**<br>Prisoners should be cared for by a health service that comprehensively assesses and meets their health needs while in prison and which promotes continuity of health and social care on release. The standard of health service provided is equivalent to that which prisoners could expect to receive in the community.<br><br>**Recommendations**<br>1. Introduction of effective communication protocols and action plans between healthcare providers, specialist services and prison staff to ensure clinic DNA (Did Not Attend) rates reduce. Healthcare providers to ensure continued implementation of the induction scheme. Scheme will also look at implementing a reserve list of patients.<br><br>2. The healthcare provider to ensure the induction procedure focuses on identifying on-going health issues amongst the prison population.<br>3. The healthcare providers to ensure all staff are well equipped through appropriate training to guarantee robust data recording and data management from the existing clinical systems. Good data recording will show an increase in the accuracy of data collection, the creation of historical disease / condition registers (including multiple prescribing and comorbidity), and the planning of regular interrogation of intelligence data on patterns of service use and epidemiology within the prison to inform |

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| | service delivery.<br><br>4. The healthcare providers to introduce the concept of active self-management to prisoners through modular or incremental health and learning programmes to enable short-term prisoners to engage in easily replicable techniques for managing their own healthcare issues. This has potential to improve the health inequalities seen in the offender cohort for the future.<br><br>5. The healthcare provider to ensure the investment in the X-ray room can reap on-going and broad health benefits for TB monitoring and minor injuries (fractures and MSK issues)<br><br>6. Healthcare services in HMP Wormwood Scrubs will conduct regular assessment and analysis of prisoner health needs and service trends and comparisons in the future in light of the prevailing changes in the wider healthcare landscape. This assessment and analysis will be done in partnership with the prison establishment staff, commissioner and other stakeholders as required.<br><br>7. To build stronger links with the education department in order to provide health promotion material to a wider audience, capitalising on the capability of the education department to reach more prisoners. |
| Lead responsibility | Patricia Cadden<br>Senior Commissioning Manager,<br>Health in the Justice System Team,<br>NHS England<br>105 Victoria Street,<br>London, SW1E 6QT |
| Progress to date | The following progress has been made against the recommendations listed above:<br>1. The DNA rates have been part of a continuing improvement programme led by the primary care provider. The data on DNAs is scrutinised by the commissioner at quarterly contract reviews and remedial solutions out in place. An example of this is the DNA rates for the dental service. Additional investment was given to the dental provider (Tooth and Mouth) to re-triage the list and cleanse their data to reflect new rates of access and any resulting DNAs. The highest rate in 2013 was running at 49%. This was reduced by the end of March 2014 to 20%. Changes in prison officer staffing due to cuts has proved challenging for all healthcare interventions. The National Offender Management Service (NOMS) has introduced a model of “New ways of working” which |

reduces staffing levels by approximately 25%. This has seen a sharp rise in Q1 2014-15 of DNAs that is outside of the control of the healthcare provider. NHS England has raised this issue with NOMS on the understanding that healthcare is fully "enabled" where possible to ensure access to healthcare as equivalent to that available in the community.

2. New induction processes have been in place all year 2013-14 and on-going to help prisoners understand their rights to healthcare; what is on offer and how to access treatment and care. These communications have been developed with consideration for the foreign national population as well as prisoners with learning difficulties/learning disabilities. Induction has now widened to be able to take place as prisoner's access other services such as the gym and education.

3. The quality and consistency of data has been managed through a specific project where the data infrastructure lead has developed a guidance document for all healthcare staff to ensure there is consistent use of read codes for conditions and interventions. Additional training by the provider was introduced to support this new work and all partner and sub-contracted providers have access to SystemOne in order to facilitate better communication. This will continue to be amended following the roll out of a new key performance indicator set from NHS England this year.

4. Additional investment was injected to change the existing Seacole Centre (a previously under-used area in the prison) into a health and well-being centre to help demonstrate and support self management techniques. There is yoga, managing musculoskeletal issues sessions and primary care mental health group interventions to promote well-being. Special sessions are also structured for those with long-term conditions to better manage their condition, as well as health checks for the targeted population pre-release.

5. On-going problems with the X-ray machine calibration have frustrated both the provider and commissioner. The x-ray pathway has been established through an audit and resulting protocol set out by NHS England; the staff have been trained; the room specification is complete; the team await the final calibration to be completed by the end of July with a fully "go-live" date on 1st September 2014

6. The prime provider has continued to conduct service audits throughout the year and review their internal and external pathways. There is a proposal to build a "segmented" health needs assessment this year to prepare for the re-procurement next year. This new way of addressing health needs assessments will offer "deeper dives" into the health pathways, interventions and where

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| | possible outcomes. Scoping work starts on this in the next month with roll-out of data and analysis in September 2014-January 2015<br><br>7. As noted above better structures are in place with all other providers in the prison including education to maximise understanding of health available and the health promotion programme. |
| Future delivery | NHS England has negotiated a new set of CQUINs (Commissioning for quality and innovation) targets with the provider (these are consistent across all of our prisons) to address Hepatitis B; Tuberculosis (x-ray); access times to mental health interventions and staffing vacancies no greater than 15% (for all WTE/Bank staff).<br><br>The new national performance indicators will allow consistency and standardisation of data as well as allowing comparisons to be run for key health deliverables/outcomes.<br><br>As part of our procurement programme, NHS England will go out to re-procure this service in 2015-16 for a new contract in April 2016 |
| Risks and issues | i. NOMS needs to decide the agreed staffing profile for public sector prisons that supports the "enabling" of healthcare continues problems with regime changes that negatively impact on healthcare will reduce the ability to offer good access health benefits to the patient.<br>ii. Reduction in prison staff can mean a reduction in access to outpatient appointments. Healthcare providers need to ensure they maximise "in-reach" services from the community. A risk is the reluctance/priorities of these community services to offer services in the prison<br>iii. Build the "offender health" pathway as an attractive career opportunity for nurses and GPs. NHS England is working with the Royal College of Nursing on this matter<br>iv. Continuity of care is not available from community services, therefore reducing the health benefits made whilst in prison |
| Actions for Health and Wellbeing Board | i. To ensure offender health is part of the community services' considerations when building their intervention pathways. That is, how best to link with prison services to maintain continuity of care<br>ii. To make links with the Transforming Rehabilitation agenda in order to support the Community Rehabilitation Companies<br>iii. To make links with local integrated offender management structures to maximise health's contribution to reducing risk and re-offending |

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| | iv. To maintain funding levels for local drug and alcohol services and for those service contracts to highlight robust pathways with the local prison to ensure continuity of treatment pathways<br>v. To build pathways with IAPT and other primary mental health interventions to improve the treatment options for primary mental health needs within the prison services<br>vi. To consider the use of the Social Care Act with borough adult social care services to support health and well-being in the prison and pathways on release<br>vii. In addition to this JSNA make considerations for the management of young offenders released to the tri-borough from HMYOI Feltham in Hounslow. |