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Report of the Director of Public Health to the meeting of the Health and Well Being Board to be held on 14 May 2013.

B

Subject: JSNA Review

Summary statement:

The Joint Strategic Needs Assessment (JSNA) for Bradford was substantially reviewed in 2012, and an executive summary was released as hard copy in early 2012.

Although Public Sector reforms have led to changes in the way Health and Social Care is organised, it is clear that JSNA is expected to be a long term component of the planning system.

Anticipating that the JSNA needs to develop to reflect that, in the latter part of 2012 the JSNA steering group undertook a review of the JSNA.

This review did NOT consider the role, scope and function of the JSNA steering group. The Board may wish to consider these factors separately.

This paper summarises the results of the Steering Group's review, and contains a number of suggestions about how the JSNA should develop in the future. The Health and Well Being Board is invited to comment upon these recommendations.

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1. SUMMARY

Introduction to the JSNA

The Joint Strategic Needs Assessment (JSNA) is a means of bringing together key data and information in a way which is accessible to local commissioners, local communities and other stakeholders.

Producing a JSNA is a legal requirement that supports the strategic planning of NHS Bradford and Airedale and Bradford Metropolitan District Council.

Guidance issued by the Department of Health in 2012 stated:

“At the heart of the health and wellbeing board’s role in joining up commissioning across health and social care, is the development of a JSNA… From April 2013, local authorities and CCGs will each have equal and explicit obligations to prepare a JSNA, and this duty will have to be discharged by the health and wellbeing board. The JSNA must consider all the current and future health and social care needs in relation to the area of the responsible authority – needs which are capable of being met, or affected to a significant extent, by the local authority, clinical commissioning group or NHS Commissioning Board functions.”

Bradford and Airedale’s JSNA identifies the health and well being needs of the local population of the Bradford district. It helps to improve the targeting of services which aim to reduce health inequalities that exist between different localities, groups and communities within Bradford and Airedale.

The key objectives of the JSNA are to inform:

- What we are doing;
- What we should we be doing;

and

- What we should be doing differently.

Bradford and Airedale’s JSNA is a ‘living’ document, available online at http://www.observatory.bradford.nhs.uk/pages/jsna.aspx. It is updated frequently in the light of economic, social or other change, arising nationally or locally, and in the light of outcomes from previous years’ initiatives.

A short executive summary was produced as hard copy in 2012. The executive summary matched the online structure of the JSNA, which is an introduction, followed by chapters about the population of Bradford and District; the wider determinants of health and well being; children and young people; adults of working age and over; and issues specific to older people.

Appendix A sets out the structure of the chapters and each of the sections within them.

<u>Review of the JSNA</u>

- The JSNA Steering Group undertook a detailed review of the JSNA following its most recent refresh.
- It is recommended following a number of conversations with key stakeholders in light of the review, that there should be no substantial change to the structure and content of the JSNA.
- It is recommended that the responsibility for updating the JSNA will remain with Public Health, following the department's transition to the Local Authority.
- These recommendations are made on the basis that substantial change would be likely to be costly, and would on balance deliver relatively little benefit to any of the key stakeholders.
- Notwithstanding the recommendation to leave the overall format unaltered, the Steering Group concluded that there are a number of key considerations that need to be taken into account as the chapters and sections of the JSNA evolve. These considerations are included in the 'Background' section of this report.

2. BACKGROUND

2.1 Scope

The Steering Group concluded:

- It is vital to ensure that the JSNA is corporately consistent with other strategic products, such as the Joint Health and Well Being Strategy (JHWS), and it is likely to be efficient to combine some elements of such products.
- It is recognised that whilst the JSNA covers the Bradford Metropolitan Area, attention will have to be paid to the area of North Yorkshire County Council which is served by Airedale Clinical Commissioning Group (CCG).
- It is recommended that consideration is given to merging the infrastructure that develops the JSNA and the JHWBS. This should be considered in the context of whether fundamentally changing the JSNA structure would substantially alter the questions answered.
- The JSNA will need to focus more than ever on answering specific questions of specific relevance to commissioners, rather than describing need in more general terms. As such, the developers of the JSNA should liaise with CCGs to ensure their interests are served by the JSNA.
- It is not reasonable to hope that the JSNA can comprehensively describe **all** of the health and wellbeing needs of the population. As such, the JSNA needs to be able to support other Needs Assessments and similar evaluations.

The Steering Group seeks guidance from the Health and Wellbeing Board

on the following:

- Does the board collectively feel that the scope should be refined to focus on a small number of specific questions which are of interest to all stakeholders? For example:
  - given the inequalities of need, care processes, spending and outcomes, to consider cardiovascular disease (CVD) and / or Diabetes.
  - providing a more 'integrated' approach to need – and for example therefore concentrating on the integration of health and social care.
  - making greater use of epidemiological data to examine the most common causes of mortality and morbidity?
- Does the board collectively feel that the JSNA could be restructured in a way that can help prioritise the needs of the population?

2.2 Format

The Steering Group concluded:

- Although there may be sound arguments to change the format of the JSNA to match the structure of the JHWS, such changes are likely to be resource-intensive and would deliver relatively little benefit to key stakeholders. As such, the format of the JSNA should remain unaltered.
- There remain key populations of interest that we have little systematic intelligence on.
- Commissioners may wish to give a steer about challenging areas where they need good quality intelligence which would support decisions, and / or whether future iterations of the JSNA should focus on a particular theme.
- The JSNA must include a more systematic review of "protected characteristics".
- The co-ordinators of the JSNA seek comment from stakeholders on the viability and method by which the JSNA might better reflect an 'asset based approach'.

The Steering Group seeks guidance from the Health and Wellbeing Board on the following:

- Taking into account the structure of the JSNA as set out in Appendix A, does the board collectively feel that there are any sections missing from the JSNA which will need to be included?
- If there are such gaps in the structure, is the board able to identify "Topic experts" who would be able to work with the co-ordinators to produce relevant sections of the JSNA?

2.3 Practical and Process issues

The Steering Group concluded:

- The Public Health department should continue to co-ordinate the production of the JSNA.
- As it does so, there must be acknowledgement that Public Health cannot be the representative of the NHS in the production of the JSNA, whereas it may to some extent have done so in the past.
- The JSNA should be refreshed to coincide with the next iteration of JHWS.
- The JSNA Executive Summary should be refreshed every 2 years subsequently,
- Following the next iteration, there should be a definitive communication and engagement plan for the JSNA.
- The co-ordinators of the JSNA should actively seek the views of the VCS on the most efficient, productive and meaningful ways to incorporate VCS input into the design and preparation of future JSNA.
- The co-ordinators of the JSNA should consider the means by which the JSNA can be linked into some form of external quality assurance, such as being peer-reviewed.

The Steering Group seeks guidance from the Health and Wellbeing Board on the following:

- Would the board like to make any recommendations about the JSNA Steering Group – in particular about its role and its membership. Guidance on this matter is sought particularly in the light of the conclusion, above, that Public Health cannot continue to represent the NHS in the production of the JSNA

2.4 Use of Data

The Steering Group concluded:

- A core indicator should be developed to monitor key indicators over time. This should be linked explicitly to the Adult Social Care Outcomes Framework, the NHS Outcomes Framework and the Public Health Outcomes Framework. Such a set of indicators would include measures of the drivers of need; of need itself; of processes of care; quality of care and outcomes. As such, indicators would include – but would not be limited to:
    - Life expectancy
    - Population
    - Demographics
    - All age, all cause mortality.
    - Fertility
    - Lifestyle

- Greater use can yet be made of epidemiological data that can be found within existing but as yet untapped sources of data, to answer questions specific to a certain area or more general questions. Examples include Public Health England profiles of ward, local authority and 'small area' indicators.

- The co-ordinators of the JSNA should continue to seek views on the extent to which we look to change the graphical representations of data to make it more meaningful and audience to engage better with it.

The Steering Group seeks guidance from the Health and Wellbeing Board on the following:

- Does the board have a collective view on the level of geography that should be used as the ‘default’ description in the JSNA?

3. OTHER CONSIDERATIONS

- none.

4. OPTIONS

- The JSNA is a legal requirement and, as such, the ‘options’ available relate to decisions about how it is delivered. The Board are asked to exercise a collective view on some aspects of this, as set out above.

5. FINANCIAL & RESOURCE APPRAISAL

- There are no significant financial or resource implications involved with accepting these recommendations.

6. RISK MANAGEMENT AND GOVERNANCE ISSUES

- there are no significant risks arising out of the implementation of the proposed recommendations

7. LEGAL APPRAISAL

- none

8. OTHER IMPLICATIONS

8.1 EQUALITY & DIVERSITY

- Emphasis will also be placed on equity of outcomes and of service access across the district
- This will be considered both qualitatively and quantitatively.
- As stated above, the Steering Group concluded that the JSNA must include a more systematic review of “protected characteristics”.

8.2 SUSTAINABILITY IMPLICATIONS

- none.

8.3 GREENHOUSE GAS EMISSIONS IMPACTS

- none.

8.4 COMMUNITY SAFETY IMPLICATIONS

- none.

8.5 HUMAN RIGHTS ACT

- no implications

8.6 TRADE UNION

- no implications.

8.7 WARD IMPLICATIONS

- none specifically identified at this time, although the judicious use of ward level data may subsequently alter this position.

8.8 AREA COMMITTEE ACTION PLAN IMPLICATIONS (for reports to Area Committees only)

- no implications

9. NOT FOR PUBLICATION DOCUMENTS

- none

10. RECOMMENDATIONS

Members of the Health and Well Being Board are invited to:

1. Endorse the Steering Group's "Conclusions" as set out in 2.4 above (i.e. those points listed as "The Steering Group concluded".)
2. Provide feedback on the areas where the Steering Group has sought guidance
3. Comment on the nature and the role of the Steering Group

11. APPENDICES

- 1: Structure Of The JSNA
- 2: JSNA Review paper

12. BACKGROUND DOCUMENTS

- None

Appendix 1

Structure Of The JSNA

1 Introduction	**1.1 Aims and Objectives** **1.2 Content** **1.3 About The JSNA**
2 The Population of Bradford and Airedale	**2.1 The Population of Bradford and Airedale** **2.2 Ethnicity** **2.3 Population Characteristics** **Further subdivided into:** **Age** **Carers** **Disability** **Gender Reassignment** **Race** **Religion** **Sex** **Sexual Orientation**
3 Wider Determinants of Health & Wellbeing	**3.1 Prosperity and Regeneration** **3.1.1 Employment and Unemployment** **3.1.2 Earnings** **3.1.3 Poverty** **3.1.4 Skills** **3.1.5 Housing** **3.1.6 Housing related support** **3.1.7 Neighbourhood perceptions and community reassurance** **3.1.8 Sustainable Transport** **3.2 Safer Communities** **3.2.1 Reducing crime and reoffending** **3.2.2 Violence against women and girls** **3.2.3 Safeguarding Adults** **3.2.4 Road Safety** **3.3 Health and wellbeing** **3.3.1 Fuel Poverty** **3.3.2 Deprivation, debt and independent advice** **3.4 The Environment** **3.4.1 The Environment**

3 Wider Determinants of Health & Wellbeing ***(continued from previous page)***	**3.5 Strong and Cohesive Communities** **3.5.1 Active Citizenship and Volunteering** **3.5.2 Equality and Social Inclusion** **3.5.3 Community Cohesion** **3.5.4 Advice on Community Legal Rights and Entitlements**
4 Children and Young People	**4.1 Staying Healthy and Well** **4.1.1 Child poverty** **4.1.2 Educational attainment** **4.1.3 Emotional Wellbeing of Children** **4.1.4 Pregnancy, Smoking, Breastfeeding and Birth Weight** **4.1.5 Teenage Pregnancy and young people's Sexual Health** **4.1.6 Childhood Accidents** **4.1.7 Childhood Obesity** **4.1.8 Childhood Tobacco** **4.1.9 Substance Misuse and Alcohol** **4.1.10 Oral Health of Children** **4.1.11 Parenting and Family Support** **4.1.12 Looked after Children and Care Leavers** **4.1.13 Young Carers** **4.1.14 Safeguarding Vulnerable Children** **4.1.15 Early Years** **4.2 Primary Care** **4.2.1 Vaccinations and Immunisations** **4.3 Disabilities** **4.3.1 Children with Disabilities, Learning Disabilities and complex health needs** **4.4 Long Term Conditions** **4.4.1 Long Term Conditions** **4.5 Life Expectancy** **4.5.1 Infant Mortality** **4.5.2 Child Mortality** **4.6 End of Life** **4.6.1 End of Life Care**
5 Adults of Working Age And Over	**5.1 Staying Healthy and Well** **5.1.1 Obesity** **5.1.2 Alcohol Misuse** **5.1.3 Tobacco Consumption** **5.1.4 Illegal Drug Misuse** **5.1.5 Access to dental services** **5.1.6 Adult Carers** **5.1.7 Health, Work and Wellbeing**

5 Adults of Working Age And Over ***(continued from previous page)***	**5.2 Disabilities & sensory impairments** **5.2.1 Learning Disability** **5.2.2 Autism amongst Adults of Working Age** **5.2.3 Adults with physical disabilities, sensory needs and long term conditions** **5.3 Long Term Conditions** **5.3.1 Diabetes** **5.3.2 Long Term Neurological Conditions** **5.3.3 Cancer Services** **5.3.4 Vascular Disease** **5.3.5 Sexual Health** **5.3.6 Mental Health**
6 Issues Specific to Older People Aged 65+	**6.1 Staying Healthy and Well** **6.1.1 Activities of Daily Living** **6.1.2 Wellbeing amongst Older People** **6.2 Disabilities** **6.2.1 Older People with Learning Disability** **6.3 Long Term Conditions** **6.3.1 Mental Health Problems** **6.4 End of Life** **6.4.1 End of Life Care**
7 Appendices	**Supporting data and information** **A. Health and Wellbeing Ward Summary** **B. Strategies Dashboard** **C. Forecasting Tool** **D. QOF Prevalence Summary** **E. Important Information About Craven District** **F. Craven District JSNA Summary** • **CCG profiles** • **Public Health Analysis Team CCG profiles - Airedale, Wharfedale & Craven** • **Public Health Analysis Team CCG Profiles - Bradford City** • **Public Health Analysis Team CCG Profiles - Bradford Districts** • **Airedale, Wharfedale & Craven CCG Commissioning Profile** • **Bradford City CCG Commissioning Profile** • **Bradford Districts CCG Commissioning Profile**

Appendix 2

Review of JSNA post 2012

Introduction
JSNA 2012 has been available since Sept 2012. The exec summary has now been widely disseminated.

The JSNA steering group, and other fora including a review of JSNAs in W Yorkshire, have discussed “the future” of JSNA.

It is clear that JSNA is expected to be a long term component of the planning system. Many elements of this system are changing rapidly. As such the JSNA needs to develop to reflect that.

This review did NOT consider the role, scope and function of the JSNA steering group. This might be something that JHWB should consider.

Following discussion among the JSNA Steering Group, a number of suggestions have been made for how the JSNA should develop in the future. These are noted below, with some specific recommendations for members of the Health and Well Being Board.

Recommendations and questions for consideration by the Health and Well Being Board

1	Scope and structure

Scope of the JSNA

- Consideration should be given to the extent to which it may be efficient to combine some or all elements of the “State of the District” and the JSNA – there is much common ground, particularly with respect to the underlying analysis.
- It is recommended that the JSNA remains Bradford Metropolitan Area focused and integrate a component of the N Yorks JSNA for Craven
- It is recommended that consideration is given to merging the infrastructure that develops the JSNA and the JHWBS

Ensuring the JSNA helps answer questions of specific relevance to commissioners.

- CCGs should consider how they wish to input into the JSNA
- It is recommended that all stakeholders provide some advice to the developers of the JSNA on whether they need “a picture of everything” or a more bespoke focus on particular themes of mutual interest. If the latter – what those themes might be.

Format of JSNA

- Should the format change to reflect the H&WB Strategy structure? The above point re combining JSNA and State of District has a bearing on this question.
- There remain key populations of interest that we have little systematic intelligence on.
- Commissioners may wish to give a steer about challenging areas where they need good quality intelligence which would support decisions, and / or whether future iterations of the JSNA should focus on a particular theme.

Equality Duty

- Given the diverse ethnic profile of Bradford, it is recommended that we make use of the tools developed as part of the EEiC project (http://research.shu.ac.uk/eeic/ html/item7/item7c.html) to analyse of the extent that our JSNA describes the needs of local minority ethnic communities?
- **Moving to an asset based approach.**
- Stakeholders are invited to comment on the viability and method by which the JSNA might better reflect an asset based approach to describing a district and a comprehensive and balanced picture of place?

2 Practical and process issues

Timing of refresh

- It is recommended that the JSNA is refreshed to coincide with the next iteration of the H&WB strategy.
- It is recommended that the JSNA Exec Summary is refreshed every 2 years subsequently,
- Following the next iteration, there should be a definitive communication and engagement plan for the JSNA. We should include Comms expertise in the steering group to assist with this communication strategy.

Who should “lead” the JSNA.

- Should PH remain the “function” that brings it all together, as per now? It is broadly agreed this should be the case.

Role of the VCS in input to the JSNA.

- Views are sought on the most efficient, productive and meaningful ways to incorporate VCS input into the design and preparation of future JSNA.
- It is recommended that we proceed with a plan to robustly test a process of encouraging detailed VCS input into specific areas of the JSNA where it is felt overall intelligence is weak, or where there are rapidly emerging needs that have not yet been reflected in formal statistics.

QA and external challenge

- Should the JSNA be linked into some process of external QA or formal scrutiny? If so, how?

3 Data. Uses and types of data that inform the JSNA

Macro Population Indicators

- It is recommended that we develop a core indicator set to monitor key indicators over time. This should be linked to the various Outcome Frameworks
- Views are sought on the level (geographic) at which these are monitored. It is recommended the “level” is that which makes most statistical and pragmatic sense to do so.
- It is recommended that we make greater, but still intelligent and parsimonious, use of the wealth of epidemiological data that can be found within existing but as yet untapped sources of data.

Untapped sources of quantitative data

- It is recommended that we make greater, but still intelligent and parsimonious, use of the wealth of epidemiological data that can be found within existing but as yet untapped sources of data.

Data representation

- Views are sought on the extent to which we look to change the graphical representations of data to make it more meaningful and audience to engage better with it.

Detailed considerations.

1 Scope and structure

a) Scope of the JSNA

JSNA was originally incepted to be focused on developing a shared understanding of "need" within the Health and Social Care agenda. This is widely taken to also incorporate the well being agenda. Health, social care and well being are quite broad in scope, and arguably could be all encompassing. The extent to which there is cross over with other descriptions of the district is untested. There may be overlap with the State of the District.

Consideration should be given to the extent to which it may be efficient to combine some or all elements of the State of the District and the JSNA – there is much common ground, particularly with respect to the underlying analysis.

It has always been clear that the JSNA is, by definition, strategic. It does NOT replace or usurp more detailed needs assessment of specific areas or bespoke pieces of analysis. In many cases the strategic information provided by the JSNA has been insufficient for users, especially commissioners. The more detailed information underpinning the strategic view is therefore essential.

Stakeholders are also clear that the JSNA should inform a medium to long term view of changing services and populations, and should identify short, medium and long-term priority actions to improve the health and wellbeing of the local population. Stakeholders are not convinced that the JSNA sets out the short, medium & long term priorities clearly enough.

It is recommended that the JSNA remains Bradford Metropolitan Area focused and integrate a component of the N Yorks JSNA for Craven

The JSNA is also intrinsically linked to the development of the Joint Health and Well Being Strategy. The process that develops the JSNA is currently separate to the process that develops the JHWBS. These should be more coherently linked, perhaps through a merging of the groups responsible for development.

It is recommended that consideration is given to merging the infrastructure that develops the JSNA and the JHWBS

b) Organising framework for defining "Need" (and the subsequent planning and service response)

There are a number of different stakeholders to the JSNA. All of the stakeholders may have a different way of defining "need" and designing systems and services to meet that need; this in turn affects the planning and service delivery response. As an illustrative example, consider the difference between NHS and Adult Social Care:

Adult social care has been reviewing the approach to commissioning by client group as there are many different client groups different in adult social care, and it is thought there is mileage in moving towards a more strategic approach, linking with the White Paper. As well as particular client groups, there are "ways of grouping". These might be best characterised as follows:

Promoting Wellbeing, Living Well, Staying Independent (Early Intervention), Low Level Needs, Maximising Independence (Targeted Support), Crisis, Managed (or purchased) Care,

Within the NHS (here a commissioning perspective is taken, provider may view differently), there are a number of ways in which the NHS defines needs and ways in which we design our systems to meet need. These overlap:

Geographies - CCGs are the current boundary. Disease groups - cancer, cardiovascular disease etc etc, Clinical specialty - Orthopaedics and trauma, rheumatology etc - some overlap with the above, "Systems" of care - urgent care, long term conditions, intermediate care etc, Population groups - maternity, children and families etc / age group, ethnic group etc, Primary, secondary, tertiary care / acute v community.

In policy terms there is also some debate about simplifying paradigms, for example “healthy individuals”, “long term conditions” and “complex needs” and agreeing common approach, framework and payment mechanism for such groups. Arguably none of the NHS paradigms mesh well with adult social care paradigms and "systems" of defining need and planning services. There are also concepts of co production, self care and other considerations to factor in, these apply equally to all sectors.

There is some work around integration of health and social care teams at the front line. This may be successful, and encouraging / fostering linkage at the frontline might be considerably easier than addressing these issues more strategically. There may never be true institutional integration between NHS and LA, or VCS or other sectors, nor may there be shared structures, budgets or cultures.

Might be able to use the JSNA as a tool to help the NHS and LA come to agreement about common way of defining need and defining how we design services to meet those needs.

NHS, LA, VCS all have a different way of segmenting service delivery and these do not easily or naturally align. The JSNA may offer an opportunity to work towards a model of integrated delivery across the partnerships. No specific recommendations are made on this

c) Ensuring the JSNA helps answer questions of specific relevance to commissioners.

Local Authority Commissioners, and CCGs in B&A, including Craven, will need to determine how they wish to shape and contribute to the look and feel, and level of detail of the JSNA moving forward in a way that can help them answer questions of relevance to them.

To date, the NHS representation in the JSNA process has been filled by the PH Dept. This is obviously not viable in the future.

CCGs should consider how they wish to input into the JSNA

There is a need to ensure that local commissioners and senior leaders direct the process to where they consider there are unanswered questions / pressure points. This then makes for a more focused JSNA. This is however, a process that those

local commissioners need to lead. There is a difficult balance of a JSNA that strategically “describes everything” vs something that moves towards answering specific questions of relevance to commissioners – for example integration of care.

It is recognised by all the stakeholders that commissioners may use significantly more sources than just the JSNA to inform their planning and delivery processes.

It is recommended that all stakeholders provide some advice to the developers of the JSNA on whether they need “a picture of everything” or a more bespoke focus on particular themes of mutual interest. If the latter – what those themes might be.

d) Format of JSNA

The future format of the JSNA might need to change to reflect the structure of the H&WB Strategy.

In effect this would mean the basic organising structure of JSNA would be that the chapter headings would be as per the Marmot themes, and individual sections would need to be moulded into that.
There is broad agreement for changing the format to reflect the H&WB Strategy structure. However we need to be mindful of

1) the potential knock on consequences of this in other arenas, and
2) there may be groups and populations that are not well covered by the Marmot themes. For example care needs to be taken to not lose certain population or care need groups, in particular older people.

In practice, fitting to the Marmot themes skews things towards early start to life and families. This is perhaps a reflection of the balance between potential for long term population health gain vs. resource use.

Should the format change to reflect the H&WB Strategy structure? The above point re combining JSNA and State of District has a bearing on this question.

e) There remain key populations of interest that we have little systematic intelligence on.

There is currently no systematic process for ascertaining areas, topics or population groups on which we have limited to no information on need – i.e. gaps. The process we have is relatively ad hoc. Thus we need to consider how best to address the assessment of need in “easily ignored” communities.

Gaps that have been currently identified include (but are not limited to): Older BME population, gender, transsexual population, physical health of people with mental illness, welfare reform impact, migration and how it’s affecting our population – which is having an impact on commissioning processes and service delivery. Poor data sources – local work needed.

Commissioners may wish to give a steer about challenging areas where they need good quality intelligence which would support decisions, and / or whether future iterations of the JSNA should focus on a particular theme.

f) Equality Duty

In developing the JSNA, we have a duty to pay due regard to the Public Sector Equality Duty, section 149 of the Equality Act (April 2011). This requires public bodies to consider all individuals when producing the JSNA and to have due regard to the need to

- eliminate discrimination, harassment, victimisation and any other conduct prohibited by or under the Equality Act,
- to advance equality of opportunity between those who share a protected characteristic and those who do not; and
- to foster good relations between people who share a relevant protected characteristic and those who do not.

This applies to the shaping of policy and delivery of services, as well as to the authority's employees and the JSNA should demonstrate that these equality duties have been met.

The JSNA must be published and the format for publication, and the means of disseminating the information, should be achieved in a way that makes it accessible to members of the public. Publication is an opportunity to show that action is being taken to address the needs, inequalities and key priorities identified..

The DH is working with partners to develop additional resources to support the production of the JSNA and equality is one theme they are exploring. The consultation on the draft guidance asks:

a) In your view, have past JSNAs demonstrated that equality duties have been met?

b) How do you think the new duties and powers, and this guidance will support health and wellbeing board members and commissioners to prevent the disadvantage of groups with protected characteristics, and perhaps other groups identified as in vulnerable circumstances in your area?

Further guidance on how to ensure that we have fulfilled our responsibilities to in respect of the Equality Duty whilst producing the JSNA is likely to follow.

Locally, a template to support section authors' and chapter leads to carry out an equity assessment on their material has been developed. (ATTACH)

Given the diverse ethnic profile of Bradford, it is recommended that we make use of the tools developed as part of the EEiC project (http://research.shu.ac.uk/eeic/ html/item7/item7c.html) to analyse of the extent that our JSNA describes the needs of local minority ethnic communities?

g) Moving to an asset based approach.

A number of stakeholders have recommended that the JSNA should adopt an asset based approach (describing need in terms of assets – strengths - rather than deficits – lack of……).

It is, as yet, unclear what this might actually look like in practice. However the JSNA should seek to better capture information on community assets – level of volunteering, range of grass roots community orgs, contribution of key VCS orgs,

physical assets etc. The JSNA should also incorporate intelligence from community development etc.

How to do this is not resolved. It will require a process that should involve ongoing dialogue with communities, to ensure their needs, assets and experiences are understood, and that priorities reflect what matters most to them.

In this way the JSNA (and H&WB Strategy) become a comprehensive picture of place, needs and assets, further strengthening the argument for alignment or merging with the State of the District.

JSNAs and JHWSs will need to align with other arrangements, such as safeguarding for adults and children, child poverty strategies, local economic assessments, strategic housing market assessments, and community safety strategic assessments.

Stakeholders are invited to comment on the viability and method by which the JSNA might better reflect an asset based approach to describing a district and a comprehensive and balanced picture of place?

2 Practical and process issues

a) Timing of refresh

The Health and Well Being Board are asked for views on when they would wish to see the next iteration of the JSNA

It is recommended that the JSNA is refreshed to coincide with the next iteration of the H&WB strategy.

It is recommended that the JSNA Exec Summary is refreshed every 2 years subsequently,

The individual chapters and sections should be updated continually. PH dept should ensure that no individual section should be left more than 18 months without conscious review.

Following the next iteration, there should be a definitive communication and engagement plan for the JSNA. We should include Comms expertise in the steering group to assist with this communication strategy.

This should include new media, and existing print media to engage all stakeholders.

b) Who should "lead" the JSNA.

Should PH remain the "function" that brings it all together, as per now? It is broadly agreed this should be the case.

It is estimated that to "do this job properly" requires the equivalent of 1WTE. We currently invest less than this. Most were clear that the JSNA should remain the responsibility of the PH Dept. However there was concern about sufficient capacity to lead this process, especially if making significant changes to format and structure and new areas of work needed, e.g. new HNAs, asset mapping, identified by commissioners and other stakeholders.
Project planning for the next iteration of the JSNA will be important.

c) Engaging with users of the JSNA

A system will be established to encourage users to "subscribe" to the JSNA in a way that the subscribers can be automatically alerted when an update / change is made. PH dept.

d) Accessibility of the information.

We are considering how best to make the information more accessible. Some work on Talking Media and other accessible formats of the summary and possibly use of Google Translate to give rough approximations. Following consideration, most view Google Translate as too inaccurate.

Making the JSNA (in whole or part) available in multiple formats and languages, with no budget for this, remains problematic.

e) Role of the VCS in input to the JSNA.

How best to engage the VCS in a way that is both strategic and meaningful is not fully resolved. Ensuring there is a public and service user voice is something that is easy to say…but difficult to "do" in a way that is really meaningful.

It is necessary to distinguish the “VCS” per se and LINk (then Healthwatch). It is separate (though the agendas and stakeholders do overlap) there are legitimately separate agendas.

It is recommended that there are a number of key roles for the VCS, including but not limited to:

- Intelligence, particularly soft intelligence that is not yet in the domain of statutory sector
- Case studies to illustrate key points e.g. - Impact of services, impact of policy change
- Horizon scanning
- Qualitative and sometimes quantitative input to description of needs – existing and emerging.

There is a need for more work at a system level to support and embed innovative ways of developing greater co-production in JSNA production

The Health and Well Being Partnership may be a ready means of filtering and sounding out some of the key issues in terms of qualitative information – for example what is published already / where are there gaps. Working on this is in development stages – e.g. working on Protected Characteristics sections with PCT Equality Lead and VCS, starting with Sexual Orientation first, others may follow. We are planning to pilot a methodology for VCS input to one section (possibly dementia – not confirmed). The methodology for this is likely to come from the pilot process.

Views are sought on the most efficient, productive and meaningful ways to incorporate VCS input into the design and preparation of future JSNA.

f) QA and external challenge

Should we bring in external challenge and Quality Assurance of the process? This might include inviting other LAs or PH teams to B&A to review our JSNA and make some recommendations. Most stakeholders were not adverse to external QA and or considering models from elsewhere, however there was concern for the process by which that might happen and need to ensure it is not too onerous. In the interim the producers of the JSNA need to ensure robust QA process for the sections and the data therein, his may be challenging on several fronts and resources intensive.
Feedback from B&A commissioners would be the best place to start.

Should the JSNA be linked into some process of external QA or formal scrutiny? If so, how?

3 Data. Uses and types of data that inform the JSNA

a) Macro Population Indicators

It is recommended that we develop a core indicator set to monitor key indicators over time. This should be linked to the various Outcome Frameworks

Such a set of indicators would include, but not be limited to:
Life expectancy
Population
Demographic
All age all cause mortality.
Fertility
Lifestyle

That together would help form a strategic health profile of specific pop or geography.
Commissioners input to this would be helpful.

Views are sought on the level (geographic) at which these are monitored. It is recommended the "level" is that which makes most statistical and pragmatic sense to do so.

For example: CCG, Ward, Parliamentary constituencies, Locally and naturally occurring boundaries

Doing geographic profiles for ALL potentially available boundaries is not feasible.

There is a plethora of already available and often quite bespoke information on a wide range of topics through the PHO network and elsewhere. Greater focus should be placed on judicious use of existing information on geographies, for example APHO ward profiles, LA profiles and small area indicators. Concerns have been concerns expressed about data quality, so careful interpretation is needed, for example there is a need to know the contents are accurate as well as up to date – there are some issues as uncovered recently with migration data

The implication of using already available is that we would NOT spend local analyst resource redoing this work, and spend that resource answering more bespoke questions or providing local interpretation or contextualisation of nationally available datasets.

b) Untapped sources of quantitative data

Where datasets exist, eg S1, wefare benefits, housing, employment, education, etc, they should be exploited if they are not being used. Many commented that the work of Born in Bradford could be better integrated into the JSNA.

It is recommended that we make greater, but still intelligent and parsimonious, use of the wealth of epidemiological data that can be found within existing but as yet untapped sources of data.

c) Integration of qualitative information

All of the stakeholders may have a different valuation of the role of statistical and qualitative data in informing a picture and assessment of "need".

It is recommended that we adopt a structured, systematic process of integration of qualitative information into each of the chapters. Some of this might be already available. Some might need to be drawn together. Some might be commissioned pieces of work. QA and standards for this would need to rest with chapter leads.

It is recommended that we test a process of working across the VCS to better gather qualitative information on need and related issues in specific areas where it is felt overall intelligence is weak or there are rapidly emerging needs

d) Data representation

Views are sought on the extent to which we look to change the graphical representations of data to make it more meaningful and audience to engage better with it.

1
Should we focus on

A
Ineq of
Need
Process
Spend
Outcomes

Look in a specific area
Say cvd
Or diabetes

B
Integration
Of what

2
No structural change
Won't achieve much
May take sig resource to do

3
Nhs and jointness
Dph not part of nhs
Ph lead but can't be the nhs voice

4
Q of relevance to commissioners
They need to specify

5
Getting contributions

6
Sections within chapters
Is there stuff missing
Programme of specifying areas

7
Need
Care processes
Spend
outcomes

8
Should jsna help broader prioritisation processes

9
Make greater use of what already out there

10
Profiles by population - what populations

Geography - what level
Both

11
Recognise that it can't be all things to all people and isn't going to be absolutely comprehensive

12
Crossover with understanding our district
Many areas of commonality

Some of difference

Jsna focused on hc
Soc care
Children’s services
Reflective of strategic owners

Understanding our district broader than this