REPORT TO HEALTH AND WELLBEING BOARD

Title:	**PROGRESS AGAINST 2010/11 JOINT STRATEGIC NEEDS ASSESSMENT (JSNA)**
Date:	15 July 2011
Contact Officer(s):	Rutuja Kulkarni, Asst Director & Consultant in Public Health
	01753 646334 or 07876 562539
Wards affected:	All wards

1. SUMMARY

This report summarises the progress made by the PCT against the 2010/11 Joint Strategic Needs Assessment (JSNA) and explains the legislative requirement for a joint strategic needs analysis. This requirement is aimed at identifying local health needs of the population, the inequalities that are shown and assessment of trends. This report concerns the process and impact of the analysis.

2. RECOMMENDATIONS

2.1 The JSNA for 11/12 continues with Marmot themes of needs assessment across the life course

2.2 The 2011/12 JSNA informs the Health and Wellbeing Strategy that will be later developed through the Health and Wellbeing Board

2.3 For 2011/12, the JSNA focuses on two areas for detailed needs assessment, namely, children and adults

2.4 That the JSNA is presented to the Health & Wellbeing Board with an Action Plan in November 2011

What will be different for residents as a result of this decision?
Commissioning of services (Cluster / GP Commissioning Consortia / Local Authority) will be aligned with the JSNA for the population. Health of the population should improve and inequalities reduced in the long term with particular attention to the most important areas of need.

3. SUPPORTING INFORMATION

Background

3.1 Section 116 of the Local Government and Public Involvement in Health Act (2007) places a duty on upper-tier local authorities and Primary Care Trusts (PCT) to undertake a Joint Strategic Needs Assessment (JSNA). The JSNA is a process that identifies the current and future health and wellbeing needs of a local population and informs the commissioning priorities to improve outcomes and reduce health inequalities in populations.

3.2 The JSNA can be considered a "big picture" evidence based document that shows current and historical trend information on the health and wellbeing of a population. It shows where there are priorities for action so that the commissioning plans of services can target and address inequalities as well as support overall population outcomes.

3.3 It has been a duty to have produced a JSNA since 2008. Previous local versions of the JSNA have considered the requirements of the National Outcome Indicator Set and the Local Area Agreement Priorities, therefore the format of the document has been to support those data requirements as well as the locally identified needs. Since these requirements met the end of their term, the local format of the JSNA was changed in 2010 to reflect the Marmot Review of health inequalities which was published nationally in February 2010 and is titled *Fair Society, Healthy Lives*

3.4 The Marmot Review *Fair Society, Healthy Lives* identified 6 national policy objectives where action would reduce health inequalities:

- Give every child a chance
- Enable all children, young people and adults to maximise their capabilities and have control over their lives
- Create fair employment for and good work for all
- Ensure healthy standard of living for all
- Create and develop healthy and sustainable places and communities
- Strengthen the role and impact of ill-health prevention

The JSNA for RBWM in 2010 was designed and formatted to compliment these 6 policy objectives.

3.5 The Public Health white paper (published in November 2010) *Healthy Lives, Healthy People: Our Strategy for Public Health In England* supports the Marmot approach and adopts the framework Marmot used of looking at life course and assessing inequalities in health and wellbeing at all stages of life. This includes addressing wider social determinants of health inequalities, of housing, education, employment, etc. As the JSNA requires annual refreshing to ensure the data is reflective of current needs, it is proposed to continue to use this format and style locally as it is supported nationally.

3.6 The *Equality and Excellence: Liberating the NHS* white paper strengthens the importance of having a JSNA locally, as this is the key document that supports the identification of priorities for the Health and Wellbeing Board. The data in the JSNA is the foremost evidence base for the Joint Health and Wellbeing Strategy which identifies the local strategic priorities to address the inequalities of the population. It is a requirement for all Health and Wellbeing Boards to produce their own local Joint Health and Wellbeing Strategy

3.7 The commissioning plans for the GP Commissioning Consortia and the Local Authority have to reflect the identified priorities in the Joint Health and Wellbeing Strategy, based on evidence in the JSNA, therefore the JSNA can be used to measure and assess the levels to which the priorities have been met. The JSNA and the Joint Health and Wellbeing Strategy are the foundations for the action plan of the Health and Wellbeing Board, which is a new requirement. The recent Government response to the NHS Future Forum report (Jun11) highlights "clinical commissioning groups will have a **duty to promote integrated health and social care around the needs of service users** (p. 20) and further strengthens this duty with "Health and wellbeing boards will assess local needs (through the joint strategic needs assessment) and develop a shared strategy (in the form of a new joint health and wellbeing strategy) to address them, providing a strategic framework for commissioners' plans. (p. 30-31)"

3.8 The JSNA priorities for 2010/11 for Berkshire East and the Royal Borough of Windsor and Maidenhead were identified as below in summary format. The Berkshire East priorities support the Royal Borough and some of the pertinent further details related to the priorities in both localities are outlined in Appendix 1.

Berks East Priorities	Royal Borough of Windsor and Maidenhead
1. **Chronic Obstructive Pulmonary Disease (COPD)** – Implementation of NICE classification 2. **Improve diabetes control** –Implement recommendations in the National Diabetes 3. **Extend acute stroke care** - Improvements in acute and community care improvements 4. **Implement National Dementia** - Strategy development 5. **Uptake of immunisations** – coverage for BCG, MMR2 and DTP	1. **Ageing population and impact on Long Term Conditions (LTCs)** - RBWM ageing population is projected to increase by 2025 2. **Dementia** – Prevalence is statistically significantly above England in Ascot. 3. **Coronary Heart Disease (CHD)** – Mortality from CHD is below national rates 4. **Cancer** - QoF prevalence for all cancers in RBWM marginally above national but considerably higher than the PCT prevalence

Berks East Priorities	Royal Borough of Windsor and Maidenhead
6. **Reducing admissions** - A&E, paediatric, diabetes, cardiology and musculoskeletal. 7. **Ensure access to antenatal care pathway** -NICE CG110 compliant maternity service 8. **Improve reporting of sexual health** – improve outcomes including Chlamydia screening 9. **Improve tobacco control** -delivery in line with national evidence 10. **Jointly commission** - healthy child programme 11. **Develop a child poverty strategy** 12. **Reduce impact of domestic abuse** on education, health, social care and criminal justice system	5. 6. **Falls and Hip fracture** - hip fracture rates in RBWM (615.4 per 100,000) are statistically significantly above England (479.2 per 100,000). 7. **Alcohol** – develop harm reduction programmes as alcohol attributable crimes above national and regional rates. 8. **Reduce domestic abuse, sexual abuse and violent crime** - figures increasing according to data from police incidents recorded (not statistically significant).

3.9 Progress to date against priorities in RBWM

Progress against the priorities agreed in the Royal Borough has been made through a variety of PCT mechanisms and some of the initiatives are summarised in the table below. Work undertaken to address the overall Berks East priorities specifically benefits RBWM as well.

Royal Borough of Windsor and Maidenhead	Progress to date
1. **Ageing population and impact on Long Term Conditions (LTCs)** - RBWM ageing population is projected to increase by 2025 2. **Dementia** – Quality and Outcomes Framework (QoF) prevalence in Ascot is above national 3. **Coronary Heart Disease (CHD)** – Mortality from CHD is below national rates 4. **Cancer** - QoF prevalence for all cancers in RBWM (1.43%) is marginally	1. Supporting older people with LTCs is a focus for the strategic Staying Healthy Programme (cardiovascular prevention and communicable disease) and the Preventing Crisis Supporting People Programme (telehealth, intermediate care and urgent care) 2. The Dementia Action Plan for Berks East has been agreed between partners 3. Strategic Programmes of Access (heart failure, atrial fibrillation)and Staying Healthy (breast feeding, slimming on

Royal Borough of Windsor and Maidenhead	Progress to date
above national (1.41%) but considerably higher than the PCT prevalence (1.19%). 5. **Falls and Hip fracture** - hip fracture rates in RBWM (615.4 per 100,000) are statistically significantly above England (479.2 per 100,000). 6. **Alcohol** – develop harm reduction programmes as alcohol attributable crimes above national and regional rates. 7. **Reduce domestic abuse, sexual abuse and violent crime** - figures increasing according to data from police incidents recorded (not statistically significant).	referral) have addressed CHD mortality 4. Cancer provision for the PCT is well established and delivering against targets. PCT has plans to commission the breast screening age extension programme for 70% of the eligible population women between 47 and 73 years. This will include digital mammography. Bowel cancer age extension programme commenced last year and uptake is good 5. Work continues to address Falls prevention through primary care and medicines management 6. Pharmacists trained to provide evidence based Identification Brief Advise (IBA) 7. Local Sexual Assault Referral Centre (SARC) commissioned

4. OPTIONS AVAILABLE AND RISK ASSESSMENT

Options

	Option	Comments/ Risk assessment	Financial Implications
1.	No action on the recommendations for the 2011/12 JSNA	Implications for health and social care outcomes among the population	Potential for increased costs for NHS and RBWM services
2.	Endorse the recommendations for the 2011/12 JSNA	Improvements in health and social care outcomes for the population	Resources to be identified in partner organisations
3.	Alter the recommendations for the 2011/12 JSNA	Delay in the JSNA process	As above

4.2 Risk Assessment

4.2.1 The JSNA is a statutory requirement and therefore to not develop the JSNA at this time is not a realistic option. National support for the use of Marmot's life course framework make this the most logical option with the lowest risk to impact on partners

involved as the format was used successfully last year, therefore the refresh process would be more efficient.

5. CONSULTATIONS CARRIED OUT

5.1 The use of the Marmot life course theme was agreed upon by partners in the development of the JSNA for 2010/11, the partners included the Directors of Adults and Childrens Services as well as the East Berkshire Joint Strategic commissioning board. The Health and Social Care Executive in the Borough have been consulted on the approach for 2011/12.

6. COMMENTS FROM THE OVERVIEW AND SCRUTINY PANEL

6.1 Health Scrutiny were presented with the JSNA information and format in 2010 when the format was changed to the Marmot life course style. There is an annual cycle of review which will continue to be ongoing.

Appendix 1 Expanded detail on 2010 / 11 Priorities in the JSNA (relates to s. 3.8 above)

Berks East Priorities	Royal Borough of Windsor and Maidenhead
1. **Chronic Obstructive Pulmonary Disease (COPD)** – Implementation of NICE classification (clinical guideline 101). There were 1,004 admissions for COPD in BE in 2009, predominantly from Windsor and Maidenhead. 2. **Improve diabetes control** –Implement recommendations in the National Diabetes audit including improving coverage of diabetic retinopathy screening 3. **Extend acute stroke care** - Improvements in acute care and development of community care improvements 4. **Implement National Dementia** - Strategy development for dementia and for public mental health as defined by the Royal College of Psychiatrists, 2010 5. **Uptake of immunisations** – coverage for BCG, MMR2 and DTP 6. **Reducing admissions** - A&E, paediatric, diabetes, cardiology and musculoskeletal. In 2009/10 there were 5,195 paediatric admissions, 2,136 circulatory admissions (2009/10); 946 for heart disease (63% emergency) and 700 for stroke (96% emergency) 7. **Ensure access to antenatal care pathway** -NICE CG110 compliant maternity service 8. **Improve reporting of sexual health** – improve outcomes including Chlamydia screening 9. **Improve tobacco control** -delivery in line with national evidence and quality improvements in smoking cessation and	1. **Ageing population and impact on Long Term Conditions (LTCs)** - RBWM ageing population is projected to increase by 2025, the prevalence of LTCs and the number of patients is also projected to increase substantially, e.g. Dementia 2. **Dementia** – Quality and Outcomes Framework (QoF) prevalence in Ascot (0.66%) is above national (0.45%) – this is not due to small numbers and yet dementia is under-diagnosed. Prevalence is statistically significantly above England in Ascot. 3. **Coronary Heart Disease (CHD)** – Mortality from CHD is below national rates (89.9/100,000) in RBWM (80.7/100,000) and above Southeast (76.3/100,000) rates but not statistically significant. 4. **Cancer** - QoF prevalence for all cancers in RBWM (1.43%) is marginally above national (1.41%) but considerably higher than the PCT prevalence (1.19%). **Breast cancer** mortality per 100,000: RBWM = 29.4, National= 26.8, Southeast = 27.8 – not statistically significant but rising. **Colorectal cancer mortality** (19.02/100,000) – similar to national (17.8/100,000) and SE (17.6/100,000) not significantly above. **Prostate cancer mortality** per 100,000: RBWM = 27.8, National= 24.5, Southeast = 24.3 – not statistically significant but rising 5. **Falls and Hip fracture** - hip fracture rates in RBWM (615.4 per 100,000) are statistically significantly above England (479.2 per 100,000). Falls in some areas of RBWM reached 114 to 296 per 1,000 in 2009/10. Falls in the town centre are notable in ambulance records.

Berks East Priorities	Royal Borough of Windsor and Maidenhead
support tobacco control priorities 10. **Jointly commission** - healthy child programme 11. **Develop a child poverty strategy-** Over a third of children are living in poverty levels above the national benchmark (21.9%) in selected wards in Slough, and other wards across Berkshire East have been identified with poverty levels above the Southeast regional level (14.9%). 12. **Reduce impact of domestic abuse** on education, health, social care and criminal justice system	6. **Alcohol** – develop harm reduction programmes as alcohol attributable crimes above national and regional rates. Alcohol attributable mortality and chronic liver disease in women is also above regional rates, but not statistically significant. 7. **Reduce domestic abuse, sexual abuse and violent crime** - figures increasing according to data from police incidents recorded (however increase is not statistically significant). 46% (n=200) of all domestic abuse incidents reported for RBWM in Thames Valley involved children. Similar to BF (204) but below Slough (393).

NHS
Berkshire West

Equality impact assessment: Stage 1 – Standard Screening	
Name of policy, project, strategy or service	Joint Strategic Needs Assessment
Purpose of above	To identify local needs and inform commissioning processes
Name and contact details of assessor	Rutuja Kulkarni, AD and Consultant in Public Health
Date of screening decision	7.7.11
Does it affect any groups more or less favourably than another? (Please refer to check list on flow chart)	Health inequalities is a key part of the JSNA and needs of particular groups who experience unequal outcomes are clearly highlighted in the JSNA
Proceeding to detailed screening?	No
If yes deadline for completing assessment	
If not proceeding to detailed screening, complete one of the following:	
1. Assessor's reasons for deciding there is insufficient resource to proceed (e.g. insufficient time, staff, competing priorities, etc.):	
2. Assessor's reasons why it is not necessary to do an assessment on this policy no adverse equality impacts likely within or between equality groups The JSNA highlights all of the health inequalities affecting various groups * Please attach any evidence which supports your decision not to undergo stage 2 EIA.	
Monitoring of screening decision (to be completed by line manager):	
Comments by assessor's line manager: Name: Dr Pat Riordan Director of Public Health	
Monitoring of screening decision (to be completed by Equality and Diversity Steering Group):	
Date of E& D Steering group meeting: NA	