ENCLOSURE: H

Agenda Item: 117/13

NHS Bexley Clinical Commissioning Group

Governing Body (public) meeting

DATE: 28th November 2013

Title	**Development of the Joint Strategic Needs Assessment – JSNA 2014/15**
Recommended action for the Governing Body	That the Governing Body: **NOTE** • The approach to refreshing the JSNA and the CCG's engagement in the Steering Group • The approach to engagement on the JSNA and comment on how develop this further **APPROVE** • The format of the JSNA and comment on how develop and improve it further
Executive summary	The document sets out the process used by the London Borough of Bexley to refresh the JSNA by 31st March 2014. Joint strategic needs assessments (JSNAs) analyse the health needs of populations to inform and guide commissioning of health, well-being and social care services within local authority areas. The JSNA will underpin health and well-being strategies, themselves a new statutory requirement, and each public sector organisation's own commissioning plans. The main goal of a JSNA is therefore to accurately assess the health needs of a local population in order to improve the physical and mental health and well-being of individuals and communities. A JSNA Steering Group chaired by our shared Director of Public Health is leading the production of the document. Mike Attwood has been engaged to co-ordinate the JSNA supported by a locum, experience public health analyst. The Steering Group includes a Governing Body GP (Dr Bhadra) and two Assistant Directors from the Commissioning Directorate. The JSNA is a process not a data encyclopaedia and this year is a "foundation" year where we will update the JSNA focusing on refreshed population, mortality and morbidity and pulling out the

	key messages for action. Implications for the Health and Wellbeing Board, who are the accountable, decision-making body will cover three areas:- - areas for action now - areas of concern that need to be watched and monitored - areas that we need to understand better that require a deeper needs assessment The JSNA is a facts-based, objective document. We will also focus on evidence for effective interventions, i.e. public health advice on **how** services should be best designed to respond to need. We will be reviewing QoF data as part of the morbidity mapping work. For the new JSNA we therefore need to:- - look at 5-10 year trends wherever possible to make sure that we understand areas of apparently "average" heath need that may be plateauing or slipping , rather than just "snapshotting" obvious "big" issues - have a clearer focus on inequalities and poorer outcomes within Bexley, by age, gender, race or area as appropriate - begin to size and quantify the scale of the main priorities so that they can directly inform commissioning priorities and the targeting of resources - tap public health specialist advice on the best evidence for intervention – in effect moving from re-describing **"what"** the need is to **"how"** best to intervene - complement nationally available data with local information sources to get a richer picture of both need and local assets/capacity - begin to understand community assets alongside the service interventions that the public sector might commission so that we are working more holistically with communities The approach will therefore be to make sure that we are focusing on **high burden needs, that are worsening and for which there is evidence that effective action can be taken.**

Which objective does this paper support?	**Patients:** Improve the health and wellbeing of people in Bexley in partnership with our key stakeholders	The JSNA will inform and guide both <u>how</u> the current Joint Health and Wellbeing Strategy is implemented (best evidence of how to intervene and design services) and suggest priorities for the strategy when it is next updated. The CCG is strongly engaged as a partner in the JSNA Steering Group
	People: Empower our staff to make NHS Bexley CCG the most successful CCG in (south) London	This is a key area – public health capacity is modest and a sustainable approach to embedding local capacity needs to be taken. The Public Health Workforce needs to be grown to a sustainable level. GPs are keen to be engaged and we are on a journey of better understanding GP data and will engage with localities over the coming months.
	Pounds: Delivering on all of our statutory duties and become an effective, efficient and economical organisation	The JSNA will where possible take account of programme budgeting data and is benchmarking the CCG to its "statistical neighbours". It is not a bidding process and much of its advice will focus on refining existing services through application of evidence and best practice. Gaps are bound to be identified but the focus is clear - high burden needs, that are worsening and for which there is evidence that effective

		action can be taken.
	Process: Commission safe, sustainable and equitable services in line with the operating framework and which improves outcomes and patient experience	The JSNA is one of the four key "Pillars" of the CCG's commissioning intentions

Organisational implications	Key risks (corporate and/or clinical)	N/a
	Equality and diversity	The JSNA will almost certainly advise on better targeting of existing priorities, which are largely the right ones, toward areas of greatest need – e.g. particularly deprivation, specific electoral wards, men , women with lung cancer, older people with complex needs, families with multiple needs and the growing black African population
	Patient impact	The JSNA provides objective guidance on which communities and patients need most support and treatment and on effective service design based on evidence. Careful prioritisation is likely to be needed
	Financial	Careful prioritisation as above
	Legal issues	N/a
	NHS constitution	The JSNA will focus more on the Public Health Outcomes framework and advise
Consultation (public, member or other)	An draft engagement plan is attached at Appendix C – consultation will be integrated with the commissioning process .The first whole system event is to be held on 5th December alongside the Commissioning Intentions.	
Audit (considered/approved by other committees/groups)	A programme of governance and an approval pathway for the JSNA will need to be shaped within the CCG. The JSNA will be considered in working draft form by the Health and Wellbeing in January 2014 with final approval in April 2014	
Communications plan	Attached at Appendix C – this will be owned and led by LBB	
Author	Mike Attwood	

NHS
Bexley
Clinical Commissioning Group

	Clinical lead Dr Bhadra	Executive sponsor Dr Nada Lemic
Date	14th November 2013	

Excellent healthcare – locally delivered

Development of the Joint Strategic Needs Assessment (JSNA) for Bexley

1 Context

Joint Strategic Needs Assessment (JSNA) is defined as "a systematic method for reviewing the health and wellbeing needs of a population, leading to agreed commissioning priorities that will improve the health and wellbeing outcomes and reduce inequalities" (Department of Health, (2006) Our health, our care, our say). JSNAs originally emerged from the Social Care Green Paper 'Independence, wellbeing and choice.' In 2007, Section 116 of the Local Government and Public Involvement in Health Act introduced the statutory requirement for a JSNA to be produced by each local authority and primary care trust (PCT).

The coalition government has signalled an ongoing and central role for JSNAs in the NHS reforms driven by the now implemented White Paper, 'Equity and excellence: liberating the NHS'. Health and Wellbeing Boards, convened by local authorities, have a statutory responsibility for leading the JSNA process. Health and Wellbeing boards were established in shadow form from July 2012 and by April 2013, as PH responsibility was transferred to local government, the new Health and Wellbeing boards were fully established.

Joint strategic needs assessments (JSNAs) analyse the health needs of populations to inform and guide commissioning of health, well-being and social care services within local authority areas. The JSNA will underpin health and well-being strategies, themselves a new statutory requirement, and each public sector organisation's own commissioning plans. The main goal of a JSNA is therefore to accurately assess the health needs of a local population in order to improve the physical and mental health and well-being of individuals and communities.

The NHS reforms have also resulted in some significant changes in the commissioning landscape and responsibilities as follows:-

- **Clinical Commissioning Groups - commissioning** the bulk of **local NHS treatment and care services** (some 70% of the commissioning portfolio of former Primary Care and Care Trusts)

- NHS England's (NHSE) **local south London team** leading the commissioning of **GP and community pharmacy** (high street chemist) services

- NHS England's **London-wide teams** leading the commissioning of **optometry, general dental and specialised services**

- **Local authorities** leading the commissioning of most **public health services**, including drugs, alcohol, sexual health, smoking cessation, school nursing, obesity and primary care health checks

- **Public Health England** leading the commissioning of **immunisation and screening programmes** and – on a transitional basis – **health visiting** with an intent for this to pass to local authorities in due course.

Given the range of multiple commissioners now focusing on shared populations, as well as the plans to implement nationally the **Integration Transformation Fund** at around 3% of CCG turnover, to incentivise integrated health and social care services for people with complex needs, the JSNA needs more than ever to ensure that there is **one shared and owned understanding of need** to safeguard a **common approach to commissioning priorities.**

Bexley Care Trust and Council worked together on a detailed JSNA Compendium of information in 2010 and a brief "refresh" document in 2012. The Health and wellbeing Board is now well established, having operated in shadow form until April 2013. The first Joint Health and Wellbeing Strategy has now been produced and consulted upon.

The Public Health transfer from Bexley Care Trust to the Council has been achieved and the Council argued nationally successfully for an increase in what was historically a very low public health budget. Despite this increase the public health resource is modest and the wider shape and development of the public health function is being guided by a Public Health Steering Group established by Bexley Council.

The Health Improvement function within public health is managed as part of the LBB Development, Housing & Community Safety function. This includes sexual health, substance misuse and obesity commissioning as well as provider functions such as smoking cessation. The public health "policy" strategic role sits with the LBB overall policy and communications function. Both posts on this latter team (a Public Health Specialist and Analyst) are presently vacant .The Director of Public Health is a shared post with the London Borough of Bromley (1.5 days per week for Bexley) and is a strategic advisory post in terms of its leadership focus.

In addition to the public health functions that sit with the council, a range of other functions have transferred either to Public Health England (PHE) or to NHS England (London Regional Team); for example PHE leads on immunisation, screening and commissioning of health visiting and NHS England leads on the health contribution to emergency planning.

2 Strategic Priorities

The main priorities for Bexley are drawn from three sources:-

- The Council's Corporate Plan
- The CCG's Commissioning Intentions
- The Joint Health and Wellbeing Strategy

These priorities are complementary. The CCG's priorities are in seven programmes as follows:-

- Developing Queen Mary's and Erith Hospitals
- Urgent Care
- Planned Care
- Long Term Conditions
- Older People
- Adults
- Children, Young People and Maternity

The Council's Corporate Plan sets out its priorities as follows: -

Priority One: Growing the economy and protecting the environment

Priority Two: Helping young people and adults enjoy the best possible quality of life

Priority Three: Building safer and stronger communities

Priority Four: Making best use of public resources

Priority Five: Building a Council for the future

The Joint Health and Wellbeing Strategy brings together the joint aspects of CCG and Bexley Council priorities as follows: -

1. Tackling childhood and adult obesity and promoting healthy choices
2. Improve our work to prevent diabetes and supporting those with the disease
3. Changing attitudes towards smoking and offering support to stop
4. Supporting residents and their families affected by dementia

This is supported by a **cross-cutting priority - Transforming the way we work and keeping services closer to home**, which will be delivered by: -

- Balancing the health economy to provide improved community based integrated care
- Improving Services at Queen Mary's Sidcup and now Erith Hospitals
- Improving Primary Care

By working in this way the Joint Health and Wellbeing Strategy reinforces the both the Council and CCG's own priorities for **service delivery** as well as giving a stronger focus on **wellbeing and prevention.**

3 Development of the JSNA

The JSNA was briefly refreshed in autumn 2012 as part of the process to achieve authorisation of the shadow CCG in time to go live in April 2013. This document has informed the current Joint Health and Wellbeing Strategy's priorities.

Positively, we are clear on the main, large strategic aspects of health need that affect the population as a whole: obesity, smoking, diabetes and dementia. This is because these issues stand out clearly by comparison with other boroughs and CCGs. As Bexley's health is generally good, however, there may have been a number of shifts in health need around the England and Wales average which we have not explored in detail so far – and our work so far has been borough wide, with a need now to understand whether we need to tackle specific health needs in different parts of the borough, or within different age, gender of ethnicity groups.

Furthermore, we have choices in how and at what stage in a patient journey we tackle the strategic health need priorities. For example, with diabetes, we could tackle either primary prevention, primary care/GP management or acute hospital aspects of delivery. We do not yet have clarity on this.

Historically too, we have mainly used nationally available data from ONS and the London Health Observatory – we could make much more use of local data such as education, housing, employment, crime, primary care (QOF) and social care to build a richer picture of need. We are also keen to engage the third sector and communities themselves in a more "asset based" approach that seeks to understand community resources and capacity alongside more "formal" delivery of public services.

This means that for the new JSNA we need to:-

- look at 5-10 year trends wherever possible to make sure that we understand areas of apparently "average" heath need that may be plateauing or slipping , rather than just "snapshotting" obvious "big" issues

- have a clearer focus on inequalities and poorer outcomes within Bexley, by age, gender, race or area as appropriate

- begin to size and quantify the scale of the main priorities so that they can directly inform commissioning priorities and the targeting of resources

- tap public health specialist advice on the best evidence for intervention – in effect moving from re-describing **"what"** the need is to **"how"** best to intervene

- complement nationally available data with local information sources to get a richer picture of both need and local assets/capacity

- begin to understand community assets alongside the service interventions that the public sector might commission so that we are working more holistically with communities

The approach will therefore be to make sure that we are focusing on **high burden needs, that are worsening and for which there is evidence that effective action can be taken.**

The JSNA will not be making recommendations; the remit for deciding priorities and action is that of the Health and wellbeing Board. The JSNA will set out the evidence of need in an objective way and illustrate what this means for Bexley, to enable the Council and the CCG to consider and decide their priorities supported by the best information and evidence possible.

Attachment A gives a work plan running from September 2013 through to April 2014, split into two phases of development for the JSNA – in effect building and refreshing the picture from national data in phase I and enriching it with local data and community asset mapping in phase 2.

The JSNA refresh is being led by Mike Attwood, Independent Consultant, supported by a freelance public health analyst, under the strategic leadership of Maureen Holkham, LBB Deputy Director of Policy and Communications and Dr Nada Lemic, Director of Public Health with input from LBB's own policy and analyst teams.

A **JSNA Steering Group** has been established which met for the first time in September. Its remit is as follows:-

Role and Purpose:

To steer the overall production of the Bexley JSNA by the end of March 2014, ensuring clarity of priority areas of need, effective interventions to meet those needs, within a holistic synthesis of national, local and community information into a richer picture.

Specific Responsibilities

To offer advice on the best sources of data and information, both local and national

To facilitate and champion the availability of local information for the new JSNA

To shape the engagement on the emerging JSNA with councillors, CCG Governing Body, clinicians/professionals, communities, the third sector and partner organisations

To review and advise on the priorities emerging from the JSNA, ensuring that it includes clarity on interventions as well as needs

To advise on "deep dive" future needs assessments that may be required in future years once the JSNA main needs and lines of enquiry are clear

To consider the implications of the JSNA for existing CCG and Council corporate priorities

To lead engagement on the development of the JSNA

Membership

Chair – Dr Nada Lemic, Director of Public Health

Maureen Holkham – Deputy Director, Policy and Communication, LBB
David Bryce-Smith – Deputy Director, Development, Housing & Community Safety, LBB
Sue Tod Dunning – Head of Health Improvement, LBB
Shanie Dengate – Health Policy Officer, LBB
Tom Brown – Deputy Director, Adult Services and Housing, LBB
Sheila Murphy – Deputy Director, Children's Social Care, LBB
Alison Rogers – Assistant Director, Integrated Commissioning, CCG/LBB
Charles O'Hanlan – Assistant Director, Transformation, CCG
Alan Luke – Assistant Director, Contracting and Procurement CCG
Dr Bhadra – CCG Governing Body GP
Sakthi Suriyaprakasham – Chief Executive, BVSC
Jeremy Burden – Director, South London Commissioning Support Unit (CSU)
Mike Attwood – JSNA Programme Lead, LBB Contractor

A representative is also being sought from Public Health England and NHSE.

4 The Format of the JSNA

The JSNA is not an end in itself and the information brought together will need to be focused and proportionate in order to aid clarity about priorities and decision making. The key features of the document will be:-

- Bexley's changing population
- Prevalence (current rate) and incidence (new cases rate) of each main area of health need and disease – is the situation improving, deteriorating or plateauing? 5-10 year trends will be mapped where possible
- How does Bexley compare to similar authorities? Are we doing as well as we should by comparison?
- Where does the greatest need lie and where should we focus within Bexley?
- What is the evidence for effective intervention and what action can be taken?
- What does this mean for the Bexley and the deliberations of the Health and Wellbeing Board?

The proposed structure of the document is set out below. This format is still evolving and comments received to date are attached at Appendix B.

SECTION	FOCUS AND CONTENT
FOREWORD	Councillor Theresa O'Neil and Dr Howard Stoate An actioned focused JSNA building on local partnership and increasing integration. JSNA key findings will be considered by the Health and Wellbeing Board to enrich our current action plans for obesity, diabetes, dementia and smoking as well as prepare for a 2014/15 refresh of the Joint Health and Wellbeing Strategy to tackle the other key areas identified. The JSNA is an overview of need and an ongoing journey - it will inform a wider programme of deeper needs assessments in areas of need that we need to understand more fully
OVERVIEW AND SUMMARY OF KEY FINDINGS	Dr Nada Lemic Headline messages; how the population is changing; areas of high need which are worsening or plateauing; how we compare to like areas Where we need to focus in differences and inequalities within Bexley Overall, what does the JSNA mean for Bexley and which key areas does the Health and Wellbeing Board need to consider? Focus will be on **how to intervene** on existing priorities as well as any update on key needs not identified until now

SECTION	**FOCUS AND CONTENT**
CHAPTER 1 – WHAT IS THE JSNA?	Statutory position; national purpose of the JSNA; what and how (needs and effective interventions) How it will be applied to support the more effective implementation of strategic local priorities National and local commissioning context Will guide partners to do what they already do more effectively → service improvement/best practice development not a financial bidding process. Not a data encyclopaedia – focus on high needs that are worsening where effective, cost effective action can be taken. A blend of national and local information. First attempt to take an assets based approach working with BVSC
CHAPTER 2 – THE BEXLEY STRATEGIC CONTEXT	LBB Corporate Plan, CCG Commissioning Intentions, Joint Health and Wellbeing Strategy point in the same direction; stabilising the local health economy; stronger community based care; effective integration of health and social care; economic realities – "better for less"
CHAPTER 3 - BEXLEY'S POPULATION	ONS census key dimensions – age, gender, ethnicity, birth rates, employment picture, population turnover and "churn". Key main ward differences. Key inequalities messages e.g. deprivation; educational attainment; health outcomes/disease morbidity; housing; employment and skills. Likely picture over ten years – what are the biggest changes we need to plan for? **3 Key Questions…..** How does Bexley compare? What are the main inequalities within Bexley? What does this mean for the Health and Wellbeing Board?
CHAPTER 4 – HOW HEALTHY ARE PEOPLE IN BEXLEY?	Life expectancy and incidence trends over 10 years Ward differences Other differences – e.g. ethnicity; gender; economic status Key trends in incidence/prevalence and mortality/morbidity for key diseases and health conditions. Include Infant Mortality Include physical and mental health headline messages, substance misuse reproductive health (birth rates, teenage conceptions, terminations) and

	immunisation/infectious diseases
SECTION	**FOCUS AND CONTENT**
	For outlier areas – state how many people affected Restate data that led to existing priorities for obesity, diabetes, dementia and smoking Position statement on Bexley's position with the Public Health Outcomes Framework and key messages **4 Key Questions…..** How does Bexley compare? What are the main areas of worsening, high need where we can intervene effectively? What are the main inequalities within Bexley? What does this mean for the Health and Wellbeing Board?
INDVIDUAL DISEASE AND CARE GROUP CHAPTERS These are brief chapters that focus on **areas by exception** **- high, worsening need compared to statistical neighbours** **- significant inequalities within Bexley** For each we will ask:- **5 Key Questions…..** How does Bexley compare? What are the main areas of worsening, high need? What are the main inequalities within Bexley? Where is there evidence that we can intervene effectively? What does this mean for the Health and Wellbeing Board? Each chapter will be clear about the steer to the Health and Wellbeing Board. → **How** to intervene for an existing Health and Wellbeing Strategy Area → A possible **new area of worsening need** to consider either for **early new action** or for a **deeper needs assessment** or for **watchful monitoring**	
CHAPTER 5 – CARDIOVASCULAR DISEASE	Mortality, morbidity and incidence/ prevalence headlines Inequalities within Bexley Evidence for action Numbers of people affected
CHAPTER 6 - CANCER	Mortality, morbidity and incidence/ prevalence headlines Inequalities within Bexley Evidence for action Numbers of people affected Cross reference to palliative/ end of life care chapter

SECTION	**FOCUS AND CONTENT**
CHAPTER 7 – INFECTIOUS DISEASES	Mortality, morbidity and incidence/ prevalence headlines Inequalities within Bexley Evidence for action Numbers of people affected Includes immunisation and screening as well as disease trends Includes sexual health and HIV
CHAPTER 8 – KEY RISK FACTORS	Covers headline messages on smoking, obesity, physical activity, hypertension, diet, drugs & alcohol, diabetes
CHAPTER 9 – MENTAL HEALTH INCLUDING DEMENTIA	Mortality, morbidity and incidence/ prevalence headlines Inequalities within Bexley Evidence for action Numbers of people affected By exception headlines for Depression and anxiety rates Suicide and para-suicide rates mild/moderate vs severe and enduring mental health referral rates to Oxleas Foundation Trust Employment, leisure and learning IAPT intelligence Out of borough placements Dementia Links between mental health and poorer physical health Carers of people with mental health problems Carers with mental health problems DAAT data for substance misuse and drugs
CHAPTER 10 – SUBSTANCE MISUSE - DRUGS AND ALSCOHOL	Mortality, morbidity and incidence/ prevalence headlines Inequalities within Bexley Evidence for action Numbers of people affected By exception headlines drawn from:- DAAT data for substance misuse and drugs contrasted with statistical neighbours
CHAPTER 11 – CHILDREN AND YOUNG PEOPLE	By exception headlines for:- Infant mortality and birth weight Immunisation Education and Skills Obesity Looked after children Safeguarding – including households with adults with serious mental health or substance misuse needs Early years trends

	Mental health
SECTION	**FOCUS AND CONTENT**
	Parenting and Early Years Substance Misuse Deprivation/free school meals Carers profile – both of and by children/young people Complex health needs – physical/learning disability; terminal illness Transition al/learning disability; terminal illness Transition to adult services Under 18 conceptions and terminations
CHAPTER 12 - OLDER PEOPLE	By exception headlines for:- Dementia Social Care referrals Nursing home/residential care vs community care trends Conditions amenable to ambulatory care- planned and actual from Integrated Care Service Acute hospital trends- especially urgent/emergency admission/readmission/discharge trends Single older people/living alone Falls Fuel poverty Something on multiple/complex need indicators/comorbidities Carer trends Housing/extra care Equipment –Joint Store trends Wellbeing and isolation
CHAPTER 13 – PEOPLE WITH A LEARNING DISABILITY	Restate any Children and Young People Issues By exception headlines for:- Adult trends Ageing in people with LD Physical health needs Acute hospital trends Employment/training Out of borough placements/continuing care Dual diagnosis Supported housing Education and leisure Carers of people with LD/People with LD as carers
CHAPTER 14 – PEOPLE WITH A PHYSICAL DISABILITY OR SENSORY IMPAIRMENT	% of population Local data from social care Neurological and neuro-disability profile for MS, MND and other key conditions Out of area hospitalisation and continuing care Need to build a local picture

SECTION	**FOCUS AND CONTENT**
CHAPTER 15 – PALLIATIVE AND END OF LIFE CARE	By exception headlines on:- Dying at home trends Dying in nursing or residential care trends Emergency admissions for end of life care Cancer/non- cancer mix Draw on local end of life care strategy
CHAPTER 16 - CARERS	By exception headlines on:- Draw from existing carers strategy ONS data Local Carers' Third Sector data
CHAPTER 17 – TAKING ACTION	Summarise areas of high, worsening need where effective, cost – effective intervention is possible. Framed as areas for consideration by the Health and Wellbeing Board for early action, further needs assessment or watchful monitoring Include actions that flesh out our Health and Wellbeing Strategy practical interventions for diabetes, dementia, obesity and smoking Options to intervene at stage of:- - Primary prevention - Primary Care - Secondary Care - Self-care and long term condition management Actions can either be:- - Bexley-wide or - targeted by ward or population sub-group

5. Engagement on the JSNA's Development

Appendix C sets out a draft approach to engagement on the JSNA. The key principle is to use a mixture of large events – building a slot on the JSNA into the CCG's events on the development of the Commissioning Intentions, the first of which will be held on 5th December – and outreach with partners using a classic segmentation approach. For CCG purposes, linking into the Primary Care Advisory Group and localities will be key.

The CCG Governing Body is asked to:-

1. **NOTE** the approach to refreshing the JSNA and the CCG's engagement in the Steering Group
2. **ENDORSE** the format of the JSNA and comment on how develop and improve it further
3. **NOTE** the approach to engagement on the JSNA and comment on how develop this further

ATTACHMENT A

Bexley Joint Strategic Needs Assessment – Draft Project Brief

Objective: To develop local evidence-based priorities for commissioning which will improve the public's health and reduce inequalities. The JSNA output, in the form of evidence and the analysis of needs, and agreed priorities, will be used to help to determine what actions local authorities, the local NHS and other partners need to take to meet health and social care needs, and to address the wider determinants that impact on health and wellbeing in Bexley.

Key tasks and outputs

01/09/13 to 31/03/14

	Description	Specific Tasks	Anticipated actions/outputs	Risks
1	Review current position	Analysis of previous JSNA and evidence base. Review of best practice Review of JSNA for neighbouring boroughs/statistical neighbours. Meet relevant staff – DPH, Project leads (Maureen Holkham, Shanie Dengate, Sarah Valentine from CCG), analysts (Jamie Dickie and Raj Sidhu)	Understanding of current state of play	
2.	Governance arrangements	Establish multi agency governance forum to oversee production of the JSNA and evidence base and to ensure buy in partners.	Multi agency JSNA group established, with Chairman (DPH) and members from Health Policy (DD), Adults (DD) Children (DD) Public Health (DD), CCG (Director of Commissioning) , Voluntary sector (CEO BVSC) (providers - Oxleas and acutes?), NCB, CSU, Healthwatch, TOR and timescales agreed; meetings established. Information sharing arrangements agreed.	Lack of buy in from other parts of the Council or partners.

	Description	Specific Tasks	Anticipated actions/outputs	Risks
3	General population data	Compile general demographic material for the borough including life expectancy, mortality, age/gender/births deaths, disability, ethnicity, religion, sexuality.	Evidence base covering metrics listed, with clear attribution. Report on implications for service commissioning in Bexley, with future demand trends.	**Lack of analytical support – now resolved; agency specialist analyst in place**
4.	Lifestyle data	Compile data sets covering smoking, obesity, physical activity, alcohol, drugs, teenage pregnancy	Evidence base covering metrics listed, with clear attribution. Report on implications for service commissioning in Bexley, with future demand trends.	**Lack of analytical support – now resolved; agency specialist analyst in place**
5	Causes of poor health	Compile data sets covering stroke, falls, diabetes, dementia, Coronary heart disease, respiratory disease, cancer, mental health, sexual health and infectious diseases.	Evidence base covering metrics listed, with clear attribution. Report on implications for service commissioning in Bexley, with future demand trends.	**Lack of analytical support – now resolved; agency specialist analyst in place**
6	Wider determinants of health	Safeguarding (adults and children) at Cabinet member request. Other determinants such as housing and education will be included in Phase 2.	Evidence base covering metrics listed, with clear attribution. Report on implications for service commissioning in Bexley, with future demand trends.	**Lack of analytical support – now resolved;**

	Description	Specific Tasks	Anticipated Actions/Outputs	Risks
7	Health inequalities	How needs may be harder to meet for those in disadvantaged areas or vulnerable groups who experience inequalities, such as people who find it difficult to access services; those with complex and multiple needs including looked-after and adopted children, children and young people with special educational needs or disabilities, troubled families, offenders and ex-offenders, victims of violence, carers including young carers, homeless people, Gypsies and Travellers, people with learning disabilities or autism who also have mental health conditions or behaviours viewed as challenging.	Co-ordinating evidence base from Healthwatch, Independent Advocacy Service, Voluntary sector, CCG (and others as appropriate) about where inequalities exist and action required to address. Report on implications for service commissioning in Bexley.	May be difficult to evidence at this stage, given that Healthwatch and IAS are newly established
8	Community assets	Consider what assets local communities can offer in terms of skills, experience, expertise and resources that could help local authorities and the NHS to address the identified needs and impact on the wider determinants of health. This could be a range of assets including formal or informal resources, social networks, or skills in organisations or the community; such as the ability of groups to take greater control of their own health or manage long-term conditions. Local partners, especially in the voluntary sector, can help boards understand the strengths and assets within local communities.	Co-ordinating evidence base from Healthwatch, Independent Advocacy Service, Voluntary sector, CCG (and others as appropriate) to identify self help assets and how these might be further developed. Report on implications for service commissioning in Bexley.	May be difficult to evidence at this stage, given that Healthwatch and IAS are newly established
9.	Draft Report		Report to be agreed by multi agency JSNA group in January/February 2014.	

Resources Support available from

1. Data analyst (Jamie Dickie and Raj Sandhu - both half time on PH issues)
2. Policy and performance officer (Shanie Dengate)

23rd August 2013 – updated 4/11/13

Appendix B

Comments on Draft JSNA Framework – Steering Group 11/11/13

- **Population Chapter –** give numbers of potential population growth by age (esp. children, very elderly, ethnicity). Try to set out population growth split between local endemic change and migration/"churn"

- More use of **GIS (?) maps** possible for some data – Chrissie Edwards is the link via Jamie

- Need strong emphasis on **obesity** – either separate chapter or strong section in risk factors chapter with highlighting in the main "How Healthy is Bexley" Chapter. Bexley's no. 1 issue probably!

- Separate Chapter or very strong/prominent Risk Factors section on **diabetes** – make strong link with obesity

- Add maternity, immunisation and early years element **into children and young people's** chapter.

    - Also include **mental health/CAMHS headlines.**
    - Greater emphasis on young people – 10-19 age group. Perhaps split into 0-5; 5-10, 19+?.
    - Access GLA data on school places
    - Maureen Holkham will make **Education Commissioning Plan** available

- **Cancer** chapter

    - Expand morbidity conclusions to complement mortality
    - to cover screening for bowel, breast and cervical cancer and HPV immunisation
    - Include colorectal and lung cancer
    - Make link between smoking obesity and lifestyle cause and effect
    - ? is there an industrial north Bexley legacy issue e.g. oesophageal cancer?
    - Include 5 year survival rates
    - Review Thames Cancer Registry information
    - Highlight concerns with PHE delays in providing screening data for 13/14

- **Risk Factors Chapter**

    - Include a table of attributable risks by scale and impact
    - Include PHE data extrapolating childhood obesity = impact of what will happen if we do nothing as the population grows up

- **Older People chapter -** split 75+, 85+; 90+

- Need to find a way of pulling out **complexity and multiple needs**. Examples would be:-

    - Substance misuse tends to link with smoking and sexual health issues
    - Growing number of older people with multiple/complex problems
    - Links between smoking and obesity
    - The multiplier effect of poverty and deprivation on lifestyle and morbidity/mortality
    - Early years/right start issues for multiply deprived children or "problem" families
    - Each chapter to have a paragraph on **links/co-morbidities** with other diseases or wider determinants e.g. mental health and smoking prevalence

- Expand **societal references** (perhaps a new chapter) e.g.
    - Bullying (also cross refer in **children'**s chapter)
    - Hate Crime (which is growing)
    - Social isolation (also cross refer in **older people's** chapter)
    - Work/worklessness trends

- Include summary of Bexley's position on the **PHOF** in one of the early chapters

- Each chapter to include:-

    - One/two Bexley wide headlines – absolute and "How do we compare?"
    - Key individual ward headlines by exception
    - Headlines to drop out of 5-10 year trends where possible
    - Set out some key ward trends
    - Try to extrapolate what will happen if we do nothing for the headline issues
    - Good that we are quantifying numbers of people affected where possible
    - Pointers/advice ("recommendations"!) for Health and Wellbeing Board-split into three categories – area for action now; area for monitoring/keeping and eye; area for deeper need assessment
    - Worth splitting "recommendations" between prevention and treatment
    - Try to reference who should lead each recommendation e.g. implication for general practice; mental health trust; acute care etc. Aim here is to enable organisations to take responsibility for best practice within existing services as well as highlight real gaps in need for commissioners/HWBB
    - Working assumption that we have around three main evidence links for each chapter or theme

- Develop **morbidity** focus in each chapter by linking QoF GP data to ONS/population data where possible esp. CHD and diabetes. 4-5 year trends should be possible. N.B. **check with Nada the formula/algorithm for converting GP data into population conclusions** (conversion from registered to resident population)

- Include evidence from Liverpool University study – more proactive GP management of CHD

APPENDIX C

JSNA 2014/15 - Engagement Plan Approach and Outline Timetable

1 CONTEXT

Bexley JSNA 2014/15 draft 1 will be produced by ***end of January 2014*** with the final version produced by ***end of March 2014.*** This will be a "Foundation" JSNA which seeks to act as **a focus for action**, not a data "encyclopaedia". It will therefore **update core nationally available information** making sure that a **holistic picture** is given, setting out wider population trends and life expectancy, covering the key aspects of mortality and morbidity and integrating key messages about disease and illness with a profile of health improvement, wellbeing, wider determinants and lifestyle risk factors.

For the first time it will also ensure that the main drivers of health inequalities are drawn together, that local statutory and voluntary sector available information is used where available to paint a richer picture of need and that a start is made on a **community assets** approach. It will compare Bexley to other similar authorities to support, challenge and confirm the key needs that are identified, attempt to highlight where best to focus within Bexley dependent on inequalities and clearly reference best evidence that will guide how best to intervene.

2 POSSIBLE KEY MESSAGES

- The JSNA is **statutory requirement** led by local authorities through Health and Wellbeing Boards
- **Strategic decisions and priorities are set using its findings** – by the Health and Wellbeing Board and by the individual commissioning organisations – particularly LBB and the CCG; but increasingly we hope other statutory organisations e.g. the Metropolitan Police as Community Safety partners
- It has **an objective, "knowledge and facts" focus** – it advises not recommends
- This year is a **"Foundations" updating year**; an **overview of key trends** and set out **a future programme of needs assessments** in high priority areas
- It will draw together **national and local sources** of intelligence
- It is **holistic** and covers mortality and morbidity, illness/disease; health/wellbeing and wider determinants of health
- It will look at **how Bexley compares** with other similar authorities and draw out **main inequalities** within Bexley
- It is not an end in itself – we need to **avoid data for data's sake**; it therefore covers advice on effective interventions, **how to intervene**, what works and how best to respond to greatest areas of need. This is particularly true for our existing Joint Health and Wellbeing Strategy Priorities
- We are building a **"community assets" approach**

- Advice to the HWBB, LBB and the CCG will range from – areas for high **priority action now**; areas to carry out a deeper **future needs assessment**; areas of potential concern that need **ongoing monitoring**

3 CORE AUDIENCES

There is a need to decide **what the balance** will be between **engagement delivered on an outreach basis** through existing networks and forums (which is always preferable as it mainstreams and integrates the approach) **and larger "whole system"** events. In practical terms, there is a **system-wide event planned for 5th December** which the CCG and LBB are planning to use to engage on the NHS Commissioning Intentions. Perhaps the most pragmatic approach would be to use this event to launch the JSNA in a more global way and undertake engagement outreach during January and February 2014. A common presentation to accompany the draft JSNA documents would be produced. Support will be needed to tailor the materials for particular audiences e.g. people with learning disabilities.

A possible lead has been identified for each audience grouping and a sample grid is shown which would need to populated with meetings, dates and feedback received. Communications capacity will be needed to support the process.

Potential **engagement "audiences"** are as follows:-

1 Internal "core" CCG and LBB — LEADS: JON WINTER/SHANIE DENGATE?

- **CCG Governing Body**
- **CCG Executive Management Committee**
- **CCG Commissioning Intentions "Task and Finish" Group**
- **LBB Cabinet**
- **LBB Health and Social Care Scrutiny Panels**
- **LBB Management Board**
- **LBB Directorate Management Teams**

The CCG Governing Body and LBB Corporate Management Board will be receiving a formal update on the JSNA at their November meetings.

2 <u>"Wider" CCG clinical engagement</u> **LEAD: CHARLES O'HANLON?**

- **Primary Care Advisory Group**
- **Localities x 3**

3 <u>Partnership Focus - Integrated Commissioning and Joint Strategic Working</u> **LEAD: ALISON ROGERS?**

- **Health and Wellbeing Board**
- **Health and Wellbeing Executive**
- **Public Health Working Group**
- **Integrated Commissioning Board**
- **Individual Partnership Boards for**
    i. **Carers**
    ii. **Mental Health**
    iii. **Learning Disability**
    iv. **Physical Disability and Sensory Impairment**
    v. **Older People**
    vi. **Children and Young People**
    vii. **Community Safety/Drug and Alcohol Action Team (DAAT)**
- **Public Health England**
- **NHS England, Primary Care Commissioning Teams x 2 (GP/pharmacy for south London; Dental/Optometry – London-wide)**
- **NHS England – London Specialised Commissioning Team**

4 <u>Service Users, Patients and the Public</u> **LEAD: JON WINTER/SHANIE DENGATE?**

- **Locality Patient engagement Groups x 3 (CCG)**
- **CCG Patients Council**
- **Need advice here…….also consider assets based approach**

5 **Third sector** **LEAD: ALISON ROGERS/JUNE KNOWLES?**

- **Co-ordinate via BVSC – seek advice…….**

6 **Individual Providers** **LEAD: ALAN LUKE/?**

- Offer bi-laterals to main NHS Trusts 1:1; invite to system-wide events;
- Oxleas, Greenwich and Lewisham, Dartford and Gravesham; Kings Healthcare; Guys and St. Thomas' NHS/Foundation Trusts
- **Public Health Service Providers?**
- **Social Care Providers…..?**

AUDIENCE: Internal 'core' CCG and LBB				**LEAD: CHARLES O'HANLON?**
Meeting/Forum	**Date**	**Time**	**Presented by**	**Feedback / comments**

The JSNA Steering Group is asked:-

1) to consider the approach to engagement on the JSNA using:-

- key messages - target, segmented audiences - a lead for each audience grouping
- initial whole system event on 5th December with segmented outreach in January/February 2014

2) to review the audiences for gaps and omissions

3) to consider the pragmatic scale and depth of the engagement to be conducted with the capacity and resources available

Mike Attwood
10th November 2013