

Community wellbeing

Culturally responsive JSNAs:

a review of race equality and Joint Strategic Needs Assessment (JSNA) practice

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Foreword

This report is the outcome of research jointly undertaken by Shared Intelligence and Race for Health, and funded by the Department of Health. It is one in a series of publications taking a thematic look at JSNA. Others in the series will cover:

- JSNA and vulnerable adults
- JSNA and housing
- JSNA and spatial planning
- JSNA and commissioning

The NHS White Paper, Equity and Excellence: Liberating the NHS identifies an ongoing and central role for JSNAs in future health care reforms. Health and wellbeing boards, convened by local authorities, will have responsibility for leading the statutory JSNA process.

The publications provide examples of how local councils and their partners are addressing some of the outstanding and enduring challenges in undertaking JSNA in an increasingly complex landscape.

The publications aim to support councils as they make the transition to the new public health reality and as they work with health and wellbeing boards to ensure that JSNA speaks to new audiences such as GP Consortia.

We hope you find much to learn from in the publications and that they resonate with your experiences locally.



Councillor David Rogers OBE

This report has been commissioned by the Department of Health, written by Shared Intelligence and Race for Health and published by Local Government Improvement and Development's Healthy Communities Programme. The views expressed in this publication are those of the authors and not necessarily those of Local Government Improvement and Development.

Executive summary

Addressing race equality in health saves lives, reduces health costs and increases social cohesion. Race equality is at the heart of the challenge to reduce overall health inequalities. Race equality in health is about fairness and the effective allocation of resources.

Joint strategic needs assessments (JSNAs) enable local areas to:

- identify need
- commission services
- engage communities in improving health and wellbeing.

They are the foundation upon which action to improve health and reduce inequalities follows.

In England today, race equality is beginning to be recognised and addressed in JSNAs. Overall, our review found that the approach taken to race equality in the majority of JSNAs could best be described as ‘developing’.

Positive first steps have been taken. However, there is wide variation between areas in the quality of JSNAs produced and the responsiveness of JSNAs to cultural diversity.

The impact of this variation in quality is in some cases a limited understanding of the health needs of culturally diverse communities and limited identification of action to reduce race inequalities in health. Our findings on JSNAs help explain some of the difficulties England has faced in meeting health inequalities targets (National Audit Office, 2010).

To guide future JSNAs, this report proposes a framework which identifies the dimensions of excelling practice. If local areas adapt this framework to their unique circumstances, then JSNAs will be more effective in shaping services to meet diverse community needs.

Learning from the practice observed, we have identified five broad national-level opportunities that will strengthen race equality in JSNAs. These were identified as significant by participants in the research:

- utilising a consistent framework for improvement
- supporting better use of available data
- offering supported learning and good-practice sharing on race equality
- encouraging evaluation
- positioning improvements in culturally responsive practice within an overall context of improvements to JSNAs.

JSNAs will provide a significant opportunity for the reformulated local partnerships to give practical effect to the often-stated aspiration of reduced inequalities and more effective use of resources.

The opportunities identified here are already reflected in the plans and activities of key partners, suggesting that further improvement and development will be a feature of future JSNA practice.

Our overall assessment is that JSNAs have an important role to play in ensuring that health care and wellbeing services are:

- responsive to diverse community need
- meet equalities obligations enshrined in law and expected by service-users.

As the NHS reforms are implemented by all partners, local and national, government and non-government across the sector, have the opportunity to foster a stronger platform from which JSNAs can approach race equality.

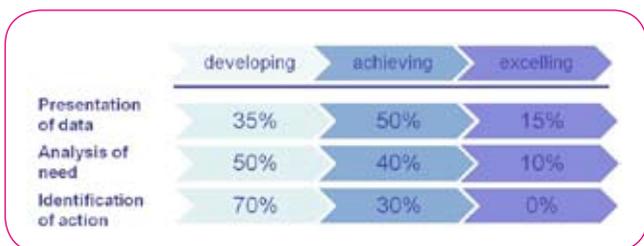
Our key findings

Race equality is beginning to be recognised and addressed in JSNAs, although there is considerable scope for improvement.

Clarity in understanding the relationship between race or ethnicity and health is an influential factor in determining how well a JSNA approaches race equality.

We found that composition of the community – the level of ethnic diversity present – has no observable impact on how JSNAs address race equality issues. This suggests all JSNAs can be ‘culturally responsive’ regardless of the demographic profile of the community they describe.

From the sample of JSNAs we reviewed we found the following distribution of practice:



We did not find a single definable approach that produced the most culturally responsive JSNA. Nevertheless, the framework we used and refined through this research provides a useful diagnostic tool to identify the features of an excelling JSNA.

The approach taken, or process used, to develop JSNAs is significant in the preparation of an excelling JSNA. We found that areas that had developed the more culturally responsive JSNAs had worked with communities and stakeholders, aligned strategies and were leading purposefully.

There was limited recognition of the relationship between race equality and other equalities in JSNA approaches. We also found only limited intersection between JSNAs and other race equality strategies and documents. But there is more widespread and promising practice observed in the use of equality impact assessments (EIAs).

Our findings do not conclusively support a view that in depth assessments on race and health – eg separate needs assessments for minority communities – are a precondition for culturally responsive JSNAs, although they are helpful.

What can local areas do differently?

To develop a more culturally responsive JSNA, local areas – including primary care trusts (PCTs), health and wellbeing boards, local authorities, GP consortia and civil society organisations – should:

- **review** and **benchmark** the existing JSNA documentation and JSNA process to the ‘achieving’ and ‘excelling’ features in each of the three dimensions included in the framework for culturally responsive JSNAs (see page 5)
- examine the **innovations in practice** provided in this report and documented on the Local Government Improvement and Development (formerly the IDeA) community of practice – good practice sharing and supported learning should be available through networks like Race for Health and LG Improvement and Development
- bring together local health and other **intelligence stakeholders** to maximise the use of available data on culturally diverse communities
- establish **evaluation mechanisms** for existing and planned JSNA processes
- position improvements in culturally responsive practice within the **overall context** of improvements to JSNAs and joined-up organisational activity on equalities – such as the local authority equality framework and equality impact assessment process.

Opportunities for national action to improve race equality in JSNAs

The Government's health reforms confirm the central importance of JSNAs to the national health infrastructure. Securing the future quality of local JSNAs will continue to be a major priority for central government and for national agencies with a stake in fostering healthy local communities.

Learning from the practice observed, we have identified a number of broad, national-level opportunities that will support JSNAs to make a more substantial contribution to eliminating race-related health inequalities. These opportunities are the shared responsibility of local and national, government, non-government and sector partners.

Utilise a consistent framework for improvement

The framework we developed to review the unique approaches taken by local areas to race equality provides one potential improvement diagnostic that could be used to foster more culturally responsive JSNAs. Supporting a consistent framework for improvement that is dedicated to or includes race equality would help local areas to clarify their understanding of the relationship between race and health need or health inequalities.

The framework also has the advantage of offering simple steps to assist implementation while remaining entirely adaptable to context.

Support better use of available data

More finely grained data at a local level that enabled analysis of ethnic diversity would be welcomed by local areas, although this does not appear to be currently preventing good practice.

The core dataset includes only minimal reference to race and ethnicity. Given how well some areas have made use of available data, further guidance on what race-related data is available, how it can be used or further developed would be beneficial.

Offer supported learning and good-practice sharing on race

Case study sites all commented on the desire to share and learn from the practices of others and many spoke favourably of existing SHA and other supports.

Supporting an infrastructure for networking, peer support and information sharing specifically around culturally responsive JSNA practice (or equalities responsive, more generally) would significantly improve practice in England.

Encourage evaluation

Evaluation is often seen by local areas as a luxury that can be cut in straightened financial times. Given the nascent state of JSNA practice in England, it is essential that local evaluation of the impact of JSNAs is encouraged and race equality is a feature of national evaluation.

Position improvements in culturally responsive practice within an overall context of improvements to JSNAs

Many of the challenges and key messages identified through this report in relation to race equality are likely to be relevant to an overall assessment of JSNA practice. At a local area level this means that a culturally responsive JSNA is likely to also be a 'good' JSNA overall (although we did not test this hypothesis).

At a national level this suggests that wider review of JSNA practice may find it useful to pick up and further explore the challenges and key messages identified in this report.

The new NHS

Finally, the NHS, local authorities and public health currently face a challenging period of change. Transition to the new arrangements could provide an opportunity to consider the key messages identified in this report. In particular, as PCTs are phased out and local authorities increase their responsibility in population health, there is an opportunity to consider how local authority culture and processes around race equality can be supplemented by the insights from this report.

Our review approach

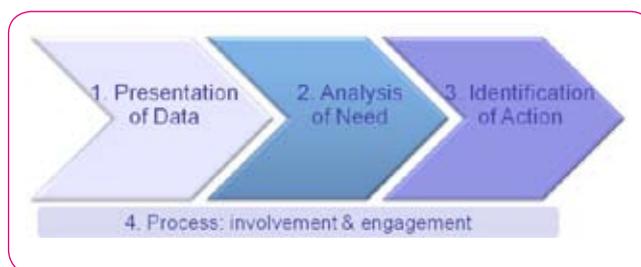
‘Race for Health’ and ‘Shared Intelligence’ were commissioned by the Department of Health to produce a report exploring approaches, taken by joint strategic needs assessments (JSNAs), to understanding race equality in health and healthcare.

This report analyses and compares the approaches taken to race equality, providing a picture of practice and identifying key messages arising from this practice.

In reviewing JSNA practice across England, this report does not evaluate or rank local areas. Instead, we have drawn from practice to reflect on the significant challenges faced. We also highlight the features of JSNAs ‘achieving’ and ‘excelling’ in relation to what we have termed ‘culturally responsive needs assessment’. The experience of local areas has also enabled us to identify some recommendations intended to support improved practice.

To present a coherent analysis of practice and to guide our investigation, we developed a unique ‘JSNA Race Equality Framework’. A framework adaptable to the context-driven nature of JSNAs was essential, because there is no single agreed standard for JSNAs – either overall or in relation to race and other equalities.

The diagram below summarises the four basic dimensions to our ‘JSNA Race Equality Framework.’



For each dimension we identified three levels of development – developing, achieving or excelling.

The JSNA Race Equality Framework draws on **the Equality Framework for Local Government** – on the LG Improvement and Development website.

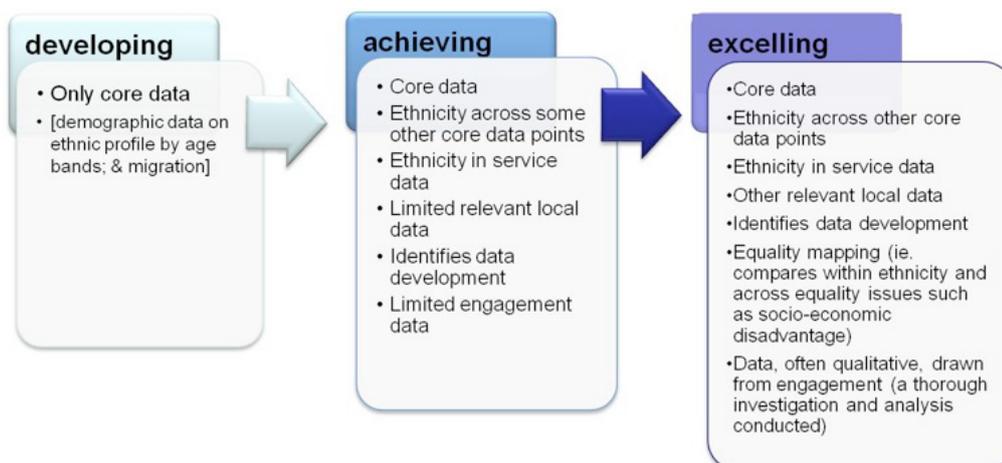
<http://www.idea.gov.uk/idk/aio/9585101>

In each dimension, involvement and engagement were essential to assessing the level of development.

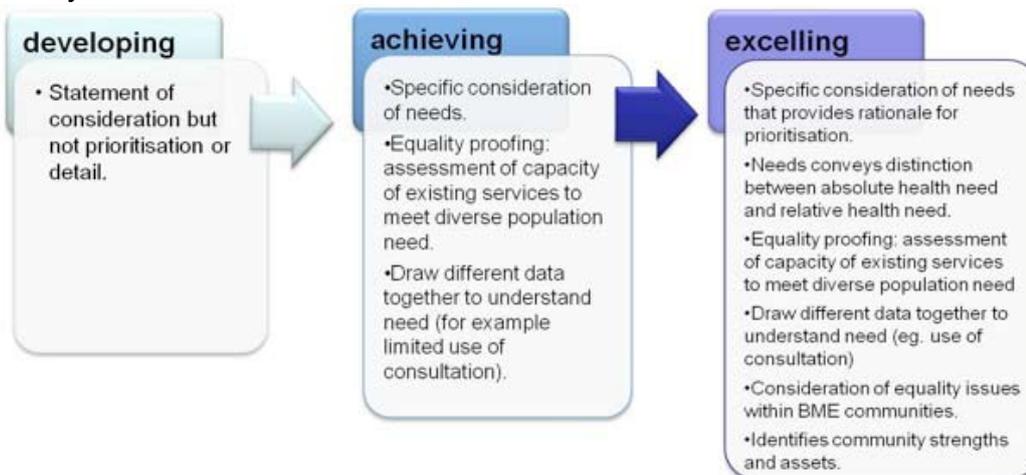
Within each dimension we observed a range of approaches and also key challenges. The individual elements of the framework are represented on the following page.

A framework for culturally responsive JSNAs

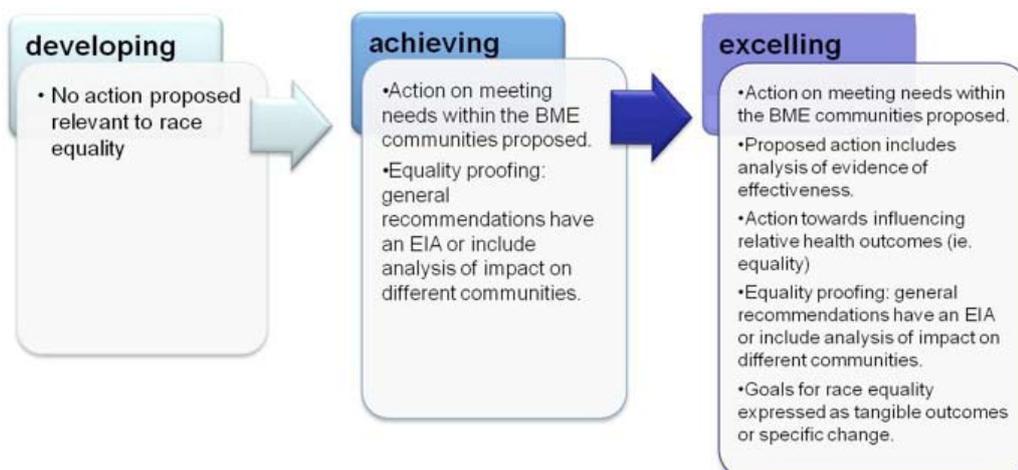
Presentation of data:



Analysis of need:



Identification of action:



Innovations in local practice

Case study stories and innovative practice are presented through this document. Six innovative responses to the most common challenges in the three dimensions of the culturally responsive framework are highlighted in this section.

Presentation of data

Availability and quality of data

North Tyneside used **monitoring data** on the use of social care services to present a picture of the challenges facing particular groups of residents. Using monitoring data enabled the local area to identify barriers in how services are accessed and the type of services provided.

Going beyond research generalisations

Suffolk used their '2008 Director of Public Health report' to deepen the **local research on ethnicity** presented in their original JSNA. The report includes findings from qualitative research with the Bangladeshi community. This research was particularly important because sufficient routine data was not available at a local level. Presenting this research helped Suffolk avoid making generalisations about the needs of the community in Suffolk.

Developing and sustaining joint intelligence

Joint intelligence was central to the successful development of **Birmingham's** JSNA. Birmingham has established a single public portal presenting intelligence data which is used by a variety of stakeholders. The partnership prepared a framework document with an explicit philosophy of "**integration, support and empowerment** of existing networks" in relation to data collaboration. As a result the Public Health Information Team at the heart of the JSNA draws from a wide array of intelligence and research.

Analysis of need

Involving the community in needs assessment prioritisation

NHS Westminster has taken a novel approach to building a better understanding of diverse community need. In addition to developing the BAME Health Forum, Westminster has employed **community researchers**. The training and use of community researchers in forum projects regarding access illustrates a commitment to developing skills that can provide an insight about need 'on the ground'. It provides vital links with marginalised and less engaged communities.

Identification of action

Working within the context of effective policy making

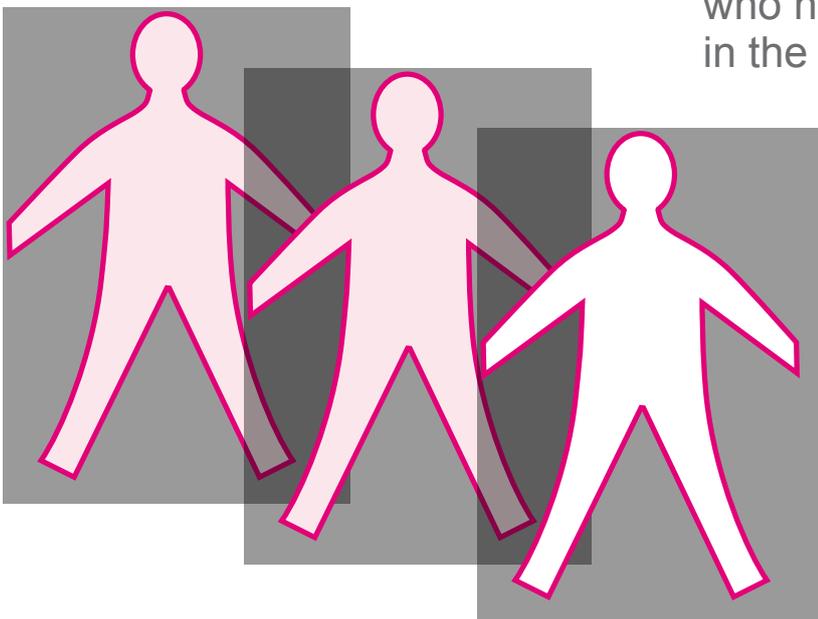
Luton JSNA has sought to answer the ‘so what’ factor – rather than simply presenting needs. Central to their strategy to improve influence has been an **evaluation** of the JSNA process and its impact. The evaluation situates the JSNA in the context of the complex and fluid environment in which health priorities are set and commissioning takes place.

Taking responsibility for action

Newcastle’s first generation JSNA was less about setting new priorities and more about bringing together existing priorities. This time around the JSNA is seeking to drive more new action. To enable this, each section of the JSNA has been given a local authority lead and a health lead. The leads are being asked to work together to identify appropriate **collaborative action**.

“the whole point of the JSNA is to influence commissioning plans”

“getting people together who haven’t got together in the past”



Introduction

Aims and context

This report was commissioned by the Department of Health as part of a wider review examining joint strategic needs assessments (JSNAs) since their inclusion as a statutory duty in 2007. The report aims also to contribute to a planned review of JSNA guidance, by the Department of Health.

It explores the approaches to understanding race equality and ethnic diversity within current JSNAs. It sets itself three specific aims:

- to analyse the extent to which race equality is acknowledged and addressed within JSNA documentation
- to explore and contrast different approaches that partnerships have taken to understanding race equality in relation to health within JSNAs
- to draw out examples of good practice and highlight further support needs.

The report was initiated at a critical transition point for the conduct of JSNAs. The first generation of JSNAs have now had sufficient opportunity to influence the commissioning cycles of local public and civil society organisations.

Preparation for the second generation of JSNAs has commenced or is about to commence in many areas. Building from lessons learnt, the report is oriented towards guiding and supporting improvement into the future.

This report also follows major reviews of progress in England to reduce health inequalities – for example the Marmot Review and the National Audit Office Review.

By examining approaches to race equality in JSNAs, this report identifies how local areas can give practical effect to the aspirations for health equality expressed in national strategies.

Finally, while research for this report was underway, significant reforms to the NHS and public health were announced. Early indications suggest that JSNAs will maintain a prominent role. As a result, the report is presented with a view to maximising the opportunities NHS reforms provide to translate our findings into practice.

The purpose of JSNAs

According to the Department of Health's 'Guidance on joint strategic needs assessment' published in 2007, a JSNA is intended to be:

“a systematic method for reviewing the health and wellbeing needs of a population, leading to agreed commissioning priorities that will improve health and wellbeing outcomes and reduce inequalities.”

“[The JSNA]... identifies ‘the big picture’ in terms of the health and wellbeing needs and inequalities of a local population.”

Joint strategic needs assessments – on the Department of Health website.

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_081097

JSNAs are a statutory duty imposed by the Local Government and Public Involvement in Health Act (2007).

They were originally understood to be one element of a performance framework for local government and health. The duty was recognised as a partnership duty, involving a range of statutory and non-statutory partners.

Broad guidance on the content, format and process for JSNAs was provided in 2007 by the Department of Health. This included a core dataset that all JSNAs were supposed to include, covering:

- demography
- determinants
- risk factors
- health or disability outcomes and services.

The core dataset included only minimal explicit reference to race, ethnicity, migration or culture. However, the guidance on JSNAs also acknowledged local people, service users and their carers should be an important source of information and the guidance encouraged engagement to build the data profile.

JSNAs were also intended to include, where possible, projections of future needs, in addition to current needs. Specific actions to meet need, evidence of the effectiveness of proposed action and links to other plans were all features suggested in the departmental guidance.

Beyond the core dataset and guidance, primary care trusts (PCTs) and local authorities were given flexibility on how to:

- structure the JSNA process and its written outputs
- go about preparing the JSNA
- use the JSNA.

As a result, each JSNA prepared since 2008 has reflected local decisions and contexts. There is considerable variation in the content and format of JSNAs between areas.

The department has made clear that the JSNA should be more than a document. The process of carrying out a needs assessment jointly across partner organisations was always intended to be a key feature of JSNAs. There was an expectation this process would assist to unify agencies around a common understanding and common priorities.

Understanding race and health

Race for Health has worked across the NHS supporting improvements in health for people from black, Asian and minority ethnic (BAME) backgrounds. From this experience we know that the interaction between race or ethnicity and health and wellbeing is a complex area of health and social policy.

In its previous work, Race for Health has found it helpful to clarify what is meant by race, and how race or ethnicity may influence health and wellbeing. The following section unpacks the key terms, providing a foundation from which our method and the results of our research can be understood.

As we shall demonstrate, part of the challenge in improving JSNA practice is supporting a clearer understanding and more informed discussion of how race and health interact.

Race equality

Race equality has both specific legal and general social connotations relevant to health and wellbeing, and to the conduct and content of JSNAs.

In the legal context, public bodies have a duty to carry out all their functions with due regard to:

- eliminating unlawful racial discrimination
- promoting equality of opportunity, and
- promoting good relations between people of different racial groups.

In addition – to demonstrate compliance with these duties – ethnicity monitoring data must be collected and analysed across the workforce and service delivery areas of public bodies.

This legally oriented view establishes an essential minimum for public bodies and all aspects of their work, including the conduct of JSNAs. JSNAs and the major recommendations sometimes contained within them are subject to, and often inform, mandated equality impact assessments (EIAs).

This view also suggests that JSNAs could serve an important function in identifying where services need to act to eliminate unlawful discrimination or promote equality.

A more aspirational perspective on equality was put forward by the 2007 Equalities Review in its report 'Fairness and Freedom':

“An equal society protects and promotes equal, real freedom and opportunity to live in the way people value and would choose, so that everyone can flourish. An equal society recognises people’s different needs, situations and goals, and removes the barriers that limit what people can do and be.”¹

This perspective when applied to health and wellbeing encourages an approach based on responsiveness. That is, an understanding respectful of and relevant to the health beliefs, health practices, culture and linguistic needs of ethnically diverse individuals and populations.

Race, ethnicity and health: a culturally responsive understanding

We are learning more about how ethnicity, language and beliefs influence health outcomes. This understanding is saving lives and making them healthier.

The interaction of ethnicity with health or wellbeing has been the subject of substantial research. There are at least four interactions directly relevant to assessment of need and therefore to what JSNAs could consider.

The social determinants of health

Health is largely shaped by the social circumstances in which people are born, grow, learn and live. Ethnicity also reflects and influences these social circumstances.

Altering social circumstances and the association between these circumstances and ethnicity directly influences health outcomes. For example, the relationship between poverty and ethnicity is in part influenced by labour market discrimination, and an appropriate response is to eliminate this discrimination.

Service access, service quality

There is strong evidence that people from ethnically diverse backgrounds – particularly patients with low English language proficiency – can receive poorer quality services compared to others, and are more likely to experience adverse events in their journey through the health system.

This can happen in subtle, barely perceptible ways and is not necessarily the consequence of individuals holding avowedly discriminatory views.

¹ Fairness and Freedom: The Final Report of the Equalities Review. Crown Copyright. 2007.

Health beliefs and health-related behaviours

Sometimes ethnicity also influences exposure to particular risks or health-behaviours that impact on health. Chewing betel liquid and paan among some Asian men, for example, is strongly associated with mouth cancer.

In addition, how people promote or seek assistance with their health reflects a range of social factors and experiences all of which can be influenced by ethnicity.

Biology and genetics

Finally, there is evidence that biological factors arising from ancestry can play a part in the prevalence of particular health conditions. A proportion of the greater prevalence of diabetes among south Asian men is thought to be associated with patterning in genes.

Among many health services in England, the terms 'race' and 'ethnicity' tend to be used to refer to the categories described by the 2001 Census where people were asked to subjectively assign themselves to particular ethnic groups.

While this neat categorisation of the population can helpfully enable services to consider discrete needs, it is important to remain aware of the lived complexity.

A person's ethnicity is a complex mix of their country of origin, ancestry, culture, language and religion. Different elements in this picture will be more or less important at different points in time and in different contexts.

The individual and social experience of ethnicity is not lived in isolation from how people relate to each other. So, for example, racist discrimination powerfully shapes what 'being Jewish' may mean.

Nor is it lived in isolation from other social relations – such as gender or social class – such that in a given context the experience of being a woman may be of more relevance than having diverse ancestry or vice versa.

Many people find it challenging to think of ethnicity as a dynamic concept, preferring fixed categories and identities often assumed to have a biological basis.

Discussion of ethnicity often emphasises differences or deficits at the expense of understanding commonalities and strengths.

These understandings of ethnicity and the interaction between ethnicity and health have informed the development of culturally responsive services and an evidence base that supports responsive practice. The features of a culturally responsive service system have been described by a number of researchers within and beyond England.

In addition, a growing evidence base is demonstrating that culturally responsive services improve user experience and service quality for the whole population as well as those traditionally under-served.

See Appendix 1 for useful references to this discussion.

Methodology and review framework

Methodology for the review

There were four main elements to the review underpinning this report.

Sample of JSNAs

A purposive sample of twenty JSNAs was selected to include examples from:

- all English regions
- different types of local authority and geography
- different levels of ethnic diversity.

Depending on the approach in each area, we reviewed:

- JSNA overview documents
- a sample of supporting needs assessments
- data reports where they existed.

In addition to reviewing the JSNA-related documents, we also examined related strategy and decision documents such as:

- the sustainable communities plan
- the local area agreement
- the director of public health reports.

In-depth case studies

Six areas were selected on the basis of promising practice found. Semi-structured interviews with JSNA leads or their nominees were conducted to explore what has facilitated good practice and what future supports may be beneficial to improving practice. The case study sites were:

- Cumbria
- Suffolk
- Birmingham
- Newcastle
- Luton
- Barking and Dagenham.

Expert Review Group

Race for Health hosted a review group discussion to generate comment on the initial findings of the research and to discuss implications for recommendations aimed at improving practice.

Desktop analysis

Finally, the research also included desktop analysis of key research on:

- the conduct of needs assessments
- the interconnections of ethnicity and health
- the application of equalities knowledge in health and social care.

A framework for reviewing race equality in JSNAs

To generate the best understanding of the approaches taken to race equality in JSNAs we developed a unique review framework.

This was necessary because there is no ‘one model’ for the production of a JSNA, and different areas have approached the process in different ways. A single standard for a good or effective JSNA does not exist.

Similarly, no existing race equality benchmark is sufficiently appropriate for applying to JSNA practice. However, the Local Government Improvement and Development ‘Key Principles Equality Framework’ for local authorities provides an influential guide.

The Equality Framework for Local Government – on the LG Improvement and Development website.
<http://www.idea.gov.uk/idk/aio/9585101>

The framework we developed is based on an understanding of the JSNA process, content and format combined with knowledge of culturally responsive needs analysis. Development of the framework was iterative – as we reviewed JSNA practice and spoke to JSNA leads we further refined and improved the model.

The diagram below summarises the four basic dimensions to the JSNA race equality framework.



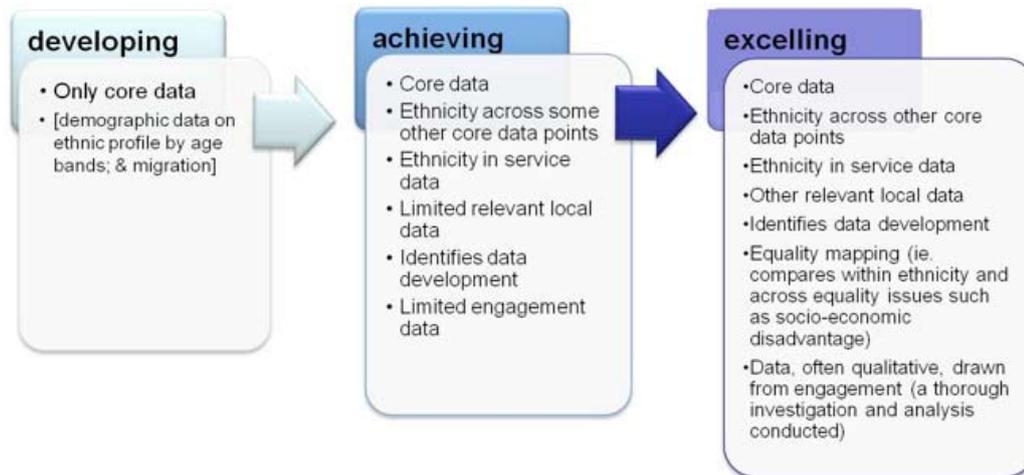
As each JSNA was reviewed, rather than simply establishing an ideal for each dimension which JSNAs either achieved or failed to achieve, we set three levels of development – **developing, achieving or excelling**.

These three levels allow a more nuanced picture of the state of practice to emerge and also establish a **trajectory of improvement**. We can learn from practice and move towards excellence.

Within each dimension and matched to each level of development we have built a diagnostic, identifying common approaches taken by JSNAs to address race equality. The typical features present in each dimension at each level of development formed the template we used to review JSNAs. These are outlined in the four following sections.

Presentation of data

Our review assumed that clear and comprehensive data is the foundation for a coherent needs assessment. In our review, the features we looked for at each level of development were as follows.



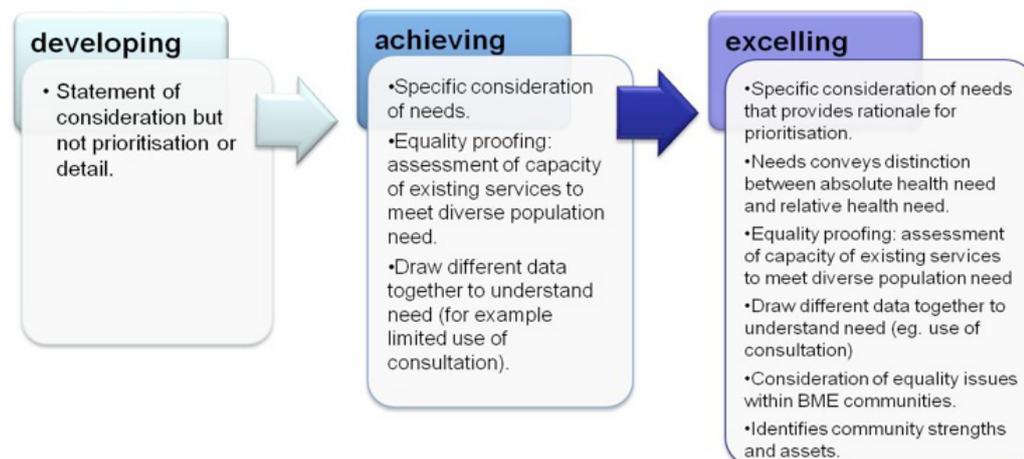
Analysis of need

To understand need in a local area, we assumed that JSNAs should go beyond profiles of a population or using data to only describe health and wellbeing.

JSNAs should also synthesise and analyse the data to paint a picture of:

- where needs are significant
- where there are issues that partners should be aware of
- how needs interact, and so on.

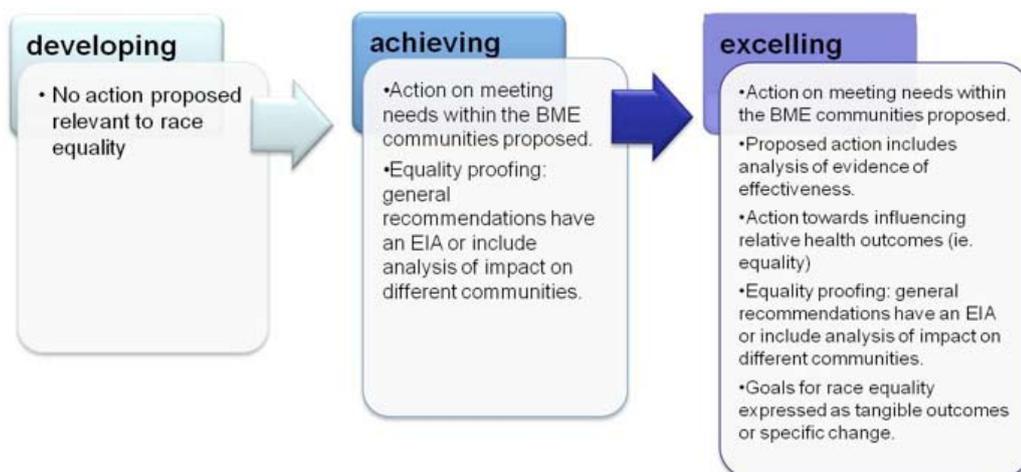
We set out factors relating to the analysis of need at each level of development.



Identification of action

JSNAs are a tool to inform more effective service provision, and as such, should aim to influence prioritisation and commissioning to meet the needs identified.

We considered the extent to which JSNAs identified evidence-based action in relation to race equality. At each level of development we examined the following features.

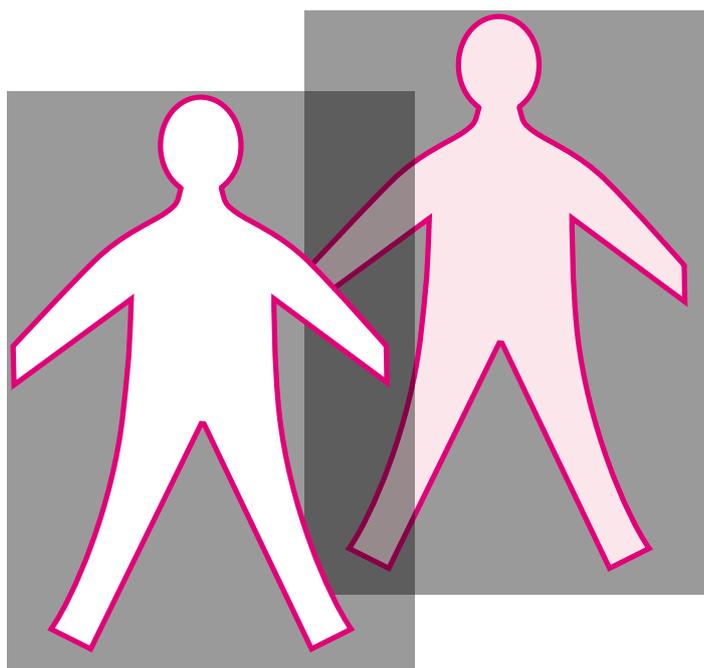


Process

Our review also sought to capture the priority attached to JSNA process and the place-shaping potential arising from the conduct of JSNAs.

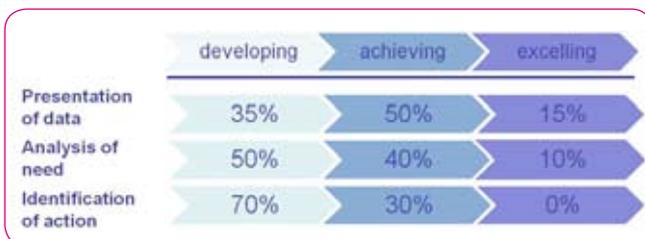
Rather than setting assessment of this dimension as discrete from the others, we examined process – the ‘how’ of conducting a JSNA – as a part of reviewing each of the dimensions above. In each dimension we looked in particular for greater degrees of:

- involvement and engagement of the community and stakeholders
- leadership and ownership
- the alignment and linkages of the JSNA with other guiding plans and strategies.



Review of current JSNA practice

The diagram below provides an overall picture of the current state of JSNA practice. The figures are drawn from the sample of 20 JSNAs reviewed in our research.



These results suggest there is considerable scope for improvement in each of the JSNA dimensions. Confirming these overall messages, many of the JSNA leads we spoke to as part of this research saw the JSNA process as a journey of discovery and learning.

Each lead had reflections on how their journey was leading them towards an improved JSNA.

For some, the first JSNA was initially about drawing everything that was already known together into a coherent whole. The ‘second generation’ JSNAs were promising to be far more effective and influential.

How well did JSNAs present data on race equality in health?

In our sample, 35 per cent of JSNAs included data on ethnicity for only those few items specifically identified in the core dataset – ethnic profile by age-bands and migration. Some JSNAs had not included all of these items.

We found that over half the areas sampled had stepped beyond the core dataset.

Achieving

Using ethnicity as a variable across other core data

The JSNA core dataset includes basic epidemiological indicators covering:

- demography
- determinants
- risk factors
- health or disability outcomes
- services.

Several of the JSNAs included ethnicity as one of the variables in presenting these indicators. This provided a very straightforward way of presenting the interaction between ethnicity and the determinants of health or health outcomes.

In Norfolk, for example, a separate but linked in depth assessment was conducted on BAME communities that examined some of the key indicators present in the broader Norfolk JSNA. This was one more common method by which richer data on ethnicity and health could be presented.

Using service data to understand interaction between ethnicity and service use

Due in part to the obligations established by the public duties for equality, most health and social services collect data on the ethnicity of service users.

We found a number of areas who viewed this equalities monitoring as a valuable source of data on whether or how services are being used. JSNA leads saw the advantage of this data being already collected and readily available. The North Tyneside JSNA used data on utilisation of social care services to present a picture of the challenges facing particular groups of residents. The JSNA concluded that:

“North Tyneside has a consistently low number of people from diverse ethnic backgrounds and those people accessing social care support has also been historically low. Further work is required to accurately understand the reasons for the low level of use for social care and to ensure that this does not represent barriers in how services are accessed or the type of services provided.”

We also found that monitoring data was most frequently used in the context of mental health services – a probable consequence of the independent inquiry into the death of David Bennett

<http://www.scie-socialcareonline.org.uk/profile.asp?guid=6f01d41c-5ef8-46c1-a317-ed117ac7fbe6>

and ‘**Delivering Race Equality**’ recommendations.

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4100773

Nevertheless, using monitoring data brought some challenges. Several reviewers noted that the quality of local monitoring data was compromised by inconsistent collection methods and questions.

Identifying where data could be further developed in future

Our review observed that JSNAs which strove to include a more comprehensive picture of ethnicity and health often expressed frustration at the lack of readily available data to present.

While acknowledging this challenge, a number of areas like Southampton used their reports to identify specific recommendations for future data development.

Excelling

Broader local data including data drawn from engagement

A number of JSNAs chose to include data that was drawn from beyond the core dataset or local service data. These JSNAs often sourced this data through engagement processes where local communities could identify specific health or determinants of health issues. Community intelligence was valued highly by some areas.

In Westminster, for example, community research has directly engaged local people in articulating an understanding of health in the area.

Similarly, Barking and Dagenham formatted some of the data in their JSNA to make explicit the material collected from talking to communities. Subsections of the JSNA were entitled 'what we know from consultation'.

We observed that in many instances the data drawn from engagement was qualitative, triangulating quantitative material present in these excellent JSNAs.

The integration of qualitative data – or people's intelligence and experience – into public health evidence is a challenging area of development. Several researchers in the UK, such as Jennie Popay <http://www.lancs.ac.uk/shm/dhr/profiles/Jennie-Popay/>, have been involved in helping local areas incorporate qualitative data into the development of JSNA profiles.

Using national research where local data was lacking

The 'excellent' JSNAs we observed also sourced data from relevant national or international studies and considered how the findings from these broader studies might apply to the local context.

We found these JSNAs engaged with broader research, using it to highlight potential issues but avoiding merely assuming an applicability.

Equality mapping

We discovered that the complex relationship between ethnicity and health was only rarely represented in the presentation of data. An equality mapping approach is one that compares indicators within ethnic groups or across other equality issues like disability or gender.

Our assessment was that an excellent JSNA did not treat ethnic groups as homogenous but instead explored how within and across ethnic groups there is extensive diversity that shapes different health and wellbeing needs.

Challenges in the presentation of data

Availability and quality of data

Many areas, particularly those with very small minority ethnic population groups, found it challenging to generate up-to-date data that could be used in the JSNAs. Among those who articulated this challenge, the role of leadership at a national level was identified.

One participant commented:

"Some kind of national focus on the problems with data would be good. Although we have a local problem in getting this data, it is a reflection of the national problem. It is hard to use national estimates on our local data because the Census gets outdated really quickly."

However, we noticed that this problem was far from conclusive. A number of our case study areas commented that there was more than sufficient local data on ethnicity available. We found that JSNAs could present fairly extensive pictures of health and ethnicity using a combination of national and local data, complemented by community intelligence.

The overall picture on data availability is, therefore, mixed. Our assessment is that many local areas could make better use of what is available, for example by using local service monitoring data.

Getting beyond generalisations

The aspiration to include relevant ethnicity-related data appeared to encourage unspecific and unsubstantiated comment in place of real data.

Two statements taken from different JSNAs typify this common challenge:

“A sizeable proportion of newly diagnosed HIV has been amongst immigrants from Sub-Saharan Africa and Eastern Europe.”

No insight was provided on what ‘sizeable’ meant. And:

“...in general this community [the Indian] is a healthy one”.

We also observed that wider epidemiological research was used out of context or without qualification as a way of supporting generalisations about need among particular ethnic groups.

Developing and sustaining joint intelligence

A number of case study sites, such as Birmingham, commented on the value local joint intelligence groups offered to the successful compilation of local data.

The richness and diversity of data presented in JSNAs depends on collaboration between public authorities and others who hold and analyse data. We found that several areas with achieving or excelling JSNAs in data presentation used formal structures to maintain collaboration.

Collaboration in data presentation and analysis was also identified as important for avoiding unnecessary duplication and promoting learning from experience.

In addition, community intelligence was identified as something that should be shared. For example, Kent County Council commissioned a preparatory study of the health needs of Gypsy and Traveller communities. The report is informing accommodation needs assessments and other service appraisals, but is also being used by other local areas.

How well did JSNAs analyse needs relating to race equality in health?

Overall, the JSNAs we reviewed were stronger in data presentation than in analysis of needs. This was reflected in their analysis of needs relating to race equality.

Half of the JSNAs reviewed in our sample either contained no statement at all about ethnicity and need, or relied on ambiguous general statements affirming the significance of ethnicity as a factor influencing need, but indicating no prioritisation.

Typical statements reflecting insufficient depth of analysis – and comprising the entire analysis present in their respective JSNAs – included:

“There are groups of people which are thought to face particular challenges in achieving equitable access to services or outcomes. These include those with complex needs, from BAME communities, with autistic spectrum disorder and those not accessing specialist services. Monitoring and action should be taken to improve the situation.”

“Assessment of the ethnic mix of the... population [in this area] is important for a variety of reasons. Different ethnic groups can have differences in the prevalence or incidence of important health problems such as diabetes and various types of cardiovascular disease. Equally importantly, service provision needs also to take account of ethnicity to ensure that services are provided equitably, and in a way that takes account of cultural diversity.”

JSNAs tended to be stronger in needs analysis relating to socio-economic inequality or relating to some population groups – particularly children, young people and older people.

Achieving

The remaining half of JSNAs made more robust and explicit considerations of need. For example, Sandwell's JSNA used ethnicity as a variable in most of the data it presented in its first JSNA. As a result, the analysis of need was able to present a clearer picture of how the incidence of disease could be reduced among the whole population.

The original Sandwell JSNA also recommended the development of a number of in depth assessments. These not only presented data but also further analysed needs, including the needs of ethnic groups. For example, the in-depth review of coronary heart disease analysed a range of data including:

- prevalence data
- health improvement activity data
- elective, non-elective and emergency admissions data.

Because ethnicity was used as a variable in most of the data presented, the assessment drew a clearer picture of need for particular ethnic groups in Sandwell.

Another aspect of a more culturally responsive approach to needs analysis was the assessment of the capacity of existing services to meet diverse population need. We have called this 'equality proofing' and a signature feature was the use of equality impact assessments.

In Luton, for example, the development of a single equalities scheme is being used in the new JSNA process as a way of encouraging greater engagement and challenging old ways of working. The equality impact assessment process enables the capacity of services to be assessed.

This experience was similar to Cumbria, where use of equality impact assessments grew side by side with the further development of the JSNA. According to the JSNA lead in Cumbria, understanding of need is now far more fine-grained, with ethnicity a key factor given consideration in service development.

Excelling

Ten per cent of sampled JSNAs were considered to be excelling in the analysis of need dimension. The approaches evident or appropriate for the most culturally responsive JSNAs are as follows.

Identification of community strengths and assets

We observed that ethnicity and race are often 'problematised'. As LG Improvement and Development has recently acknowledged, framing the representation of communities in this way often obscures the strengths that enable communities to function.

A Glass Half-full – on the LG Improvement and Development website
<http://www.idea.gov.uk/idk/aio/18410498>

Introducing the asset-based approach into ethnicity and health has led, for example, to identifying the very powerful endorsement of health promotion in the text of the Qur'an – an approach that has proven effective in helping services meet community needs.

The Sheffield JSNA included a general statement on the value and importance of BAME communities in Sheffield. It used community engagement to identify strengths in the local area. Although this JSNA did not make specific recommendations for action, BAME communities were identified as the top priority for action to the health and wellbeing partnership.

Analysis of need within BAME communities

Excelling JSNAs did not treat ethnic groups as homogeneous. Instead they explored how within and across ethnic groups there is extensive diversity that shapes different health and wellbeing needs.

In Birmingham, for example, disease prevalence was reviewed for each ethnic group – rather than just black and minority ethnic in total – and by age band among some ethnic groups. The analysis, after presentation to commissioning boards, has directly informed unique service delivery options for the groups identified.

Analysis based on broader local data drawn from engagement

Only a small proportion of JSNAs we reviewed followed the JSNA guidance advice on including a specific ‘voice’ section in the JSNA with analysis of need based on engagement.

Luton’s inclusion of a public voice section usefully summarised the results of extensive consultation. It also identified how civil society organisations were proposing to contribute to meeting identified needs. Reflection on practice in Luton indicated that allowing the community to comment on drafts of the JSNA had influenced the analysis of need.

Challenges for improving the analysis of need

Linking ethnicity to the wider determinants of health

We found that many JSNAs articulated a strong understanding of the social determinants of health as they applied to socio-economic inequalities in health.

Several JSNAs included a specific chapter or discussions about these inequalities. Some used the Dahlgren and Whitehead ‘**Rainbow Model**’ to represent the influence of non-health factors on health and wellbeing.

http://www.euro.who.int/_data/assets/pdf_file/0018/103824/E89384.pdf

For example, in one area, the need to reduce levels of obesity was approached in partnership with urban planners. Health need was explicitly connected to urban planning outcomes like accessibility, amenity and housing density.

However, we did not find that this understanding extended to race or ethnicity-based inequalities in health.

Addressing future need

We were aware that JSNAs had been tasked to assess future as well as current need. Only a small number of JSNAs included robust assessment of future need with predictive modelling and forecasting.

These methods were more commonly observed in commissioning plans for particular conditions or commissioning work-areas, but rarely included in JSNAs.

The JSNAs that included more detailed forecasting tended to be more comprehensive overall and better aligned with internal PCT or local authority planning structures.

Involving the community in needs assessment prioritisation

A number of case study interviewees reflected that taking a whole community perspective was sometimes challenging – particularly where relative needs had to be balanced against each other. As one interviewee commented:

“Consultations helped to add to that picture but it would not allow us to explain how

BAME groups access services and we still have a lot of work to do”

The challenge here is to encourage full engagement while also acknowledging that not all needs can lead to specific action.

For example in one JSNA we reviewed the community voice was included as a dialogue with the rest of the JSNA findings. The subtitle ‘We know that’ was followed by the subtitle ‘You have told us’ followed by ‘We need to ensure that’.

This is an excellent example of inclusion, but does not weigh which expression of need should be selected for action or why.

How far did JSNAs identify action relating to race equality in health?

In our sample, only one in three JSNAs identified culturally responsive action or specific action to address race equality.

This finding was consistent with a wider limitation within JSNAs. The identification of any general or specific action required to meet any need –including, but not limited to race equality – was not a common feature in the JSNAs sampled.

Achieving

The actions proposed by JSNAs in relation to race equality varied substantially in their specificity and their topic. We found that most actions tended to be expressed as general ‘priorities for action’ rather than commitments with specific goals, timelines and resources.

Perhaps unsurprisingly given this early stage in JSNA development, the majority of race-related recommendations concerned improved data, analysis or monitoring.

Nevertheless, several case study and sample JSNAs included brief analyses of the different expected impact of actions on different parts of the community. In addition a number of JSNAs, when securing approval through health scrutiny or council cabinet meetings, were subject to separate equality impact assessments. None of these appeared to fully appraise the detail of the respective JSNAs, although commitments for further action were made.

Simultaneously, a number of equality action plans at a local authority level also identified as a goal or action the influencing of JSNAs. These findings suggest that equality impact assessments can provide a simple mechanism by which the general recommendations of a JSNA could be assessed for differential impact.

What would ‘excelling’ look like?

Through our research and review we did not identify any areas that could be described as ‘excelling’ in the identification of action. We did, however, clarify what we consider to be key features of an excelling JSNA.

Evaluating JSNA impact

Local evaluation of the impact of the JSNA potentially provides JSNA leads with far better insight into what works best, particularly for influencing the uptake of JSNA findings.

Impact on race equality should be considered as an area for evaluation, in the context of wider evaluation questions. Formal evaluation of JSNAs have commenced in some areas, for example in Luton.

Presenting evidence of effectiveness

The JSNA guidance strongly encouraged local areas to include evidence of effectiveness and cost-effectiveness as part of developing recommendations to address need. In relation to race equality we found no evidence that this had been done to any significant degree.

Making the case for investment – or disinvestment – in equality enhancing or culturally responsive initiatives is relatively new within the NHS. However, an economic case for culturally responsive services can be made.

Outcome focused

We observed that in several JSNAs the ‘priorities for action’ were very general and non-specific. We suggest that an excellent JSNA would move beyond merely a general aspiration for equality to clear and specific steps to achieve change.

Identifying actions to improve relative health outcomes

Improving the health of black and minority ethnic groups is essential for securing health equity. However, equity is a relative concept.

This means that action towards equality must consider relative health outcomes. For example, if the health of the Bangladeshi community improved but at a slower rate than the rest of the community, then inequalities would have widened.

This emphasis on relative outcomes is central to effective equality impact assessment practice.

Challenges in identifying action

Working within a fluid policy making context

Several case study sites suggested assessments of the impact of JSNAs needed to consider the very fluid nature of the policy process. JSNA leads argued that the ‘so what’ factor in presenting an assessment of need was addressed through dialogue over time with commissioners.

In practice this means that in many areas the JSNAs ‘fed’ action plans informally. Specific identification of action within the JSNA was not, in these situations, seen as desirable.

In shaping action, the timing of the JSNA was also crucial. Different pieces of the policy puzzle had to fit, or be made to fit, at the right time.

These are tensions in the policy making process. JSNA leads and advocates for race equality need to manage and understand these to maximise the impact JSNAs have on shaping local action. In Birmingham, for example, unpublished recommendations have been used to support service identification of change opportunities.

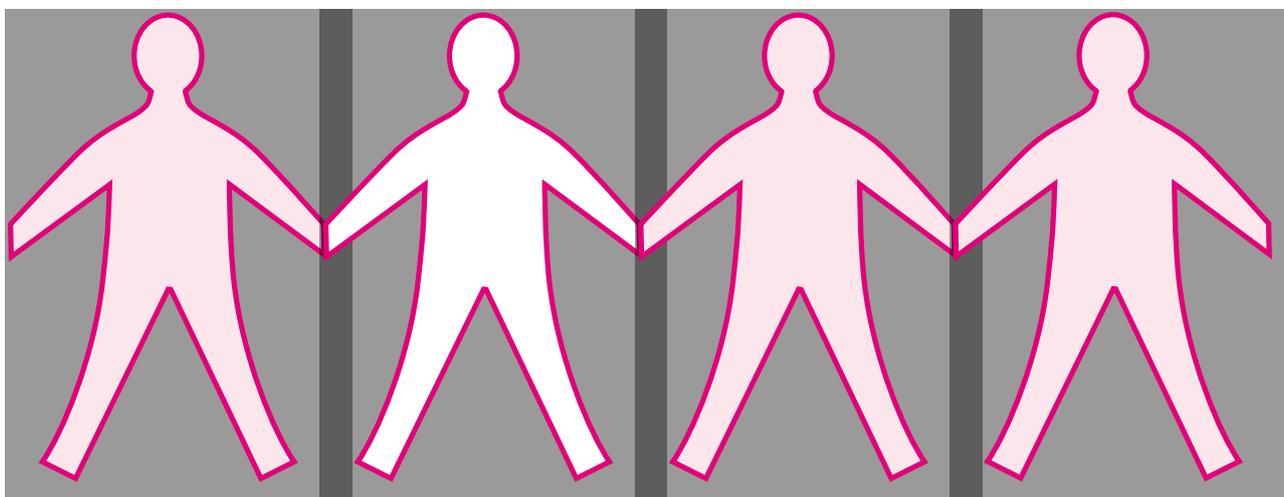
Taking responsibility for action

In Newcastle a novel approach has been to distribute responsibility for the development of needs analysis and recommendations across the council and health organisation, with prompts for consideration of equalities issues.

This method has the advantage of bringing those responsible for implementation directly into the conversation at the earliest possible stage.

In Cumbria, another approach taken was to use the JSNA as a prompt in presentations across the local area. Relevant directors were able to talk to local providers and organisations about the analysis of need and areas for action in the JSNA as a way of building support for solutions proposed.

Identifying action is one step towards change, identifying and ensuring responsibility for action is another critical step.

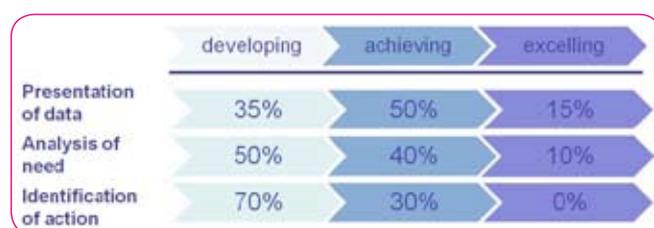


Key findings and conclusions

Is race equality recognised in JSNA practice?

Race equality is beginning to be recognised and addressed in JSNAs. Our review found that a majority of JSNAs had moved beyond the core dataset and were presenting locally unique and relevant data. Flowing from the presentation of data, some JSNAs understood and were exploring needs relevant to race equality, using community engagement to enhance the professional evidence-base.

The current spread of developing, achieving and excelling practice across the different dimensions of our JSNA framework suggests that – with some support and guidance – a coherent trajectory of improvement could develop.



We found that composition of the community, the level of diversity present, had no observable impact on the extent to which JSNAs addressed race equality issues.

On the one hand this finding is extremely positive – all JSNAs across England can acknowledge and include race equality considerations.

On the other hand this finding suggests there are some highly diverse areas relatively underserved by incomplete recognition of race equality.

Which JSNA approach works best to reduce race inequalities?

Our review confirmed the significant variation, across England, in approach and final format of JSNAs. We found this variation extends to the approaches taken to race equality. Our findings suggest that there is not one model or single definable approach that would produce the most culturally responsive JSNA in most circumstances.

The framework we have used and refined through this research provides a useful diagnostic tool which does identify what an excelling JSNA may look like. JSNAs that appeared to be most effective in addressing race equality were ones that shared some of the key features in this framework, adapted specifically to their local context.

No one area excelled in every one of the four dimensions we assessed. This finding underscores both the degree of variation observed and also the opportunity for improvement present across all local authorities and health organisations.

How important is ‘the how’?

Our findings also reiterate the significance of process issues in the preparation of an excellent JSNA. In each dimension we explored for this research we found that more culturally responsive JSNAs involved the community and stakeholders, aligned strategies and were purposefully led.

At the same time, our findings also emphasise the significant challenge that effective engagement and involvement pose. We did not specifically explore in depth the methods for engaging black and minority ethnic groups. But it was evident in the review that an intention or enthusiasm to engage does not free areas from difficult questions about how to:

- synthesise evidence
- make use of qualitative input
- prioritise needs or actions.

Clarity in understanding the relationship between race or ethnicity and health and wellbeing also appeared to be an influential factor in the overall approach taken to the preparation of responsive JSNAs. Several JSNAs with a culturally responsive approach explicitly communicated an understanding of the relationship between race and health and why it was important.

What is the relationship between race equality and other equalities?

Race equality was far less prominent an issue in JSNAs as compared to socio-economic inequalities. The disconnect observed at a national level between the health inequalities agenda and race-based inequalities – expressed, for example, in the Marmot Review – appears to be replicated at a local level through the conduct of JSNAs.

Many JSNAs we reviewed included strong analyses of socio-economic inequalities but were not able to extend this analysis to include race equality. In addition, few areas made an explicit connection between ethnicity and deprivation, arguably one of the key drivers of race inequality in health.

We also identified far less intersection between JSNAs and other race equality strategies and documents in the local area than we expected. The opportunity to link needs assessments with local authority and health organisation diversity and equality strategies was missed.

A greater connection between population health assessments and organisational strategies could have strengthened JSNAs. A promising practice observed was the use of equality impact assessment as a part of JSNA action development or approval.

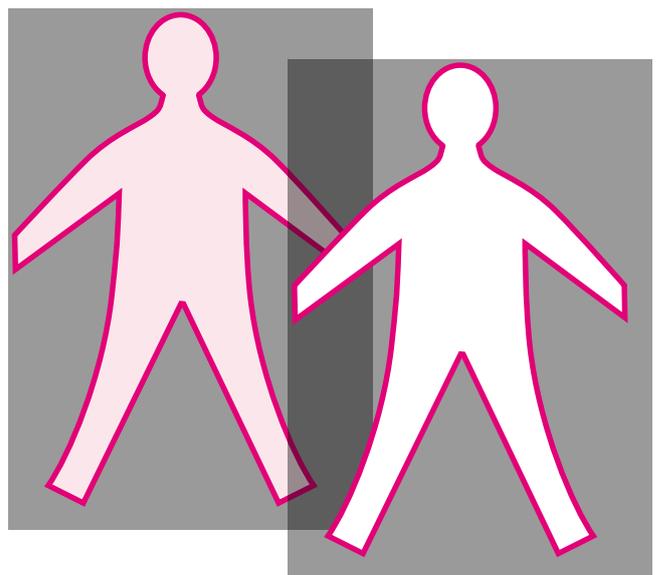
Is race equality best addressed as a separate needs assessment?

Our findings do not conclusively support a view that the only way to prepare a culturally responsive JSNA is through the conduct of a separate 'deep dive' assessment on race and health.

Although separate assessments provided much richer data and improved analysis of need, they did not always appear to influence the wider JSNA. This could have been a consequence of timing – many deep dives were conducted after the completion of first generation JSNAs.

Several JSNAs were assessed to be achieving or excelling in dimensions without having the benefit of a specific race equality needs assessment.

Several areas also conducted 'health inequalities' specific needs assessments. As noted above, these did not always consider the relationship between health inequalities and race or ethnicity.



Recommendations for improving practice - what local areas can do differently?

This review has found that most areas would benefit from improving the way their JSNAs address race equality. Opportunities to give practical effect to the often-stated aspiration of reduced inequalities or more effective use of resources are being missed.

We have identified five steps that local areas – including health and wellbeing boards, local authorities, GP consortia and civil society organisations – can implement without significant cost to develop a more culturally responsive JSNA.

Benchmark JSNA practice

Department of Health guidance on the conduct of JSNAs has, until this point, remained very general. The advantage of this has been that local areas are free to adapt and develop their JSNAs to meet their unique circumstances.

To encourage better practice, we recommend that **local areas review** and **benchmark** their existing JSNA documentation and JSNA process with the framework for culturally responsive JSNAs – see executive summary.

JSNAs should aim to move from ‘developing’ to ‘achieving’ and ‘excelling’. Further development of this benchmark is expected in future years.

Seek and share good practice

This report contains a review of practice across the country. It offers a number of examples of how local areas have responded to the challenge of producing a culturally responsive JSNA.

Six **innovations in practice** are summarised at the start of this document.

The Local Government Improvement and Development community of practice also provides further examples of innovation in practice. **Good practice sharing and supported learning** should be available through networks like Race for Health and Local Government Improvement and Development.

Consolidate local data

The availability and use of data was an area of considerable comment. As noted in the report, there was not a shared view about the sufficiency of existing data.

A feature of excelling local areas was the collaborative approach they took to the development, collation and analysis of local data. Without compromising data security or quality, local areas were able to share intelligence functions or identify clear roles so that a far more sophisticated profile of a local area could be developed.

We recommend that local areas bring together local health and other **intelligence stakeholders** to maximise the use of available data on culturally diverse communities.

Evaluate

Only a small number of JSNA sites specifically mentioned or identified evaluation of the impact of the JSNA, or evaluation of the process of developing the JSNA. Availability of evaluation results would enable areas to be more effective in monitoring the efficacy of their approach to race equality and the responsiveness of their JSNA.

We recommend that local areas establish **evaluation mechanisms** for existing and planned JSNA processes. These evaluations should include inquiry on how equalities have been addressed in JSNA processes and findings.

Link equalities

The processes to achieve a culturally responsive JSNA are likely to be very similar to processes necessary for a JSNA to be **'equalities responsive'** more generally – such as disability, sexuality, gender, migration.

This is a key advantage of using 'responsiveness' as a framework to understanding and assessing need. This approach also matches to the personalisation agenda embedded in NHS and local authority practice.

In addition, among local authorities in particular there is substantial existing activity around equalities practice. Some of this is driven by external-facing statutory obligations and some of this is driven by internally-focused workforce and workplace development. Examples of this include the local authority equality framework and equality impact assessment process.

We recommend that local areas position improvements in culturally responsive practice within **overall context** of joined-up improvements to JSNAs and organisational activity on equalities.

Useful references and sources

Understanding race and health

A useful research overview produced for the UK Parliament.

[Parliamentary Office of Science and Technology \(2007\) Postnote: Ethnicity and Health](#) – on the website of the UK Parliament

The UK Centre for Evidence in Ethnicity, Health and Diversity, (CEEHD) at Warwick Medical School supports interdisciplinary, collaborative research in the field of ethnicity and health. It works with trusts, community groups and other academic centres and has published some helpful overview papers.

[Ethnicity, Health and Diversity](#) – on the CEEHD website

The Better Health website provides access to the Race Equality Foundation briefing papers on health and race equality, providing good practice examples and signposting to other useful resources in the field.

[The Better Health website](#)

Culturally responsive practice – health evidence and practice

Race for Health is a Department of Health-funded, NHS-based programme that works with PCTs and trusts to drive forward improvements in health for people from black, and minority ethnic backgrounds. Examples of relevant work include 'In Powerful Health', a guide to community engagement.

[Race for Health's library of resources](#) – on the Race for Health website

The NHS has a useful library of sources and resources on ethnicity and health with news and information about the latest support available to local areas in England.

[NHS Evidence, ethnicity and health](#) – on the NHS website

'Cultural competence in healthcare' is a summary document from a policy and practice support agency on the key issues in developing culturally responsive health services.

[Cultural competence in healthcare](#) – on the website of the Diversity Health Institute, Australia

The National Centre for Cultural Competence in the USA has been leading work on cultural competence. Its website provides a range of useful frameworks and evidence summaries.

Equalities resources for local authorities

Excellent equality and diversity resources on the Local Government Improvement and Development website include the Equality Framework for Local Government.

[Equality and diversity](#) – on the Local Government Improvement and Development website

The Equality and Human Rights Commission has a statutory remit to promote and monitor human rights and to protect, enforce and promote equality across the seven ‘protected’ grounds – age, disability, gender, race, religion and belief, sexual orientation and gender reassignment.

[The Equality and Human Rights Commission website](#)

Race and health inequalities in the UK

Responses to the 2010 Marmot Review, lamenting the absence of analysis of race as a factor in socio-economic health inequalities, from Sarah M Salway, James Nazroo, Ghazala Mir, Gary Craig, Mark Johnson, Kate Gerrish.

[Fair Society, Healthy Lives: a missed opportunity to address ethnic inequalities in health, BMJ, 340, c684 \(2010\)](#) – on the British Medical Journal website

The national audit of the delivery of health inequalities strategies in England included an assessment of inequalities in health due to ethnicity in Lambeth, as a case study.

[Review of Health Inequalities 2010](#) – on the National Audit Office website

‘Agency and structure: the impact of ethnic identity and racism on the health of ethnic minority people’ was published in 2002. Written by Saffron Karlsen and James Y Nazroo, it looks at the direct effects of racial oppression on health, and the role of ethnicity as identity.

[Agency and structure](#) – on the Sociology of Health and Illness website

Local Government Improvement and Development

Layden House
76–86 Turnmill Street
London EC1M 5LG

Telephone 020 7664 3000

Facsimile 020 7664 3030

Email info@local.gov.uk

www.local.gov.uk



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