Department of Health consultation on Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies – draft guidance

1. I write with regard to the Department of Health consultation on Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies – draft guidance.

2. The Royal College of General Practitioners is the largest membership organisation in the United Kingdom solely for GPs. Founded in 1952, it has over 44,000 members who are committed to improving patient care, developing their own skills and promoting general practice as a discipline. We are an independent professional body with enormous expertise in patient–centred generalist clinical care. Through our General Practice Foundation, established by the RCGP in 2009, we maintain close links with other professionals working in General Practice, such as practice managers, nurses and physician assistants.

3. The College welcomes the opportunity to respond to this consultation. As you will know, we responded to the similar consultation in February of this year, the response to which is appended as many of the points we made then remain relevant.

4. In particular, we are not sure that the revised document resolves the question, which we raised before, of how different bodies will be persuaded to work together
constructively, or what recourse there will be should they refuse to do so. We also, in our earlier response, raise questions around the efficient use of JSNA data to support GP practices and CCGs in developing local solutions, the need for more guidance around engagement with local communities, and issues of resourcing for CCGs involved with Health and Wellbeing Boards (HWBs) – the need for backfill etc.

5. With those reservations, we welcome the greatly abbreviated and clarified text, by comparison with the version we considered in February – this version is far more likely to be read, quoted and used by those involved in CCGs and Health and Wellbeing Boards.

6. We have addressed the specific consultation questions below:-

1. Does the guidance translate the legal duties in a way which is clear in terms of enabling an understanding of what health and wellbeing boards, local authorities and CCGs **must** do in relation to JSNAs and JHWSs?
   Yes, this does make the legal duties much clearer, and as such will be useful tool for members of CCGs and Health and Wellbeing Boards to explain the duties in relation to JSNAs and JHWSs. That said, we are still not convinced that is clear enough on how systems will be held to account to ensure that these duties are fulfilled, in a situation where a Health and Wellbeing Board has insufficient authority. For example, while it is stated that the HWB may refer a CCG that is not meeting its obligations to the NHS Commissioning Board, in the case where it is the local authority that has failed to take account of the JSNA or JHWS the HWB can only ‘raise its concerns with the local authority’ (p6) – it is not clear how credible the system will be in these circumstances.

2. It is the Department of Health’s (DH’s) view that health and wellbeing boards should be able to decide their own timing cycles for JSNAs and JHWSs in line with their local circumstances rather than guidance being given on this; and this view was supported during the structured engagement process. Does the guidance support this?
   Yes, it does.

3. Is the guidance likely to support health and wellbeing boards in relation to the content of their JSNAs and JHWSs?
   The guidance does give some indication as to the potential breadth of content. It may be right that much is left to local interpretation, but it will be essential to provide ways for sharing best practice if the quality of JSNAs and JHWSs is not to be patchy nationwide.
4. Does the guidance support the principle of joined-up working, between health and wellbeing board members and also between health and wellbeing boards and wider local partners in a way that is flexible and suits local circumstances?
Yes, it does.

5. The DH is working with partners to develop wider resources to support health and wellbeing boards on specific issues in JSNAs and JHWSs, and equality is one theme being explored.
a) In your view, have past JSNAs demonstrated that equality duties have been met?
Past JSNAs arguably have not had as much influence in this area as would have been desirable.

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?
We agree that the new duties and powers, coupled with obligations on CCGs and local authorities, may have a positive effect in preventing disadvantage and actively encourage tackling of inequalities. As stated above, the chief concern is that systems will not be held sufficiently to account if they fail to achieve this.

6. a) In your view, have JSNAs in the past contributed to developing an understanding of health inequalities across the local area and in particular the needs of people in vulnerable circumstances and excluded groups?
As above – they have not been sufficiently influential in the past, and they have not captured issues of the wider agenda – housing, employment, worklessness, social cohesion, transport, planning and economic development. It is the hope that JSNAs reconstituted as described under health and wellbeing boards may be better able to capture this.

b) What supportive materials would help health and wellbeing boards to identify and understand health inequalities?
As already mentioned, supportive materials should prioritise the sharing of best practice, particularly the most innovative, as the best way to encourage positive development across the country.

For GPs, and GPs as commissioners, we would welcome more focus on practice information overlaid with local authority data – armed with this, health and wellbeing boards and CCGs
may be able to do more to evaluate and tackle inequalities at the most local level. Up to now, JSNAs on the whole have failed to make use of the wealth of practice data available.

7. It is the DH's view that health and wellbeing boards should make use of a wide range of sources and types of evidence for JSNAs and they should be able to determine the best sources to use according to local circumstances. This view was supported during the structured engagement process. What supportive materials would help health and wellbeing boards to make the best use of a wide range of information and evidence to reach a view on local needs and assets, and to formulate strategies to address those needs?

As above, we believe there is great potential in the use of IT tools to link aggregated GP practice data and the local community – guidance on how to apply such strategies would be very useful.

8. What do you think NHS and social care commissioners are going to do differently in light of the new duties and powers, and as a result of this guidance? – what do you think the impact of this guidance will be on the behaviour of local partners?

If applied as described, the impact could be considerable. The new duties and powers mean that NHS and local authority commissioners should no longer be able to pay lip service to joint commissioning plans. There should be a real expectation that health, social care and other services will work effectively together. The remit specifically to tackle health inequalities is also something that we strongly welcome, and it is of the greatest importance that this not be allowed to evaporate in later iterations of this guidance.

So, yes, if all this happens in practice it could have a significant impact – our reservation remains whether there is sufficient leverage to ensure that local authorities and CCGs apply this in practice.

9. How do you think your local community will benefit from the work of health and wellbeing boards in undertaking JSNAs and JHWSs? – what do you think the impact of this guidance will be on the outcomes for local communities?

As above – the impact could be significant, but will depend both on the will to require compliance with JSNAs and JHWSs, and on the availability of information about best practice that can be applied at local level. At the moment, it is all too often the case that health and wellbeing strategies are something that are done to local communities, rather than with them, and there is a need for a significant change of culture in this respect for the
identified goals to be achieved. This guidance could be a tool in this change of culture, but of course does not in itself guarantee the will to apply it.

7. We gratefully acknowledge the contributions of members of our Centre for Commissioning and Health Inequalities Standing Group in formulating this response.

Yours sincerely

Professor Amanda Howe MA Med MD FRCGP
Honorary Secretary of Council
Appendix: RCGP Response to consultation on JSNAs and Joint Health and Wellbeing Strategies, February 2012

16th February 2012

Department of Health consultation on JSNAs and joint health and wellbeing strategies – draft guidance

8. I write with regard to the Department of Health consultation on JSNAs and joint health and wellbeing strategies – draft guidance.

9. The Royal College of General Practitioners is the largest membership organisation in the United Kingdom solely for GPs. Founded in 1952, it has over 44,000 members who are committed to improving patient care, developing their own skills and promoting general practice as a discipline. We are an independent professional body with enormous expertise in patient–centred generalist clinical care. Through our General Practice Foundation, established by the RCGP in 2009, we maintain close links with other professionals working in General Practice, such as practice managers, nurses and physician assistants.

10. The College welcomes the opportunity to respond to this consultation. As a general principle, we appreciate the opportunity, as outlined in this guidance, for GPs in CCGs to work closely with local authorities and the local community to devise appropriate healthcare and public health solutions. The caveat, always, is that the approach taken should seek to avoid being overly bureaucratic, such that clinicians are taken away from their primary role without adequate backfill.

Questions

1. a) Does this draft include guidance on all the essential elements of good JSNA and joint health and wellbeing strategy processes?

Yes, this draft guidance provides a reasonable summary of what belongs in JSNAs and joint health and wellbeing strategies, and though we would argue that it is overly wordy in places, in general it identifies the correct elements. We particularly welcome the emphasis on health inequalities and the requirement to consider the needs of all members of local communities, including unregistered and homeless
populations (e.g. in section 5.2). However, there are omissions and areas that needs further development, as we describe below.

b) Are there other things it could include that would be helpful?

The guidance as it stands is perhaps overly idealistic. Effective JSNAs and joint health and wellbeing strategies will depend on integrated and effective co-operation between a whole raft of newly constructed organisations:

- public health local authority structures at county or unitary level with links to subordinate district councils;
- clinical commissioning groups;
- National Commissioning Board;
- clinical senates;
- clinical networks;
- local Healthwatch

Section 5 suggests that this can best be achieved by ‘true partnership working… including open and honest conversations based on evidence’ and ‘clear roles and responsibilities for staff in the Health and Wellbeing Board’. In reality, and as argued by our colleagues with experience in local government, it may be that the representatives of all these new organisations will be jockeying for positions of maximum advantage. In essence, in endeavouring to avoid any sort of ‘top-down’ direction, the draft leaves the resolution of these serious issues to the creative tension between the different elements. The draft could be more clear about how the situation will be resolved if this creative tension does not produce the desired results.

More could be said about the use of data, which will be of great importance, and of particular interest for GPs, whose practice data will be a major contribution. For example, GPs will hope that they will be able to break down the data and analysis of JSNAs to provide practice-level analyses around local populations – one can imagine clusters of practices seeking ways to adapt the JSNA to their area, and it makes sense for guidance to encourage the documents to be produced in a way that suits this kind of use.

Practice risk-profiling data will be useful to those responsible for the JSNA, and guidance should consider this – always being careful to balance open use of data against the need for patient confidentiality.
It is noted, by a contributor who currently works with a shadow Health and Wellbeing Board on behalf of their local LINK organisation, that a current problem is the relative lack of qualitative as opposed to quantitative data – qualitative data will be harder to use, but without it JSNAs and joint health and wellbeing strategies will lack the fine grain analysis that would maximise their usefulness, particularly in relation to marginalised populations. Our contributor puts this down to the failure to establish a coherent ‘voice’ for local populations and hard to reach groups. The commitment to engage with these group and with local populations generally needs to be backed up with a real commitment to find better ways of public involvement, so that local public voice in this process is more than a tick-box exercise.

Related to this, the guidance doesn’t consider the role of GP patient groups, which could play an important part in feeding practice-level data into JSNAs via local HealthWatch. This could go some way to providing a more fine-grained picture, but only if patient groups have some clarity about the kinds of data and modes of engagement expected. This will need some top-down direction, and could be usefully discussed in this guidance.

It is noted that the JSNA is one among several forms of local assessment – such as the Pharmaceutical Needs Assessment and the Community Safety Assessment. It will be important for Health and Wellbeing Boards to establish and clarify in advance the relative significance of these different assessments – i.e. which feed into and which complement the JSNA.

c) Does it include things that you consider unhelpful?

No.

2. Is the guidance clear to follow and does it provide the necessary level of detail?

As already suggested, the guidance is perhaps rather aspirational in places, and over-wordy in others, where it could in fact be more specific and detailed.

3. a) Would a glossary of terms be useful?

Yes, especially as there are so many new organisations and ways of working involved in this process.

b) We have compiled a draft of terms (at Annex C) what else should we include?
Definitions that should be added include those for ‘clinical senates’ and ‘clinical networks’ – and, as concepts that are very important to the guidance but open to interpretation, what is meant here by ‘community’ and ‘local ownership’?

Additionally, we query the description of Directors of Public Health as ‘independent advocates for the health of their local population’ – independent of what?

4. The previous guidance contained a diagram of the JSNA cycle – would an update to this be helpful?

Yes – there should also be a flow diagram that links how the setting of priorities is made by the CCG and/or local authorities, so that local populations are aware of how they are able to feed into the process and have some ownership.

5. a) Given the LGG Data Inventory published in 2011, would you like to see an updated “core data set” of suggested (but not mandated) data sets?

Yes.

b) Alternatively, would it be helpful to have a resource which signposts to data sources?

One or other of these solutions would be suitable.

6. a) What topics would be useful to cover, and what would you like to see included within these?

We have already listed a number of areas for expansion at 1b above. In particular, a resource on the optimum use of GP practice data to inform JSNAs would be very valuable – this could also cover ways to make the JSNA and strategy maximally useful for day-to-day general practice (and others such as public health staff).

Similarly, a resource on methods to obtain qualitative data from local populations, especially hard-to-reach groups, which could also cover the involvement of GP patient groups, would be useful.

b) Are there sector leaders you think should be leading or inputting into these topics?

The RCGP would welcome being consulted on the questions above.
c) Are there existing resources that you find fit for purpose within the modernised health and care system, which you would like us to signpost to?

No comment.

7. In advance of the formal consultation period, what additional support and resources will you need to ensure that local communities are aware of and have the opportunity to feed in their views?

No comment.

8. Do you have any further general comments you’d like to make?

As described in the guidance, participation by CCGs in JSNAs and joint health and wellbeing strategies would appear to place a considerable burden on their resources – they are required to gain Health and Wellbeing Board approval of their commissioning plans and revisions thereof, and the Board are able to refer disagreements to the NHS Commissioning Board. Equally, the NHS Commissioning Board and the CCG itself are required to review the CCG’s performance against the JSNA and joint health and wellbeing strategy every year; therefore CCGs will have to be resourced to carry out continuous monitoring of their own actions in relation to externally controlled management/planning tools that are ‘continuous and iterative processes forming part of the commissioning cycle’. In addition there are many other external requirements that CCGs will need to meet (COF indicators, Monitor regulations etc). Of course it’s right that CCGs will be accountable to local communities – but the guidance risks making their involvement appear overly bureaucratic and time-consuming.

On a technical note, looking at the table in Annex A page 28, we should have thought it was just as important for a local authority as for CCGs to have a ‘duty to cooperate with the HWB in the exercise of its functions’.

11. We gratefully acknowledge the contributions of members of our Patient Partnership Group, Health Inequalities Group and commissioning leads in formulating this response.

Yours sincerely
Professor Amanda Howe MA Med MD FRCGP
Honorary Secretary of Council