REPORT TO THE HEALTH AND WELLBEING BOARD

JOINT STRATEGIC NEEDS ASSESSMENT: UPDATE ON PROGRESS

1. PURPOSE OF REPORT

1.1 The purpose of this report is to provide the Health and Wellbeing Board with an update on progress in developing the new Joint Strategic Needs Assessment (JSNA).

2. RECOMMENDATIONS

It is recommended that:-

2.1 Members note the report and the timescale for submission of the JSNA of the 1st October 2013.

3. INTRODUCTION/BACKGROUND

3.1 JSNAs are assessments of the current and future health and social care needs of the local authority. Local authorities are free to undertake JSNAs in a way that is best suited to their local circumstances - there is no template or format that must be used and no mandatory data set to be included.

3.2 A JSNA steering group has bee established, chaired by the Acting Director of Public Health, which has been working on the development of the new JSNA to bring it to the Health and Wellbeing Board for final approval at the meeting on the 1st October 2013.

4. STRUCTURE OF THE DOCUMENT

4.1 The JSNA steering group have recognised that there is a need to streamline the quantity of indicators used in the JSNA. An exercise has been conducted in order to reduce the number of indicators to a manageable number whilst maintaining sufficient quantity to highlight the priorities for Barnsley. This exercise drew information on over 200 indicators drawn from population statistics and recently published national outcome frameworks for the NHS, social care, public health and children and young people.

4.2 The steering group have also been examining ways to structure the JSNA report and present the data. The chapter structure of the previous JSNA was viewed as being quite siloed in its approach and other options were looked at. A particular option that presented itself was to use the life course approach as suggested by the Marmot report into health inequalities. The Marmot report recommended an approach across the life course and the JSNA steering group have agreed to adopt the use of this framework.

4.3 Whilst this structure does have many strengths and is certainly an aid when looking at tackling health inequalities, it does require introductory chapters that set the scene, particularly around the Wider Determinants of Health that impact on health and wellbeing throughout the lifecourse. Moreover, it will be important to make sure that the individual chapters overlap and interact with each other.

4.4 The streamlined indicators have been matched to a structure based on Marmot and can be found at Appendix A.

5. PRESENTATION AND LAYOUT

5.1 The previous JSNA was largely web based through the LASOS (Local Area Statistics online service) web portal. This system has now been decommissioned and has required that we look at an alternative. Examples of best practice were examined and a good example can be found at Cheshire East JSNA via https://www.cheshireeast.gov.uk/social_care_and_health/jsna.aspx

5.2 In developing the layout for the JSNA the steering group were keen to ensure that the front pages provide a simple and easy to use web page that will allow users to quickly see the position of Barnsley against the indicators and to provide access to more indepth information without the need to download and search through huge documents.

5.3 At the same time, the documents will need to contain the key items of information and intelligence and these will need to be presented in a visual manner. Each document will therefore present the following:

- Chapter heading
- Indicator description; why it is important, what it tells us
- Cross reference to related sections
- Visual description of indicator (map, chart, table) and any comparator / benchmarking information
- Headline messages
- Evidence of best practice and how this relates to the Barnsley population
- Asset map
- Community Voice
- Suggested actions

An example is provided at Appendix B

5.4 Further consideration has also been given to the need to engage communities in the JSNA process. The intention is to utilise existing consultation findings to populate the JSNA documents. A mapping exercise has been conducted and there are sufficient recent or planned consultation / engagement exercises for this purpose. For this reason, we are not proposing to arrange any bespoke JSNA consultations sessions. However any gaps in consultation will be flagged and be included as a recommendation for further action.

6.0 Future developments

6.1 Work is progressing at pace supported and coordinated by public health with the involvement of relevant officers from the local authority, CCG and other partners. The intention is to bring the JSNA back to the Health and Wellbeing Board at its meeting on the 1st October 2013. Work will, however, continue to develop the indicators that are not yet ready for analysis. The intention is also to provide, at a later date, further analysis of the indicators at sub-Barnsley geographies, potentially around the Council's new area council structure. As the JSNA process evolves and the analysis begins to look at the area council level geographies there may be

scope to arrange for more meaningful engagement exercises. This will be kept under review and any future proposals will be brought back to the Health and Wellbeing Board for consideration.

APPENDICES

Appendix A Layout and Indicators
Appendix B Draft Example of Starting Well and Developing Well Chapter

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Introduction

People and Place

Barnsley – Census
Barnsley – Education Attainment
Barnsley – Population
Barnsley - Transport
Barnsley – Housing
Barnsley - Environment
Barnsley – Economy
Barnsley - Community Safety

Starting Well and Developing Well

Starting Well

Maternity and Post-Natal Care

- Women's experiences of maternity services (NHSOF) & (HSCIC)
- Smoking at the time of delivery (PHOF)
- Breastfeeding rates (PHOF)

Family Life and Parenting Styles

- Child Poverty (PHOF)
- School readiness (PHOF)
- Domestic abuse (PHOF)
- Emergency gastroenteritis admissions in under 5s (HSCIC)
- MMR vaccinations (PHOF) & (HSCIC)
- Tooth decay at age 5 (PHOF) & (PHE/BASCD)
- Excess weight in 4-5 year olds (PHOF) & (HSCIC)
- Excess weight in 10-11 year olds (PHOF) & (HSCIC)

Developing Well

Supporting Young People

- Admissions from injuries in under 18s (PHOF)
- Alcohol specific admissions in under 18s (PHE/CHIMAT)
- Smoking at age 15 years (PHOF) & (BMBC)
- Young people and substance misuse
- Chlamydia diagnoses (15-24 year olds) (PHOF)
- Under 18 conceptions (PHOF)
- First time entrants into youth justice (PHOF)

Living Well and Working Well

Overarching Outcomes

- Healthy life expectancy (PHOF) & (ONS)
- Differences in life expectancy (PHOF) & (HSCIC)
- Mortality from all cardiovascular diseases (PHOF) & (NHSOF)
- Mortality from cancer (PHOF) & (NHSOF)
- Mortality from respiratory disease (PHOF) & (NHSOF)

Mental Wellbeing

- Hospital admissions as a result of self harm (PHE)
- Suicide (PHOF)
- Excess under 75 mortality from serious mental illness (PHOF)

Lifestyle Choices

- Smoking prevalence - adults (over 18s) (PHOF)
- Successful completion of drug treatment
- Reoffending

Community Impacts

- Air pollution (PHOF)
- Noise (PHOF)
- Killed or seriously injured on the roads (PHOF)
- Statutory homelessness (PHOF)

Alcohol Harms

- Alcohol-related hospital admissions (PHOF) & (PHE/LAPE)
- Mortality from liver disease (PHOF)

Ageing Well

Emergency Hospital Admissions in the over 65's

- Emergency admissions in the over 65's
- Major reasons for admission
- Falls and fall injuries in the over 65's (PHOF)
- Hip fractures in the over 65's (PHOF)

Winter Health

- Fuel poverty (PHOF)
- Excess winter deaths (PHOF) & (PHE/WMPHO)
- Seasonal Flu Vaccination (PHOF)

Co-ordination of Care

- Access to GP service (NHSOF) & (HSCIC)
- Proportion of people feeling supported to manage their condition (HSCIC)
- Dementia and its impacts (PHOF) & (HSCIC)
- End of life care (HSCIC)
- Ageing well

Chronic Disease Management

- Recorded diabetes (PHOF) & (HSCIC)
- Breast cancer survival (NHSOF) & (HSCIC) & (PHE)
- Bowel cancer survival (NHSOF) & (HSCIC) & (PHE)
- Lung cancer survival (NHSOF) & (HSCIC) & (PHE)
- Prostate cancer (HSCIC) & (PHE)
- Chronic obstructive pulmonary disease (COPD) (HSCIC)
- Improving outcomes from strokes
- Cancer incidence and referrals (HSCIS) & (PHE)
- Cancer diagnosed at stage 1 and 2 (PHOF)

• Pupil absence (PHOF) • 16-18 year olds not in education, employment or training (NEET) (PHOF) • Young people in care • Vaccination against cervical cancer (PHOF)	Screening and NHS Health Checks • Breast cancer screening (PHOF) & (HSCIC) • Cervical cancer screening (PHOF) & (HSCIC) • Bowel cancer screening (HSCIC) • Diabetic eye screening (PHOF) • Take up of NHS health checks (PHOF)	
Summary of Priorities	**Glossary**	Acknowledgments

Glossary of Terms

BASCD – The British Association for the Study of Community Dentistry (part of PHE)

CHIMAT – Child and Maternity Intelligence Network (part of PHE)

HSCIC – Health & Social Care Information Centre

LAPE – Local Alcohol Profiles for England (part of PHE)

NHSOF – NHS Outcomes Framework

PHE – Public Health England

PHOF – Public Health Outcomes Framework

WMPHO – West Midland Public Health Observatory (part of PHE)

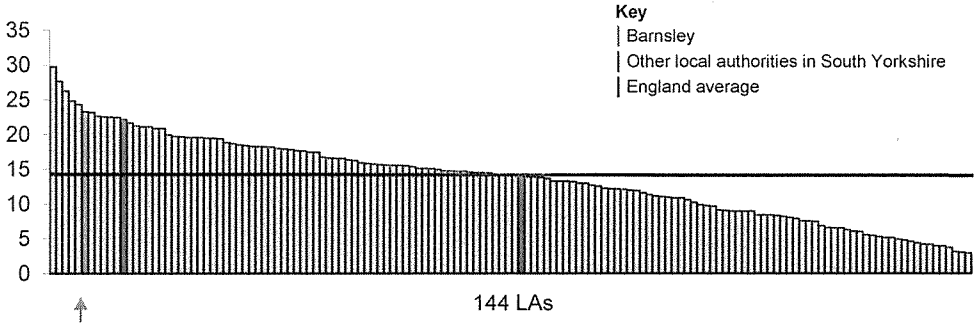
Starting Well and Developing Well

Smoking prevalence – adults over 18 (PHOF) 2.14
Infant mortality (PHOF) 4.1
Smoking prevalence – 15 year olds (PHOF) 2.9

Barnsley JSNA

Smoking status at time of delivery (PHOF 2.3)

Rate of smoking at time of delivery per 100 maternities



Smoking status at time of delivery (2011/12)

	Smoking at time of delivery	Number of maternities	Proportion smoking at time of delivery	Compared with England
Barnsley	705	3,025	23.3%	☹
Doncaster	808	3,644	22.2%	☹
Rotherham	n/a	n/a	n/a	n/a
Sheffield	919	6,536	14.1%	☺
England	**87,637**	**664,598**	**13.2%**	**-**

Source: Public Health Outcomes Framework Data Tool (May 2013)

The smoking rate amongst pregnant women in Barnsley, at 23%, is 10% higher than the national average.

In 2011/12 only 35% of pregnant smokers successfully quit in Barnsley. This was significantly fewer than both the national and regional averages of 45% and 49% respectively.

Smoking in pregnancy is a major Public Health concern increasing health risks to both mother and baby. It is the single most modifiable risk factor for adverse outcomes, which include complications during pregnancy, an increased risk of miscarriage, premature birth, still birth, low birth weight. In addition children exposed to tobacco smoke in the womb are more likely to suffer from respiratory, ear nose and throat infections, psychological problems such as hyperactivity (Button et al 2007) and a detrimental effect on child's educational performance (Batstra et al 2003).

Reducing the prevalence of smoking in pregnancy will not only reduce the increased risk of complications in pregnancy and the long term health effects of the child, but also contribute to a reduction in infant mortality as evidence demonstrates smoking during pregnancy increases the risk of infant mortality by an estimated 40% (DH 2007).

The earlier in pregnancy a mother can stop smoking, the better the health outcomes for her and her baby.

The majority of pregnant smokers who continue to smoke during their pregnancy reduce the amount they smoke throughout their pregnancy. However evidence indicates that their intake of toxins is not actually reduced. The focus by practitioners need to be on stopping and not just cutting down, which could discourage pregnant mums from taking the final step and quitting (Lawrence 2003).

Each year it is estimated that more than 3000 women smoke during their pregnancy in the South Yorkshire area. Data shows that babies born before 26 weeks' pregnancy spend at least 111 days in hospital during infancy at a cost of more than £100,000. Across South Yorkshire and the region, this means costs of between £3.3m and £5.5m for 2009-2010. There will also be an emotional and financial burden placed on the families and community support systems (Godfrey 2010).

Smoking status at time of delivery (PHOF 2.3)
Rate of smoking at time of delivery per 100 maternities

Suggested Actions

Specialist stop smoking midwife led service based in the hospital maternity service

Fit Mums – healthy lifestyle programme

Continue to adopt the opt out model started in April 2013

Local maternity and Stop Smoking services to implement NICE Public Health Guidance 26: Quitting smoking in pregnancy and following childbirth.

Evidence of what works

Opt out model for pregnant smokers, meaning they are automatically referred to the stop smoking services unless they specifically request not to be. All women are Carbon Monoxide tested as smoking can be detected by this

Specialist stop smoking midwives based in the hospital maternity service

Stop smoking help being offered to partners and significant others' who smoke

The NICE Public Health guideline 26 (2010)

Asset Map

Stop Smoking Service (SWYPFT) with national Centre for Smoking Cessation and Training (NCSCT) qualified Practitioners

Fit Mums service targeting under 19's

Midwifery (BHNFT)

Health Trainer Service

School Nursing service

Health Visitors

Schools and College

Children's centres

Healthy Settings Service

Community Voice

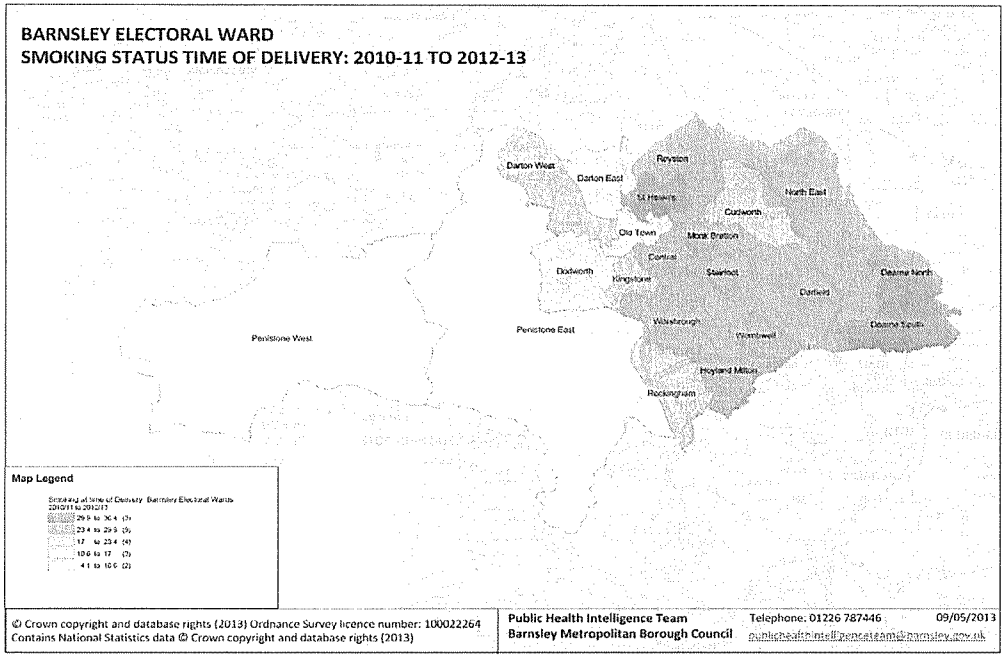
Barnsley Stop Smoking Service feedback:

"Being pregnant gave me the reason to quit. I didn't even need to think about it as I was concerned the baby would have breathing difficulties or health problems if I carried on. Weekly meetings helped me to stay on track" (Sams Story).

"When I found out I was pregnant I knew I had an important decision to make. What I once thought was 'the impossible' has now become a reality" (Kerry's story).

Smoking status at time of delivery (PHOF 2.3)

Rate of smoking at time of delivery per 100 maternities



Source: ONS (2012)

Deprivation is worst in eastern parts of the borough. The map shows that this pattern of deprivation is reflected in the pattern of mothers smoking at time of delivery.

There are large geographical variations in the rate of mothers smoking at delivery, ranging from 4.2% in Penistone East to 36.3% in Dearne South.

Further Information

Public Health Outcomes Framework
http://www.phoutcomes.info/

References

Batstra L, Hadders-Algra M, Neeleman J (2003) Effect of antenatal exposure to maternal smoking on behavioural problems and academic achievement in childhood. Early Human Development 75: 21-33.

Button T.M.M, Maughan B, McGuffin P (2007) The relationship of maternal smoking to psychological problems in the offspring. Early Human Development 83 (11): 727-32.

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Lawrence T, Ayeyard P, Croghan E (2003) What happens to women's self-reported cigarette consumption and urinary cotinine levels in pregnancy? Addiction 98: 1315-20.