Joint Strategic Needs Assessment in the South East - Review of Practice

January 2011
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Foreword

This review was undertaken collaboratively in 2010 between the regional Public Health and the Social Care Teams at the Department of Health South East (DHSE). The review was researched by Dr Rachel Gill, Speciality Registrar in Public Health and by Janaka Perera, independent researcher and written by Dr Rachel Gill. The project was jointly supervised by Dr Imogen Stephens, Consultant in Public Health Medicine and Educational Supervisor, Sue Hunt, Joint Improvement Partnership Lead, and Tim Parkin, Social Care Transformation Manager, Department of Health South East. For further information please contact rachelgill@nhs.net or i.stephens@nhs.net

We would like to thank our local authority and Primary Care Trust colleagues who participated in this review. In particular, we would like to thank colleagues who commented on early drafts of the review: Catherine Scott (Consultant in Public Health, NHS West Sussex), Dr Jonathan Sexton (Assistant Director of Public Health, NHS Eastern and Coastal Kent), Dr Cynthia Lyons (Deputy Director of Public Health, NHS Hastings and Rother and NHS East Sussex, Downs and Weald); and our colleagues at DHSE, Dr Yvonne Arthurs (Deputy Regional Director of Public Health, DHSE), Peter Rush (Programme Manager, ‘Jobs and Homes’ and LINks, DHSE), and Carl Petrokofsky (Specialist in Public Health, DHSE).
### Abbreviated report

### Introduction
Since 1st April 2008, upper-tier and unitary local authorities and Primary Care Trusts (PCTs) have been under a statutory duty to produce a Joint Strategic Needs Assessment (JSNA) to establish the current and future health and wellbeing needs of the local population\(^1\).

JSNAs are based on the geographical area of the upper tier local authority (or unitary council) and PCTs feed into the JSNA for the local authority area(s) in which the PCT geographical boundary falls. The South East region includes nineteen upper tier local authorities, including seven county councils; Hampshire, West Sussex, East Sussex, Surrey, Kent, Oxfordshire and Buckinghamshire, and twelve unitary authorities; Portsmouth, Milton Keynes, West Berkshire, Reading, Wokingham, Bracknell Forest, Windsor and Maidenhead, Slough, Southampton, Isle of Wight, Brighton and Hove and Medway.

There are seventeen PCTs which overlap these upper tier and unitary local authority boundaries, with seven PCTs sharing the same geographical boundaries as their corresponding local authorities (including five unitary authorities). Two PCTs have boundaries which include three separate unitary councils, one of which undertakes one JSNA (working with the three unitary councils) whereas the other produces three separate JSNAs. Therefore only seventeen JSNAs are undertaken across the region (see appendix 1 – table and map). Throughout this review, we will refer to the local authority(ies) and PCT(s) who undertake a JSNA together as a ‘JSNA area’.

This review was undertaken collaboratively by the regional Public Health and Social Care Teams at the Department of Health South East (DHSE).

### Aims and objectives
This review aims to provide an overview of how JSNA are undertaken and utilised across the South East region, sharing examples of good practice in order to support the development of the JSNA process. JSNA has been identified by both the NHS White Paper, ‘Equity and Excellence: Liberating the NHS’\(^2\) (July 2010) and the ‘Vision for Adult Social Care: Capable Communities and Active Citizens’\(^3\) (November 2010) as the key mechanism for setting strategic priorities and informing local commissioning across health and social care (see main report for further details). In light of the recent Coalition Government’s proposals, this review also aims to provide future direction for JSNAs and recommendations to support the transition.

There are four main objectives for this review:
- identify and outline how JSNAs have been undertaken
- identify how the JSNAs have been utilised
- identify challenges to JSNA and summarise local successes
- provide recommendations to strengthen JSNAs in the future
Methods
We invited all JSNA leads in the nineteen local authorities (LAs) and seventeen Primary Care Trusts (PCTs) across the region to participate in an interview. We spoke to JSNA representatives in eight local authorities (42%) and seventeen PCTs (100%), therefore at least one representative from every JSNA area (see main report for further details). The interviews were undertaken prior and during the Government transition, therefore may not fully reflect the proposed policy changes.

Key findings
The key findings have been grouped under three main headings:
1. How are JSNAs undertaken?
2. How are JSNAs utilised?
3. Joint learning – challenges and successes

As mentioned above, throughout this review we will refer to the local authority(ies) and PCT(s) who undertake a JSNA together as a ‘JSNA area’. Although seventeen individual JSNAs were undertaken across the region, three of these were undertaken by one PCT using the same methodology and process. Therefore, we will present the data in terms of fifteen JSNA areas to reflect this.

1. How are JSNAs undertaken?

Leadership and governance

- All JSNA areas had some form of leadership and governance structures in place. Two main structures were identified; a JSNA ‘steering’ group (47%, n=15\(^a\)), which generally reports to a strategic partnership group and a JSNA ‘project’ group (33%, n=15), which has strategic lead from a partnership group, such as the Health and Wellbeing Board.

- Three JSNA areas had leadership and governance arrangements other than a ‘steering’ or ‘project’ group. One JSNA area (7%, n=15) is co-ordinated by a Joint Strategic Commissioning Board (three unitary councils working with one PCT), which is a partnership group representing senior members of local organisations and reports to the three LSPs (corresponding to each unitary council). One JSNA (7%, n=15) is co-ordinated and led by a JSNA Board, supported by a technical ‘working’ group and another JSNA (7%, n=15) is co-ordinated by a JSNA reference group, both which report directly to a strategic partnership group.

- Nearly half (47%, n=15) of all JSNA areas described their JSNA process as ‘jointly’ led by the LA and PCT and nearly half (47%, n=15) described ‘health’ (generally the Director of Public Health) as leading the process, although there was a partnership approach to the JSNA. Only one JSNA area (7%, n=15) described their JSNA as led by a

\(^a\) ‘n’ represents the size of the sample.
strategic partnership. See case study - JSNA Leadership and Governance in East Berkshire

• Less than half of all JSNA areas (40%, n=15) had dedicated staff specific to JSNA and, due to capacity issues, one third (33%, n=15) of JSNA areas reported commissioning external consultants to undertake all or parts of the JSNA work.

JSNA process

• Although there was evidence to suggest that some JSNA areas initially focused on a discrete document, most (93%, n=15) now show evidence of approaching JSNA as an on-going process.

• Two thirds of all JSNA areas (67%, n=15) have little evidence of any strategic steer to set the focus and priorities of the JSNA, with 13% (n=15) reportedly determined by the Directors of Public Health and 40% (n=15) agreed within the JSNA steering groups. One third (33%, n=15) of JSNA areas reported that the focus and priorities for their JSNA were negotiated with a strategic partnership, such as the Health and Wellbeing Partnership Board.

• All JSNA areas recognise that part of the JSNA process involves analysis of the core data set to produce summary report(s). Just over one third of JSNA areas (40%, n=15) re-analyse the core data set on an annual basis, one third (33%, n=15) undertake on a three yearly refresh, and just under one third (27%, n=15) approach core data set analysis as an on-going process.

• Two thirds (67%, n=15) of JSNA areas have or are working towards a dynamic ‘live’ core data set available via the LA or PCT website (e.g. Local Information Systems), which is updated regularly as new data becomes available. See case study – Milton Keynes Intelligence Observatory (MKi)

• As well as analysis of the core data set, six JSNA areas (40%, n=15) have identified another strand of JSNA work; comprehensive needs assessments, which complement the core data set analysis and cover specific topics identified as requiring a more in-depth review.

• Over one third (40%, n=15) of JSNA areas commented on the current format of the core data set and felt that the format made it difficult to translate the data into useful information for commissioners and strategic partners. Many JSNA areas (67%, n=15) had recognised and acted on this, presenting their JSNA in a format other than ‘domains’, such as by themes or key priorities. See case study – JSNA Themes in Kent

b The remaining 13% (n=15) stated that there was no strategic steer, but did not specify exactly how the focus and priorities were agreed.
• We were unable to identify any formal processes being used to monitor or evaluate JSNA, other than as part of the statutory World Class Commissioning assessment.

Third sector engagement
• One of the key vehicles for involving the third sector was through the Local Strategic Partnership (LSP)c, but the level of engagement of LSPs in the JSNA process has been difficult to assess. Although LSPs or subgroups, were included in the governance structure of many JSNAs, only one JSNA area actually described the strategic partnership group or LSP as leading the process.

• In two thirds of all JSNA areas (67%, n=15) the LSP seemed to have a relatively passive involvement, mainly through regular governance updates. It was recognised that active LSP involvement can be more difficult if the council is not unitary and has several LSPs to coordinate.

• Local Involvement Networksd (LINks) were another key mechanism for third sector engagement. Some JSNA areas did report engaging LINks in the JSNA process, but mainly during the dissemination stage. Two JSNA steering groups had membership from a LINks representative, therefore enabling LINks to have a more active role in the JSNA process.

• Three JSNA areas engaged third sector agencies directly through presentations, undertaken throughout the JSNA process to enable third sector agencies to help shape the JSNA. One JSNA area used a JSNA workshop, attended by third sector agencies and other key stakeholders to discuss and identify local priorities for the JSNA.

See case study – Surrey JSNA ‘roadshows’

Wider engagement
• Two thirds of all JSNA areas (67%, n=15) undertook some form of consultation with the public, services users and carers specifically for the JSNA, mainly via existing channels, such as Local Involvement Networks (LINks) and User Led Organisationsë (ULO).

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c The Local Strategic Partnership (LSP) is a statutory partnership body that brings together organisations from the public, private, community and voluntary sector within a local authority area, with the objective of improving people’s quality of life.

d LINks are Local Involvement Networks and replaced Patient and Public Involvement (PPI). LINks are run by local individuals and groups in the community, with the role to find out what people want, monitor local services and to provide a community voice in how their health and social care services are delivered (see www.nhs.uk/links).

e User Led Organisations are organisations of and for disabled people that promote all aspects of independent living for disabled people, including provision of services that support independent living.
• Findings from previous consultations, local surveys, public events and complaints were all used to inform the JSNA work. The statutory ‘Place Survey’\(^\text{\textsuperscript{f}}\) was a key source used to gain public views and perspectives.

• Several JSNA areas felt that they needed to develop a process for the public to be able to voice their perspective of ‘need’.

> See case studies – ‘Day in the Life’ Research in Buckinghamshire and Local Consultation in Southampton

2. How are JSNAs utilised?

Strategic planning
• Nearly all JSNAs (80%, n=15) were reported to inform Sustainable Community Strategies (SCS) and Local Area Agreement (LAA) discussions, with only two JSNAs areas reporting having no influence on these. Lack of influence seemed to be due to different time scales for the two duties, with the deadline for LAAs submission preceding their JSNA.

• Many JSNA areas (82%, n=11\(^\text{\textsuperscript{g}}\)) agreed that the JSNA helped to identify clear and agreed joint priorities. However, it was acknowledged that the competing priorities of different organisations presented a challenge to the process of agreeing joint priorities.

• Health inequalities were identified as a particular area which was supported by the JSNA work. Not only did the JSNA work help to identify unmet need and health inequalities, but it also provided common evidence from which to co-ordinate a joint approach to tackle them.

• Some JSNA areas with two tier local authorities raised the issue that although JSNA informed county level planning, it was harder for it to feed down and inform district level decisions. It was felt that this could be due to lack of engagement with district councils and this was an area identified for further work.

• Three JSNA areas have identified a ‘JSNA champion’, such as a Chief Executive or Director, to maintain a high profile for JSNA and push the agenda forward. See case study – Engaging District Councils in West Sussex

\(^\text{\textsuperscript{f}}\) Introduced as a statutory survey in 2008, The ‘Place Survey’ is to be undertaken by local authorities every two years. The survey has been designed to capture local people’s views, experiences and perceptions of the quality of life in their local area, including the contribution of local public services.

\(^\text{\textsuperscript{g}}\) Four JSNA areas did not answer this question.
See case studies – Identifying Deprivation in Kent and Oxfordshire’s ‘Rural Share of Deprivation’

Strategic commissioning

- All JSNA areas (n=14) reported that the JSNA had informed strategic commissioning decisions. However, some JSNA areas found it easier than others to align the JSNA work with commissioning cycles, therefore allowing it to become fully integrated in the commissioning process. See case study – Intelligent Commissioning Model in Brighton and Hove City Council

- Two representatives said that the JSNA had such a high profile and acceptance that “if it wasn’t in the JSNA, it was not a commissioning priority” and that it had become generally accepted that funding followed the JSNA.

- Six JSNA areas reported undertaking joint commissioning as a consequence of the JSNA. Two of these JSNA areas reported that they had established pooled budgets, one of which is undertaking a pilot to explore the possibilities of linking Personal Health Budgets with adult social care Personal Budgets.

See case studies – Joint Commissioning for Dementia in Kent JSNA and Joint Commissioning for Mental Health in East Sussex

- It was clear that the practice of joint commissioning was still becoming established and some JSNA areas were just starting to explore the possibilities of joint commissioning a range of community health and social care provision.

Service development and delivery

- All JSNAs areas (n=15) reported that their JSNA had influenced service development and delivery in some way. In many JSNA areas the JSNA had enabled them to identify key areas for service development and this was felt to have led to improvement in local services. See case studies - Service Development

Role of third sector

- There was limited evidence of third sector involvement in the utilisation of JSNA findings across the region. One JSNA area was working closely with Age Concern to provide on-going support to Age Concern’s analysis of the needs of Older People.

See case study – Community Link Worker in Kent

Dissemination of JSNA findings

- A wide range of methods were used across the region to disseminate JSNA findings.

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Data missing from one JSNA area.
Some JSNA areas undertook dissemination as an ongoing process, mainly involving presentations to key stakeholders. These individual presentations allowed them to tailor the information and present data at the relevant level for different stakeholders, such as district level for district LSPs and practice level (or aggregation of practices) for Practice Based Commissioning (PBC) groups in order for the findings to be meaningful to each stakeholder.

See case study - Health and Social Care Maps in Kent

One JSNA area had a rolling programme of presentations which coincided with local commissioning cycles.

3. Joint learning – challenges and successes

Challenges

- An issue of ownership was identified as a challenge. It was recognised that many JSNAs were initially led and driven by the PCT and that lack of engagement by local authorities at a senior level was a barrier which had to be overcome in some JSNA areas, in order to ensure joint ownership of the JSNA.

- It was acknowledged by some LA representatives that a population ‘need’ based approach to commissioning required a culture shift and the challenge of changing their current practice.

- Issues with data sharing and data sources were common barriers. It was highlighted that often information recorded in social care reflected performance, which is not always the most useful data. It was noted that it can be difficult to analyse LA data at a district level or below, due to the way the data are recorded.

- Data sharing issues were raised, for example local authorities and PCTs have different protocols for dealing with small data sets and consider a different level of suppression\(^1\) appropriate to protect data confidentiality.

- The robustness of data provided by wider partners was often an issue and some JSNA areas felt that further work to strengthen data sources was required.

- Lack of resources was identified as a challenge, in particular specialist analytical expertise. It was highlighted that using external consultants to undertake JSNA work can prevent the development of local ‘in

\(^1\) Suppression means that data is not published if it could breach confidentiality, for example if a data set is too small and individuals could be determined from the data set.
house' skills, especially as JSNA is not just a one off project but an ongoing process.

- It was suggested that if national or regional analysts could provide support, such as trends/comparisons for the whole region by local authority or district areas, it would reduce the local workload.

- Issues were raised with the structure of the recommended national core data set. The main problem identified was that the current format of domains made the data difficult to use and translate into useful information for commissioners. It was suggested that the core data set would be more useful if organised by topic areas (e.g. obesity and smoking) or specific groups (e.g. children and older people), rather than its current format.

- A few JSNA areas suggested that national data guidance should provide high level headings, which allow JSNA areas the flexibility to make the data set locally relevant.

- Several barriers to joint commissioning were identified, such as the fact that local authority and PCT commissioning cycles are not aligned, there are different budget accountabilities and the JSNA has to compete against other priorities at the level of stakeholders.

- Meaningful engagement with stakeholders was identified as a challenge, particularly with large two tier local authorities, due to the complex geographical area and multiple stakeholders.

- Some JSNA areas recognised that they had not engaged fully with third sector agencies, although the availability and capacity of key stakeholders was identified as a barrier to meaningful engagement.

- It was recognised that successful and representative public engagement could be difficult to achieve, but that more needed to be done to allow patients, carers and the general public a ‘voice’.

**Successes**

- JSNA was identified as a vehicle to break down cultural barriers and the use of different language across health and social care.

- It was highlighted that having this joint source of intelligence reduced issues regarding duplication and validity of data.

- Sharing of resources, such as a shared data repository, joint appointments and integrated teams are other successes to come out of JSNA.

- An important outcome for the JSNA in one area was that it had led to identification of gaps in intelligence. Once the gap was identified, a
systematic process was put into place to ensure that important data were collated. The availability of these data will support better health and social care.

Discussion
There are five key issues raised by this review that require further discussion: leadership and governance; JSNA process; engagement and ownership; strategic planning and commissioning; and future challenges.

Leadership and governance
It was interesting to note that many of the representatives who responded to take part in this review were based in a PCT and that two local authorities who did not take part in the review referred us to their PCT colleagues for information on JSNA. This does support the perception that ‘health’ has led the JSNA work. Whether it is that ‘health’ feel more comfortable with a population ‘need’ based approach or whether they are more experienced in data analysis – the review did not identify the answer to this. But it is, however, an interesting finding and maybe something that JSNA areas need to consider with the Coalition Government’s plans for local authorities (LAs) to lead JSNA. It would be important to establish in the coming months, how confident LAs feel to take the reins of the JSNA and start to transfer any skills or knowledge over to the LA to ensure continuity and embed the JSNA work in LA core business. This will be supported by the joint appointment of the Director of Public Health across the local authority and the proposed new public health service, Public Health England4.

There is also the issue of strategic leadership of JSNA. The review highlighted that only one JSNA area describes the strategic partnership group or LSP as leading the process and two thirds of JSNA areas (67%, n=15) determine their focus and priorities with little evidence of a strategic steer. Strategic leadership is important for the JSNA, as it should represent a complete local picture of need, taking into account data and views from wide stakeholders. JSNA areas will need to address how to strengthen the strategic leadership role and the Coalition Government has set out that this will be through new health and wellbeing boards. It is proposed that the health and wellbeing boards will develop a joint health and wellbeing strategy, based on the JSNA, which will provide an overarching framework within which a locality can develop specific commissioning plans5. The strength of having a joint source of evidence from which to base all local decision making and the power of collaboration to address the key issues must be recognised for the JSNA to reach its full potential. This ‘whole systems’ approach to health and wellbeing, such as supported by the ‘Total Place’ initiative can be both effective and efficient, particularly in addressing prevention of long term ill health and disability.

Practice Based Commissioning Groups (PBC groups and GP consortia) have been identified in the Coalition Government’s proposals as key stakeholders in future JSNAs. The recent Public Health White Paper states that, ‘GP consortia, local authorities and Directors of Public Health will each have an equal and explicit obligation to prepare JSNA through health and wellbeing
As this review was started prior to the Coalition Government, we did not include specific questions to identify engagement with PBC groups. However, our findings suggest that they were mainly involved in the dissemination stage of the JSNA process. This lack of engagement will need to be addressed in the coming months, as GP consortia will need to be fully engaged in the future JSNA process.

**JSNA process**

There is wide variation in the approach taken across the region and it became clear that JSNA means different things to different people. It was also apparent that JSNA is still evolving and that many JSNA areas have been developing and refining their JSNA process since its introduction in 2008.

JSNA is a process not a finite product, although the JSNA report or summary documents should be a product of this process. It was clear that individual JSNA areas have had to shape the JSNA process into a structure that would work for them locally. There was an apparent tension between identifying ‘high’ level need, to determine strategic priorities, and ‘low’ level need, to influence commissioning of specific services. The ‘breadth’ verse ‘depth’ approaches can be conflicting, but some areas addressed this with a combination of core data set analysis (to identify key strategic priorities) and specific needs assessments (to drill down into specific issues/service areas to inform commissioning). In this way, the service/issue specific needs assessments provide the evidence to support health and social care commissioning (see diagram below).

**Diagram 1: JSNA umbrella model**

We recognise that this model may be more of a challenge for complex two tier authorities, due to the multiple stakeholders and relatively large geographical area covered. There is evidence that many JSNA areas undertook specific needs assessments to drill down into issues raised by the JSNA, but did not
include this work under the umbrella of JSNA. This shows the work is being undertaken and maybe the model is just about the JSNA process including co-ordination and joining up of these needs assessments to feed into the strategic perspective, rather than starting a new stream of JSNA work.

There is a question as to whether the JSNA provides the right information for commissioners. It was also suggested by one respondent that some commissioners may not possess the skills and knowledge to use the JSNA data to its full potential. These issues were also raised in a recent briefing published by the North West Joint Improvement Partnership\textsuperscript{7}. Commissioners must be fully engaged in the JSNA process, both so that their requirements can be included in the JSNA and so they can understand the findings. This includes GP consortia who should be active participants in JSNA\textsuperscript{8}.

We would recommend that the product of JSNA is seen as a separate document to the Annual Public Health Report. Although Annual Public Health Reports (APHRs) have similar overarching goals to the JSNA (to improve health and wellbeing of the local population), the APHR should be a platform for the Director of Public Health to advocate independently for improving the health and wellbeing of the local population\textsuperscript{9}.

**Engagement and ownership**

The review highlighted that there had generally been poor engagement with the third sector, User Led Organisations, patients, public and carers throughout the JSNA process. It was also evident that two tier local authorities had found it a challenge to engage district and borough councils in the JSNA. These findings support previous work undertaken by DHSE on JSNA, which examined the extent to which housing needs were covered in the JSNA\textsuperscript{10}. Mechanisms for engagement of district and borough councils should be explored, such as appointing JSNA champions, to ensure ownership of the JSNA.

The third sector, User Led Organisations, and district and borough councils are all key stakeholders for the JSNA. These partners have information and influence over some of the wider determinants of health, such as housing, and have strong links with the public voice. A recent report by the Northern Housing Consortium\textsuperscript{11} also found that engagement with wider partners was variable across different JSNA areas in the north of England and identified that successful engagement was influenced by strong leadership and governance structures, which support close links between housing and health and social care. The importance of strong leadership and ownership of the JSNA were also identified by a recent report focusing on JSNA and vulnerable adults, housing and support\textsuperscript{12}. The report identified the need for clear leadership and governance structures with clarity of roles and responsibilities for all stakeholders, so wider partners were able to understand where they ‘fit into the local JSNA process’.

There are mutual benefits of engaging third sector agencies and User Led Organisations in the JSNA process, such as data sharing. These wider partners often have access to local data that is not available from any other
source, such as capturing data regarding marginalised groups and those with specialist or complex needs (e.g. homeless). In turn, the JSNA can be a useful resource to inform third sector work, such as to support them putting together business cases for new funding or for their own strategy development and service planning. Dissemination of the JSNA findings to the third sector and engaging them in planning the solutions to tackle the issues raised by the JSNA is a key step in the JSNA process. Working collaboratively is likely to be more effective than working separately and will have the greatest impact on local health and wellbeing.

Engagement through established networks, such as LINks and district or borough council networks was limited. It is important that the use of existing networks is maximised, particularly for JSNAs that cover large geographical areas, as networks will enable engagement with a wide range of smaller organisations or communities and ensure their voice is heard. The recently updated ‘Carers Strategy’\textsuperscript{13} states that the JSNA should routinely engage with carers of all ages to ensure the needs of carers in the local population are adequately identified. Issues of engagement with the third sector were considered in a recent briefing paper published by the National Association for Voluntary and Community Action (NAVCA)\textsuperscript{14}, which emphasises the importance of developing, strengthening and maximising the use of local networks to support engagement of voluntary and community groups in the JSNA.

Our review identified some barriers to successful engagement with third sector and User Led Organisations, such as capacity issues. A recent briefing paper by the Voluntary Organisation Disability Group\textsuperscript{15} considered how the role of the voluntary sector and community engagement could be more effectively embedded in JSNA. It was suggested that capacity issues could be addressed by offering in-kind support, such as setting up data collection systems and interpreting data or including participation in the JSNA in contracts with the voluntary sector.\textsuperscript{16} Other recommendations included the need to promote a better understanding of JSNA and the importance of establishing a clear role for the third sector.

We did identify some examples of successful public engagement (see case studies), but more work needs to be done to develop and strengthen channels for consultation and feedback so the public can voice their perspective of ‘need’. New proposals, such as HealthWatch\textsuperscript{j} and the Big Society\textsuperscript{k} could help strengthen the voice of the public and support them to contribute to the JSNA work.

\textsuperscript{j} HealthWatch is proposed to replace the Local Involvement Networks (LINks) and would continue to promote patient and public involvement in local health and social care services. It is envisaged that HealthWatch will also take on additional roles, including providing an NHS complaints advocacy service and supporting individuals to exercise choice, such as helping them choose a GP practice.

\textsuperscript{k} Big Society is a vision by the Coalition Government to empower local people and communities to form a strong society, taking the power away from the politicians and giving it to the people.
Strategic planning and commissioning
It was recognised that JSNA was a tool to support joint working and there were examples of how some JSNA had led to joint commissioning, but it was clear from the review that joint commissioning is still at an early stage in many JSNA areas. This is likely to be due to the potential barriers to joint working, several of which were identified by the review, such as lack of alignment of commissioning cycles between local authority and PCTs, different budget accountabilities and competing priorities. The proposed changes to health and social care will influence these issues and should support integrated commissioning. The local authority will be working with new partners, such as GP consortia, therefore potential barriers to any future joint commissioning should be identified early and addressed.

Future challenges
The proposed changes to the structure of health and social care will present many new challenges for JSNA. It will be important for JSNA areas, particularly local authorities, to consider whether their current JSNA process will support delivery of the White Paper proposals, particularly with regards to GP commissioning consortia. The review highlighted that very few JSNA areas had undertaken an evaluation of their JSNA, other than as part of their World Class Commissioning assessment. An evaluation of the current state of JSNA is imperative, as it will enable JSNA areas to plan their local transition.

Although not identified as an issue from the field work for the study, the introduction of Personal Budgets in adult social care and Personal Health Budgets within the NHS may present a challenge to the JSNA. The current JSNA guidance emphasises that the JSNA should focus on population need stating that ‘Needs assessment is an essential tool for commissioners to inform service planning and commissioning strategies. For the purpose of a JSNA, a clear distinction should be made between individual and population need. JSNA examines aggregated assessment of need and should not be used for identifying need at the individual level’17. As increasing numbers of people start to organise their own care and support, health and social care commissioners will have a role to play in aggregating these individual purchasing decisions in order to help shape the provider market. Such information may also be relevant for the JSNA. This is an area that requires further consideration.

Local authorities will have to build new partnerships, particularly with GP consortia and the new NHS Commissioning Board. Local authorities will also have to establish and lead the new health and wellbeing boards. The work that has been undertaken in JSNA areas so far will be a strong platform for local authorities to continue the ‘need’ based approach. It is important that local authorities use what they have learnt from the JSNA work, especially their increased awareness of the ‘health’ perspective, to their advantage so future partnerships benefit from this ‘head start’.

The JSNA process has come a long way since its introduction and there are many examples of good practice across the region. The work that has been
undertaken so far to develop and embed JSNA should provide strong foundations for the future changes in health and social care policy.

6. Recommendations for developing JSNA across the region

a) Leadership and governance
1. Establish clear lines of accountability and governance throughout the JSNA process
2. Strengthen strategic leadership of JSNA process, including input from third sector agencies and community representatives
3. PCT to support the LA to start leading the JSNA work, if not already, to enable smoother transition with future changes in health and social care and embed JSNA in core LA practice
4. Ensure better use of scarce analytical resources

b) JSNA process
5. Ensure that priorities and focus for JSNA is negotiated with wider partners, for example through the LSP
6. Be inclusive – involve both health and social care commissioners, third sector agencies and User Led Organisations at all stages of the JSNA process
7. Be creative with the structure of the core data set, such as arranging by themes or topic areas – make it work for you locally
8. Supplement the core data set with locally agreed data
9. As well as analysis of the core data set, the JSNA process should include a system for collating health and social care needs assessments to provide a evidence base for local commissioning decisions
10. Establish a regional intelligence resource with analysis of a sub-core data set, to prevent duplication and support consistency
11. Evaluate JSNA work in order to improve current process
12. JSNA and APHR should be separate, though clearly related reports

c) Engagement
13. Develop channels for consultation and feedback so the public can voice their perspective of ‘need’
14. Develop engagement strategy for JSNA work, including engagement with district and borough councils (in two tier authorities)

d) Strategic planning and commissioning
15. Establish joint processes across health and social care, such as alignment of planning process and commissioning cycles
16. Encourage and develop integrated teams and joint appointments
17. Have a JSNA champion to maintain a high profile for JSNA and push the agenda forward
18. Strengthen communication channels between strategic leads, analysts and commissioners
JSNA in the South East – Review of Practice

1. Introduction and background

1.1 Introduction to JSNAs
Since 1st April 2008, upper-tier and unitary local authorities and Primary Care Trusts (PCTs) have been under a statutory duty to produce a Joint Strategic Needs Assessment (JSNA) to establish the current and future health and wellbeing needs of the local population18.

Needs assessment in this context is, ‘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’. National JSNA guidance, 2007.

JSNAs are based on the geographical area of the upper tier local authority (or unitary council) and PCTs feed into the JSNA for the local authority area(s) in which the PCT geographical boundary falls. The South East region includes nineteen upper tier local authorities, including seven county councils; Hampshire, West Sussex, East Sussex, Surrey, Kent, Oxfordshire and Buckinghamshire, and twelve unitary authorities; Portsmouth, Milton Keynes, West Berkshire, Reading, Wokingham, Bracknell Forest, Windsor and Maidenhead, Slough, Southampton, Isle of Wight, Brighton and Hove and Medway.

There are seventeen PCTs which overlap these upper tier and unitary local authority boundaries, with seven PCTs sharing the same geographical boundaries as their corresponding local authorities (including five unitary authorities). Two PCTs have boundaries which include three separate unitary councils, one of which undertakes one JSNA (working with the three unitary councils) whereas the other produces three separate JSNAs. Therefore, seventeen JSNAs are undertaken across the region (see appendix 1 – table and map).

‘The JSNA will provide a framework to examine all the factors that impact on health and wellbeing of local communities, including employment, education, housing and environmental factors’. National JSNA guidance, 2007.

Directors of Public Health, Directors of Adult Social Services and Children’s Services have ultimate accountability for the JSNA, and should work in collaboration with partners from both statutory and non-statutory organisations19. Partnership working is a key element to enable JSNAs to reach their full potential. Establishing and tackling issues that cut across the ‘big picture’ of health and wellbeing requires the pulling together of resources
and expertise from all partners who are able to influence the wider determinants of health and wellbeing. The JSNA can support stronger partnerships between communities, local Government and PCTs and provide a firm foundation for integrated commissioning. If the JSNA process is effective, it should lead to the development of sustainable and effective services that meet the needs of the local population, improving health and wellbeing and reducing health inequalities.

1.2 Purpose of review
This review was undertaken collaboratively by the regional Public Health and Social Care Teams at the Department of Health South East (DHSE).

The purpose of this review is to support the ongoing development of JSNA across the region. It is recognised that JSNA has been evolving since its introduction in 2008. We would like to capture the work that has been done locally to engage partners in the JSNA, embed JSNA in core strategic planning and commissioning, illustrate (through case studies) the impact of JSNA on commissioning/decommissioning, highlight the barriers that have been overcome and share the ideas that will enable JSNA to reach its full potential.

1.3 Aims, objectives and scope
This review aims to provide an overview of how JSNA are undertaken and utilised across the South East region, sharing examples of good practice in order to support the development of the JSNA process. JSNA has been identified by both the NHS White Paper, ‘Equity and Excellence: Liberating the NHS’20 (July 2010) and the ‘Vision for Adult Social Care: Capable Communities and Active Citizens’21 (November 2010) as the key mechanism for setting strategic priorities and informing local commissioning across health and social care. In light of the recent Coalition Government’s proposals, this review also aims to provide future direction for JSNAs and recommendations to support the transition.

There are four main objectives for this review:
• identify and outline how JSNAs have been undertaken
• identify how the JSNAs have been utilised
• identify challenges to JSNA and summarise local successes
• provide recommendations to strengthen JSNAs in the future

Due to resource constraints, the report will not consider the quality of data used in JSNAs, the use of evidence based interventions or the impact of specific JSNAs, such as reducing health inequalities, although these are all important aspects of a successful JSNA.

1.4 Methods
We identified all JSNA leads in the nineteen local authorities (LAs) and seventeen Primary Care Trusts (PCTs) across the region and invited them to participate in an interview, either in person or via the telephone. A semi-structured questionnaire was used during the interviews (see appendix 2). The questionnaire was informed by the Local Government Improvement and
Development (LGID) benchmarking tool (see appendix 3) and was designed prior to the Coalition Government taking office, therefore does not fully reflect the proposed policy changes set out in the recent White Paper. However, our findings and recommendations remain equally relevant in light of the NHS White Paper, ‘Equity and Excellence: Liberating the NHS’\(^22\) (July 2010) and the ‘Vision for Adult Social Care: Capable Communities and Active Citizens’\(^23\) (November 2010). The questionnaire was piloted during the first three interviews and some minor amendments to the schedule were made.

Two researchers undertook a total of nineteen interviews, nine in person and ten via the telephone. We spoke to JSNA representatives in eight local authorities and seventeen PCTs, therefore 42% of all LAs and 100% of all PCTs in the region. We spoke to at least one representative from every JSNA (there are seventeen JSNAs). These PCT representatives included one Director of Public Health, six Deputy/Assistant Directors of Public Health, ten Consultants in Public Health/Head of Intelligence and one JSNA project manager. Representatives from local authority included one Director of Children’s Services and eight senior managers (including Heads of Commissioning, Performance and Intelligence). Four PCTs and LAs wished to undertake the JSNA interview jointly. Two of these joint interviews involved unitary councils with co-terminous PCTs, one was a two tier council with co-terminous PCT and the fourth interview involved a PCT and one of its corresponding unitary councils.

Although all LAs were invited to participate in the study, many did not respond to the invitation and two LAs referred us to the PCT JSNA Lead for the interview (these were both JSNA areas with a jointly appointed Director of Public Health). Follow up contact was made with LAs, although only one LA provided further information. This means that the findings primarily reflect a PCT based perspective.
2. Policy background and context
The requirement for the Joint Strategic Needs Assessment (JSNA) was created by Section 116 of the Local Government and Public Health Involvement in Health Act (2007), which sets out the statutory framework for Local Area Agreements (LAA). All upper tier local authorities (LAs) and Primary Care Trusts (PCTs) are required to undertake a JSNA. The JSNA should cover those issues where the responsibilities of PCTs and local authorities overlap or where their functions significantly impact on each other.

2.1 Equity and excellence - Liberating the NHS
In July of this year, the new Coalition Government published a White Paper ‘Equity and excellence – Liberating the NHS’, along with several consultation papers. The White Paper sets out the NHS strategy, with a vision to make the NHS more accountable to patients and local communities and free from excessive top-down control. The White Paper proposes a new framework for health and social care, which enhances the role of local authorities in health, abolishes PCTs and transfers NHS commissioning functions to GP consortia and the new NHS Commissioning Board.

Each local authority will be responsible for:

- Leading joint strategic needs assessments to ensure coherent and co-ordinated commissioning strategies
- Supporting local voice and exercise of patient choice
- Promoting joined up commissioning of local NHS services, social care and health improvement; and
- Leading on health improvement and prevention activity

The Government identifies four areas where the local authority will have greater responsibility for health, one of which is to lead JSNA (which will remain a statutory duty). Responsibilities for some functions of public health will be transferred to local authorities who will lead on local health improvement and prevention, complemented by a new national Public Health Service. Directors of Public Health will be jointly appointed across local authorities and the Public Health Service.

Although the responsibility and accountability for NHS commissioning will lie with the NHS Commissioning Board and GP consortia, LAs will have an influence over commissioning decisions though the statutory health and wellbeing board in each LA area. The main aim of the health and wellbeing board will be to promote integration and partnership working between the NHS, social care, public health and other local services. Through this board, NHS commissioners will be able to influence health improvement, reducing health inequalities and social care.
In order to strengthen the voice of patients and the public, a new consumer champion, HealthWatch England, will be located in the Care Quality Commission\textsuperscript{35}. HealthWatch will replace the Local Involvement Networks (LINks) and will continue to promote patient and public involvement in local health and social care services. It is proposed that HealthWatch will also take on additional roles, including providing an NHS complaints advocacy service and supporting individuals to exercise choice, such as helping them choose a GP practice\textsuperscript{36}.

The NHS Commissioning Board will be held to account for overseeing the commissioning of a comprehensive healthcare service through the NHS Outcomes Framework. The NHS Outcomes Framework will\textsuperscript{37}:

- Focus on outcomes that the NHS can influence
- Include outcomes delivered through partnership with other public services where required, supported by strategies to ensure organisations provide complementary and integrated services
- Recognise the importance of reducing inequalities and promoting equality
- Be supported by NICE Quality Standards for health and social care

**NHS Outcomes Framework - Key principles:**

- Accountability and transparency
- Balanced
- Focused on what matters to patients and healthcare professionals
- Promoting excellence and equality
- Focused on outcomes that the NHS can influence but working in partnership with other public services where required
- Internationally comparable
- Evolving over time
2.2 A Vision for Social Care: Capable Communities and Active Citizens

In November 2010, the Coalition Government launched their vision for social care, ‘A Vision for Social Care: Capable Communities and Active Citizens’\textsuperscript{38}, which is underpinned by the principle of strengthening communities and building the ‘Big Society’. The Vision focuses on personalised services and outcomes and is based on seven key principles; prevention, personalisation, partnership, plurality, protection, productivity and people.

\textbf{Vision for Social Care - Seven key principles}

- **Prevention** – empowered people and strong communities will work together to maintain independence
- **Personalisation** – personal budgets provided to all eligible people
- **Partnership** – care and support delivered in partnership between individuals, communities, the voluntary and private sectors, the NHS and local authorities
- **Plurality** – diverse service provision to meet the wide variety of people’s needs
- **Protection** – safeguards against the risk of abuse or neglect
- **Productivity** – greater local accountability will drive improvements and innovation to deliver higher productivity and high quality care and support services
- **People** – draw on a workforce who can provide care and support with skill, compassion and imagination and who are given the freedom and support to do so, including care workers, nurses, occupational therapists, physiotherapists and social workers, alongside carers and service users, to lead the changes

Local authorities will have a lead role in orchestrating the Vision and supporting their communities to take an active role in organising their care. Innovation and integrated working should be encouraged, along with the provision of services by diverse providers, including both the voluntary and private sectors.

‘JSNAs will form the foundation of priority setting, encouraging greater involvement of local voluntary and community organisations. JSNAs will help local people to hold providers and commissioners to account, agree local priorities and inform a range of commissioning strategies and plans. This will be underpinned through new statutory duties for local councils and GP consortia to work together to promote the health and wellbeing of their local population.’ A Vision for Social Care: Capable Communities and Active Citizens, November 2010
The role of JSNA is clearly set out and supports the principles of plurality and partnership. The new statutory duties for local authorities (set out in the NHS White Paper), and greater responsibility for health will enable them to lead this joined up approach across both health and social care.

2.3 Healthy Lives, Healthy People: Our strategy for public health in England

The Public Health White Paper, Healthy Lives, Healthy People: Our strategy for public health in England, was published in November 2010. This White Paper sets out the new approach to public health which encourages a wider responsibility across society to address the broad determinants of health and wellbeing, taking a life course approach which focuses on improving outcomes. Local government and local communities are placed at the centre of improving health and wellbeing and tackling inequalities, supported by the NHS White Paper proposals.

A new integrated public health service, Public Health England, will be set up as part of the Department of Health by 2012 and will receive a new ring-fenced budget. Public Health England will lead health protection and strengthen the national response on emergency preparedness, bringing together the health protection and emergency planning and response functions from the Department of Health, Health Protection Agency (HPA) and Strategic Health Authorities (SHAs).

Public Health England’s role will include:

- Providing public health advice, evidence and expertise to the Secretary of State and the wider system
- Delivering effective health protection service
- Commissioning or providing national-level health improvement services, including appropriate information and behaviour change campaigns
- Jointly appointing Directors of Public Health and supporting them through professional accountability arrangements
- Allocating ring-fenced funding to local government and rewarding them for progress made against elements of the proposed public health outcomes framework
- Commissioning some public health services from the NHS, for example via the NHSCB
- Contributing internationally-leading science to the UK and globally, in areas such as biological standards and control, dangerous pathogens and incident response.

Public Health England will allocate a ring-fenced budget for improving health and wellbeing of local populations (weighted for inequalities) to all upper tier and unitary local authorities. A new health premium will also be introduced to incentivise action by local authorities to reduce health inequalities. Public Health England will also fund services by asking the NHS Commissioning
Board to commission services or by commissioning or providing the services directly themselves.

The White Paper proposes that, ‘Public Health England should be responsible for funding and ensuring the provision of services, such as health protection, emergency preparedness, recovery from drug dependency, sexual health, immunisation programmes, alcohol prevention, obesity, smoking cessation, nutrition, health checks, screening, child health promotion including those led by health visiting and school nursing, and some elements of the GP contract (including the Quality and Outcomes Framework (QOF)), such as those relating to immunisation, contraception, and dental public health.’

The Public Health White Paper provides further clarity of the role of JSNA and the responsibilities of key stakeholders. It is envisaged that JSNAs will be prepared through the health and wellbeing boards, with GP consortia, local authorities and Directors of Public Health each having an ‘equal and explicit obligation’ to contribute to the JSNA. The proposed minimum membership of the health and wellbeing boards includes elected representatives, GP consortia, Directors of Public Health, Directors of Adult Social Services, Directors of Children’s Services, local HealthWatch and participation of the NHS Commissioning Board (where appropriate). The JSNA will inform the joint health and wellbeing strategy, which will be developed by the health and wellbeing board and provide an ‘overarching framework’ within which a locality can develop specific commissioning plans for the NHS, social care and public health. With the JSNA being led by the health and wellbeing board, it should strengthen its role in supporting joint commissioning of NHS, social care and public health services and the integration of health and social care services.

2.4 National Indicator Set
In October 2007, as part of the Comprehensive Spending Review (CSR), the Government introduced a single set of 198 national indicators which formed the new performance framework for local Government. This new framework included indicators relevant to local partners, such as Police and Primary Care Trusts, as well as the Local Authority, with the aim to encourage delivery through stronger partnership working. Local partnerships would negotiate targets (Local Area Agreements), with central Government, against the national indicators. Performance against these indicators would be reported for every single tier and county council Local Strategic Partnership.

2.5 Sustainable Community Strategy
The Sustainable Community Strategy sets the overall strategic direction and long-term (10–20 years) vision for the economic, social and environmental well-being of a local area. As the overarching strategy for the area, the issues identified in the Sustainable Community Strategy inform the priorities and targets in the Local Area Agreement (the short-term delivery vehicle for the Sustainable Community Strategy). The JSNA process should engage and
inform the upper-tier local authority in its preparation of the Sustainable Community Strategy (SCS) and identify the priorities and focus for the Local Area Agreements. In this way, the JSNA should support and strengthen partnership working.

2.6 Putting People First (PPF)
The vision of stronger partnership is reinforced in the cross-sector concordat ‘Putting People First; a shared vision and commitment to the transformation of adult social care’ (2007)\(^48\). The focus of PPF is on developing social capital (building community capacity); prevention and early intervention; making mainstream ‘universal services’ more socially inclusive and implementing self directed support through the provision of Personal Budgets. The PPF concordat recommends that this system-wide transformation should include a JSNA, undertaken by local authorities and PCTs, with the full engagement of voluntary sector organisations. In November 2010 the refresh of Putting People First, ‘Think Local, Act Personal: Next Steps for Transforming Adult Social Care’, was launched. This partnership agreement sets out areas where further action is required to transform adult social care services and the importance of JSNA has been reiterated. The JSNA remains an important underpinning to the transformation of adult social care and ensures it meets local needs. The JSNA should also shape local commissioning, supporting joint commissioning, pooling of budgets and utilising all relevant community resources, such as the voluntary sector.

2.7 Total Place: Better for Less
JSNA supports the drive towards a ‘whole area’ approach to public services, set out in the ‘Total Place: Better for Less’ initiative\(^49\). Total Place aims to avoid overlap and duplication between organisations and deliver both service improvement and efficiency of local public services. Thirteen pilot areas participated in the scheme, with the opportunity to redesign the way public services are planned and delivered. JSNA is a key process to inform these changes, supporting a ‘joint’ approach to service improvement and providing the evidence base to tailor local services to meet local needs.

2.8 World Class Commissioning
World Class Commissioning is a vision which sets out eleven key commissioning competences required in order to achieve high quality commissioning. World Class Commissioning encourages commissioners to take a strategic and long-term approach, focusing on prevention and wellbeing and the delivery of better health outcomes\(^50\). JSNA supports World Class Commissioning and contributes to the attainment of several key commissioning competencies.

- **Competency 2: Work with community partners**
The inclusion of a range of local partners, including the third sector, is fundamental to the delivery of a successful JSNA. These partners will be better equipped to work together to tackle the underlying determinants of health which contribute to health inequalities in the community identified in the JSNA.
• **Competency 3: Engage with public and patients**  
To be used effectively JSNA must include information on local ‘voice’. This could mean identifying the aspirations and concerns of different local communities so that these can be incorporated into the JSNA and used to influence local decision-making.

• **Competency 5: Manage knowledge and assess needs**  
Local JSNAs should be regularly revisited and updated to establish a full understanding of current and future health and wellbeing needs.

• **Competency 6: Prioritise investment**  
JSNA is about developing a consensus among partners on local issues and needs to be addressed. In doing this it also allows overall local strategic priorities to be set and investment decisions to be made accordingly.
3. National guidance and good practice models

3.1 Department of Health JSNA guidance

The Department of Health (DH) published guidance on JSNAs in 2007. The guidance provided a general framework for JSNA, within which local partnerships could develop a more detailed approach, focusing on their local issues in order to understand the health and wellbeing needs of their population.

The national guidance sets out the JSNA as identifying the ‘big picture’ for health and wellbeing and defines needs assessment as ‘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 guidance states that the JSNA process should be underpinned by partnership working, community engagement and evidence of effectiveness, establishing four key stages in the iterative process:

- Undertaking JSNA – identify mechanisms of engagement and identify existing assessments and plans
- Content of JSNA – collect data on local need, translate these data into information and incorporate data into needs assessment
- Using JSNA to inform SCS, LAA and commissioning decisions - make priority setting and decision making process explicit
- Feeding back findings of JSNA – publish JSNA in accessible format and ensure feedback continuously informs ongoing JSNA process

Local Strategic Partnerships are identified as having a key role to play in engaging local partners in the JSNA process. It is envisaged that LSPs will agree joint priorities and actions informed by the JSNA, which should drive the Strategic Community Strategies and Local Area Agreements.

The DH guidance included a core JSNA dataset (see appendix 4), which provided a good starting point from which local partnerships were expected to extend and shape locally. The core dataset includes a list of indicators organised in domains (demography, social and environmental context, lifestyle/risk factors, burden of ill health and services) which take into account the National Indicator Set and Vital Signs. Apart from the demography domain, the domains contain indicators which measure need directly or can be used as a proxy for need. The core dataset includes suggestions for projections and forecasting across the domains and measuring health inequalities. The core dataset was further developed by the Association of Public Health Observatories in 2008 and is currently being revised by the Health and Social Care Information Centre and Eastern Region Public Health Observatory (see http://www.ic.nhs.uk for further information).

1 The Local Strategic Partnership (LSP) is a statutory partnership body that brings together organisations from the public, private, community and voluntary sector within a local authority area, with the objective of improving people’s quality of life.
3.2 National models of JSNA
There are many examples of good practice nationally. We have identified two models one of which illustrates the approach taken in a unitary council and the other a two tier council, both with boundaries co-terminous with the relevant PCT.

The Nottingham City approach
Nottingham City Council is a unitary authority with boundaries co-terminous with the PCT. Prior to the statutory requirement for JSNA, Nottingham City had already begun to improve ‘shared intelligence’ and developed a web-based single repository for all local data and resources. This website (‘Nottingham Insight’ at http://www.nottinghaminsight.org.uk/) now hosts the JSNA and provides an evidence base for commissioning decisions and local planning.

The JSNA steering group includes both intelligence and commissioning leads from each of the three statutory directorates and is responsible for the overall programme implementation of the JSNA, on behalf of the Directors. The Directors report to the City Health Partnership, Health and Social Commissioning Care Board and the Strategic Partnership for Children and Young People at least annually. A broad range of staff from all three directorates are involved in writing the JSNA chapters to ensure the JSNA is fully embedded in the commissioning process.

The JSNA has been organised into five broad topic areas; demographics and social and environmental context, life expectancy, behavioural factors, children and young people and adults.

The Cambridgeshire approach
Cambridgeshire is a two tier local authority, including four rural district councils and Cambridge City Council. Cambridgeshire County Council is coterminous with NHS Cambridgeshire (PCT). Cambridgeshire has undertaken the JSNA in three phases. Phase one identified six ‘care groups’ within their JSNA, including children and young people, older people, adults of working age, adults with learning disabilities, adults with mental health problems and adults with physical disability and sensory impairment and long term conditions. They undertook mini JSNAs which focused on these specific populations or client groups. Phase two involved collating community views and bringing together information from local consultations in one place. Phase three identified three more JSNA topic areas; homelessness, international migrants and new developments.

The JSNAs were led through existing joint strategy and commissioning groups, feeding directly into the Local Area Agreement as well as informing commissioning. Cambridgeshire felt that the ‘care group’ approach made the data more accessible and supported the direct use of JSNA in joint commissioning strategies.
4. Key Findings
Throughout these findings, we will refer to the local authority(ies) and PCT(s) who undertake a JSNA together as a ‘JSNA area’. Although seventeen individual JSNAs were undertaken across the region, three of these were undertaken by one PCT using the same methodology and process. Therefore, we will present the data in terms of fifteen JSNA areas to reflect this.

4.1 How are JSNAs undertaken (process)?

Leadership and governance
All JSNA areas had some form of leadership and governance structures in place. There were two main types of leadership and governance structures identified; a JSNA ‘steering’ group, which generally reports to a strategic partnership group and a JSNA ‘project’ group, which has strategic lead from a partnership group.

Nearly half (47%, n=15) of all JSNAs are co-ordinated and led by a specific JSNA steering group. All steering groups are ‘joint’ and have representation from health and social care, including commissioning managers and information analysts. Two JSNA areas embraced the multi-agency partnership dimension of the JSNA and included community and third sector representatives, such as LINks\(^n\), representatives from the Black and Minority Ethnic community and Community First\(^o\) on their steering group.

Most steering groups (71%, n=7) report directly to a strategic partnership board, such as the Health and Wellbeing Partnership Board (usually a subgroup of the Local Strategic Partnership) or a Joint Commissioning Board or Joint Health Board. One steering group is actually a subgroup of the Joint Commissioning Board. Two JSNA areas (29%, n=7) did not report clear or formal governance arrangements and it was generally accepted that the steering group would feed progress of the JSNA to strategic boards, LSP and partnership boards, via the DPH or senior steering group members, as required.

Some steering groups (43%, n=7) also have a subgroup of the steering group, attended by the analysts and intelligence staff, forming a practical ‘working’ group. In one JSNA area the ‘working’ subgroup had wide analytical representation across health and social care, which enabled them to build relationships to support easier data sharing, as well as sharing knowledge and skills. It was recognised that analysts, particularly in LA departments, often lack peer support and that a ‘working’ group could provide this support, creating a better working environment for the JSNA.

\(m\) ‘n’ represents the size of the sample.
\(n\) LINks are Local Involvement Networks and replaced Patient and Public Involvement (PPI). LINks are run by local individuals and groups in the community, with the role to find out what people want, monitor local services and to provide a community voice in how their health and social care services are delivered (see www.nhs.uk/links).
\(o\) Community First brings local Voluntary and Community Organisations together to promote and develop effective local voluntary and community action.
One third (33%, n=15) of JSNAs are co-ordinated by a specific JSNA project group, which has strategic leadership from a partnership group, such as the Health and Wellbeing Partnership Board (usually a subgroup of the LSP) or Joint Health Board. One project group is a subgroup of the Health and Wellbeing Partnership.

Half of all of the ‘steering’ and ‘project’ groups (n=10)\(^8\) include the three key directors (Director of Public Health, Director of Adult Services and Director of Children Services), with the remaining led by public health consultants and/or senior managers on behalf of these Directors. Nearly all ‘steering’ and ‘project’ groups (92% n=12) are chaired by a ‘health’ representative, with only one jointly chaired by health and social care (8% n=12).

Three JSNA areas had leadership and governance arrangements other than a ‘steering’ or ‘project’ group. One JSNA area (7%, n=15) is co-ordinated by a Joint Strategic Commissioning Board (three unitary councils working with one PCT), which is a partnership group representing senior members of local organisations and reports to the three LSPs (corresponding to each unitary council). One JSNA (7%, n=15) is co-ordinated and led by a JSNA Board, supported by a technical ‘working’ group and another JSNA (7%, n=15) is co-ordinated by a JSNA reference group, both which report directly to a strategic partnership group. The three key Directors attend all these three JSNAs co-ordinating groups (JSNA Board, JSNA reference group or Joint Strategic Commissioning Board). The JSNA reference group is jointly chaired by health and social care.

Nearly half of all JSNA areas (47%, n=15) described their JSNA process as ‘jointly’ led by the LA and PCT and nearly half (47%, n=15) of JSNA areas described ‘health’ (generally the Director of Public Health) as leading the process, although there was a partnership approach to the JSNA. Only one JSNA area described their JSNAs as led by a strategic partnership. It was acknowledged that JSNA sat more comfortably with ‘health’ partners, especially initially, and that many JSNAs had been driven by ‘health’, with LAs and wider partners becoming more engaged in the work as the JSNA process developed. Many JSNA areas reported that their final JSNA documents were ‘signed off’ by the relevant PCT Board(s) and County Council Cabinet(s) and some JSNAs were taken to Health Scrutiny Committees\(^q\).

Several JSNA areas highlighted the limited resources available for this work, with less than half of all JSNA areas (40%, n=15) reporting dedicated staff specific to JSNA. Four JSNA areas have a project manager/co-ordinator dedicated only to the JSNA work and two areas have specific JSNA analysts. These dedicated posts were jointly funded across the local authority(ies) and PCT(s). Due to capacity issues, one third (33%, n=15) of respondents

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\(^8\) Data missing for two JSNA areas with regards to inclusion of three key Directors on ‘steering’ or ‘project’ group (twelve areas had ‘steering’ or ‘project’ groups).

\(^q\) Health Scrutiny Committees review and scrutinize all matters relating to the planning, provision and operation of health services in its local area, as a statutory duty (since 2003) given to local authorities by the Health and Social Care Act 2001.
reported commissioning external consultants to undertake all or parts of the JSNA work.

**Case study – JSNA Leadership and Governance in East Berkshire**

East Berkshire NHS has three unitary councils to engage with for three separate JSNAs; Slough, Bracknell Forest and Royal Borough of Windsor and Maidenhead (RBWM). Clear lines of responsibility and governance are set out for each JSNA, as shown in the diagram below.

The three JSNA subgroups were led by a Consultant in Public Health, a Strategic Programme Manager and a Unitary Authority Director. These subgroups report monthly to the Joint Strategic Commissioning Board which represents the three Unitary Authority Directors of Childrens Services, Adult Social Care and the PCT directors.

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**The JSNA process**

Most JSNA areas (93%, n=15) acknowledged that the JSNA process is still developing and evolving. There was evidence to suggest that some JSNA areas had initially focused on a discrete document which was either undertaken by the PCT/LA or by external consultants. Some of these JSNA documents were also presented as the Director of Public Health’s Annual Report. Although some areas initially focused on a discrete document, most (93%, n=15) now show evidence of approaching JSNA as an on-going process.
All JSNA areas recognised that part of the JSNA process involves analysis of the core data set to produce summary report(s). Just over one third of JSNA areas (40%, n=15) re-analyse the core data set on an annual basis, one third (33%, n=15) undertake on a three yearly refresh, and just under one third (27%, n=15) approach core data set analysis as an on-going process. Two thirds (67%, n=15) of JSNA areas have or are working towards a dynamic ‘live’ core data set available via the LA or PCT website (e.g. Local Information Systems), which is updated regularly as new data becomes available.

Case study – Milton Keynes Intelligence Observatory (MKi)

The MKi observatory is a joint venture between all the stakeholders and strategic partnerships in Milton Keynes (including the Local Strategic Partnership). It has been developed as a means by which policy makers and researchers within all sectors will be able to share information, resources and knowledge. The web site provides a ‘one-stop-shop’ for information about health and wellbeing in Milton Keynes to inform local strategy and planning. MKi supports a JSNA portal, which allows access to their JSNA report, data used in the JSNA, topic area summaries and other key JSNA resources. There is a forum to support discussion around current local issues and the web site provides links to strategic partner web pages.

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Just over one third (40%, n=15) of JSNA areas commented on the current format of the core data set and felt that the format made it difficult to translate the data into useful information for commissioners and strategic partners. It was suggested that the core data set would be more practical to use if organised by themes or topics, rather than the current domains. Many JSNA areas (67%, n=15) had recognised and acted on this, presenting their JSNA in a format other than ‘domains’, such as by themes or key priorities.
Case Study – JSNA Themes in Kent

Kent undertook two separate JSNAs, one for Adults and another for Children, as well as contributing to a JSNA for Mental Health undertaken across both Kent and Medway. The Adults JSNA was conducted in three separate phases. Year one concentrated on outlining the key demographic shift and helped concentrate the commissioners on the ageing population and long term conditions. In year two the Adults JSNA drilled down into a further three in-depth needs assessments: mental health, alcohol and dementia. Although the separation of the JSNA into themes was a product of organisational dynamics, it did allow them to focus the JSNA work and gain an in-depth view of key issues which enabled the JSNA to influence specific commissioning decisions, shape the agenda for the Kent Children’s Trust and fundamentally drive the priorities of the Children and Young Person’s Plan.

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As well as analysis of the core data set, six JSNA areas (40%, n=15) have identified another strand of JSNA work; comprehensive needs assessments. The comprehensive needs assessments complement the core data set analysis and cover specific topics identified as requiring a more in-depth review. One JSNA area has identified three strands of work in their JSNA, which include JSNA indicator scorecards, comprehensive needs assessments and focused work on increasing life expectancy. Two JSNA areas include a number of reports/analyses under the umbrella of JSNA, such as the Director of Public Health Annual Reports, Housing Strategy and the Children and Young People locality profiles.
Case Study – East Sussex JSNA Scorecards

As part of the East Sussex JSNA programme, JSNA indicator scorecards have been developed. Nearly 300 JSNA scorecards, based on the core dataset and a range of local data have been produced. Scorecards are available at two different geographical levels of aggregation; a LA hierarchy (ie. ward, district/borough, county level) and a PCT hierarchy (ie. GP practice, PBC Cluster, PCT level). The scorecards are used to inform service development and action to reduce health inequalities. A recent development has been the production of a subset of scorecards at another geographical level - Local Partnership for Children Scorecards.

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Case Study – Oxfordshire JSNA Area Approach to JSNA

As well as collection of the core data set, Oxfordshire JSNA area includes a number of reports/analyses under the umbrella of JSNA, such as the Director of Public Health Annual Reports, the Sustainable Community Strategic Joint Briefing Paper and Children and Young People locality profiles. Their approach to JSNA has developed through three phases. Phase one saw the establishment of the Oxfordshire Data Observatory in 2004. The Observatory is run through a partnership arrangement, including shared data from the PCT, County Council, District Councils, Police and voluntary sector organisations and supports the core data set. Phase two involved developing a systematic approach to needs assessment; agreeing a programme of needs assessments and establishing an electronic library resource to collate the reports. Phase three has included embedding the core data set in routine systems and developing benchmarking analysis to inform prioritisation.

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Two thirds of all JSNA areas (67%, n=15) have little evidence of any strategic steer to set the focus and priorities of the JSNA, with 13% (n=15) reportedly determined by the Directors of Public Health and 40% (n=15) agreed by the
JSNA steering groups. One third (33%, n=15) of JSNA areas reported that the focus and priorities for their JSNA were negotiated with a strategic partnership, such as the Health and Wellbeing Partnership Board. One JSNA area held a formal workshop to set the focus and priorities, which was attended by representatives from the local authority, PCT and the third sector.

In those JSNA areas (40%, n=15) that chose to undertake specific comprehensive needs assessment, the way in which topics were identified and prioritised was undertaken in different ways. One JSNA area introduced a formal process for the identification and prioritisation of topics, ensuring the process is systematic and transparent. All requests for specific comprehensive needs assessment are submitted to the JSNA steering group via a standard form, which includes a Prioritisation Score Sheet (see case study below for further details). The JSNA steering group can then prioritise the requested topics using the prioritisation matrix and identify key needs assessments to be undertaken.

Case Study – Prioritisation in Portsmouth City JSNA

- Portsmouth JSNA area undertook a workshop with wide stakeholder involvement during which they identified clear joint priorities which helped to focus and steer the JSNA work.
- A matrix for prioritising commissioning decisions is used by NHS Portsmouth, where relevance to JSNA findings was one of the essential criteria.
- All topic requests for specific comprehensive needs assessments are submitted to the JSNA steering group using a standard form, which includes a Prioritisation Score Sheet. Topics are identified by commissioning managers, senior analysts and members of the public or service users through LINk and Community Networks, as well as through analysis of the core data set. The prioritisation score sheet sets out five key issues such as:
  - the extent of strategic fit with LSP, PCT or City Council priorities
  - evidence of stakeholder, resident or service user views
  - impact or effect on inequalities.
  - Each area is scored, as high (scores 3 points), medium (scores 2 points), low (scores 1 point) or zero (scores no points)

A maximum of 18 points is available within the matrix and a score greater than 12 identifies a topic as a high priority. The score sheet enables the JSNA Strategy Group and JSNA Responsible Directors to identify key priorities for the JSNA in a transparent way.

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The remaining 13% (n=15) stated that there was no strategic steer, but did not specify exactly how the focus and priorities were agreed.
We were unable to identify any formal processes being used to monitor or evaluate JSNA, other than as part of the statutory World Class Commissioning assessment. One JSNA area based their Children and Young People’s Plan (CYPP)\(^a\) on the five key areas identified in their JSNA, and therefore will be monitored via these indicators as part of the CYPP process.

Some JSNA areas did have agreed methodologies and quality measures for the JSNA work. For example, one JSNA area produced a standard framework for their comprehensive needs assessments in order to ensure all reports were undertaken in the same way and included the key elements. Two JSNA areas have undertaken a self assessment of their JSNA, with one area identifying a lack of engagement with district councils. As a result of the self assessment, they set up a series of presentations to inform the district councils about the JSNA and involve them in the ongoing process. One JSNA area is currently undertaking an evaluation to assess the impact of the JSNA work in their local area.

**Third sector engagement**

One of the key vehicles for involving the third sector was through the LSP but the level of engagement of LSPs in the JSNA process has been difficult to assess. Although LSPs or subgroups, such as the Health and Wellbeing Partnership Boards, were included in the governance structure of many JSNAs, only one JSNA area actually described the strategic partnership group or LSP as leading the process. As highlighted in the previous section, two thirds of all JSNA areas (67%, \(n=15\)) determined their focus and priorities with little evidence of a strategic steer. In these JSNA areas the LSP seemed to have a relatively passive involvement, mainly through regular governance updates. It was recognised that active LSP involvement can be more difficult if the council is not unitary and has several LSPs to coordinate. We will consider the role of LSPs in the utilisation of JSNA further in the next section – JSNA utilisation.

Local Involvement Networks (LINks) were another key mechanism for third sector engagement and some JSNA areas did report engaging LINks in the JSNA process, but mainly during the dissemination stage. As mentioned previously, two JSNA steering groups had membership from a LINks representative, therefore enabling LINks to have a more active role in the JSNA process. Three JSNA areas engaged individual third sector agencies directly through presentations, undertaken throughout the JSNA process to enable local third sector agencies to help shape the JSNA. One JSNA area used a workshop to engage the third sector and other local strategic partners. The JSNA workshop provided a forum to discuss and identify local priorities for the JSNA. This JSNA area has a unitary council with co-terminous PCT, with already established working relationships with wide strategic partners and they recognised that engagement for the JSNA slotted into existing channels.

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\(^a\) Children and Young People’s Plans (CYPPs) set out how Children’s Trust partners will work together to improve well-being for local children and young people.
Three JSNA areas are working to develop closer relationships with third sector agencies in order to improve engagement in the JSNA process, such as by inviting their representation on JSNA steering or project groups via LINks. One JSNA was unsuccessful in getting third sector involvement in their steering group due to capacity issues of the local third sector agencies. One respondent raised the issue that because of the strategic context of the JSNA, large two tier authorities find it challenging to adequately engage with the third sector, as the third sector rarely works across such a large geographical area.

Case study – Surrey JSNA ‘roadshows’

Surrey JSNA area used a series of ‘roadshows’ to raise the profile of JSNA in their area. They identified all key stakeholders across Surrey and organised a rolling programme of presentations in order to engage with a wide cross section of partners, including all district LSPs, Health Scrutiny, Acute Trusts, Community health services, local pharmacists and dentists (via the Local Medical Committee, Local Pharmaceutical Committee and Local Dental Council), LINks, Children Alliances, Care Association, Gypsy and Traveller forum, Age concern and Action for Carers.

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Wider engagement
Two thirds of all JSNA areas (67%, n=15) reported undertaking some form of consultation with the public, services users and carers specifically for the JSNA, mainly via existing channels, such as Local Involvement Networks (LINks) and User Led Organisation1 (ULO). Findings from previous consultations, local surveys, public events and complaints were all used to inform the JSNA work. The statutory 'Place Survey'2 was a key source used to gain public views and perspectives. Several JSNA areas felt that they needed to develop a process for the public to be able to voice their perspective of 'need'.

Case study – Local Consultation in Southampton

Southampton JSNA area undertook an extensive local survey and consultation to engage local people and organisations in the JSNA work. As part of the consultation, the Director of Public Health’s Annual Report (2007) ‘Changing Southampton’, was used as a tool to engage local stakeholders and raise the profile of the JSNA. The report provided a summary of local key issues, with specific questions for stakeholders to consider. The report included a questionnaire to facilitate feedback, which included questions to validate the key findings of the report. The issues raised in the stakeholder consultation were published in the City magazine, ‘Health Matters’ and both were made available on the PCT and CC websites. Local people were able to provide feedback about these publications and their key findings through direct consultations, via the website or by post. Southampton’s public engagement consultation, ‘What Southampton’s people told us’, lasted from November 2007 to March 2008. Key priorities from this consultation were based on data and information on inequalities, direct comments and feedback, as well as an adult lifestyle survey.

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1 User Led Organisations are organisations of and for disabled people that promote all aspects of independent living for disabled people, including provision of services that support independent living.

2 Introduced as a statutory survey in 2008, The 'Place Survey' is to be undertaken by local authorities every two years. The survey has been designed to capture local people’s views, experiences and perceptions of the quality of life in their local area, including the contribution of local public services.
Case study – ‘Day in the Life’ Research in Buckinghamshire

Buckinghamshire JSNA area is undertaking focused consultation with a small number of vulnerable children and young people to form a better understanding of their lives and the challenges they face. Six children/young people and their families will be visited a number of times by a researcher and will complete a series of activities, such as keeping a diary, taking a photo of their favourite place and describing their perfect day. These activities will enable the child/young person to communicate their lives and allow an insight into the world of each family. This qualitative research will feed into the JSNA and support improving services.

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4.2 How are JSNA findings utilised?

Strategic planning
Nearly all JSNAs (80%, n=15) were reported to inform Sustainable Community Strategies (SCS) and Local Area Agreement (LAA) discussions, with only two JSNAs areas reporting having no influence on these. Lack of influence seemed to be due to different time scales for the two duties, with the deadline for LAAs submission preceding their JSNA. In one JSNA area the timescales for the LAA worked to their advantage and the LAA process was being scoped alongside the JSNA, so it was easy for the JSNA to inform the LAA process.

Many JSNA areas (82%, n=11+) agreed that the JSNA helped to identify clear and agreed joint priorities. However, it was acknowledged that the competing priorities of different organisations presented a challenge to the process of agreeing joint priorities. JSNAs were reported to be referenced in a wide range of strategies and plans for both health and social care, such as Healthy Community Strategies, Primary Care Commissioning plans, Carers Strategy and Estates Strategy. One JSNA area representative felt that incorporating the JSNA priorities into individual organisation plans helped to systematically embed the JSNA in the core business of the organisations.

Three JSNA areas have identified a ‘JSNA champion’, such as a Chief Executive or Director, to maintain a high profile for JSNA and push the agenda forward. Many JSNA areas with two tier local authorities raised the issue that although JSNA informed county level planning, it was harder for it to feed down and inform district and borough level decisions. It was felt that this

+ Four JSNA areas did not answer this question.
could be due to lack of engagement with district and borough councils and this was an area identified for further work.

**Case Study – Engaging District Councils in West Sussex**

In West Sussex JSNA area the West Sussex Public Services Board (equivalent of the LSP) appointed the Chief Executive of Chichester District Council as the JSNA champion, which helped to raise the profile of JSNA in district councils and support their engagement.

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Health inequalities were identified as a particular area which was supported by the JSNA work. Not only did the JSNA work help to identify unmet need and health inequalities, but it also provided common evidence from which to co-ordinate a joint approach to tackle them. A representative from one JSNA area felt that by bringing partners together to identify issues, the JSNA had encouraged joint ownership of the problems and supported joint solutions. Although the same representative felt that some of the issues that the JSNA raised had also caused tensions between partners due to the conflicting agendas of different organisations.

**Case Study – Identifying Deprivation in Kent**

The JSNA work for Adults in Kent decided to include social marketing segmentation tools to identify the population profiles of people with long term conditions and people known to social services in Kent to better help commissioners understand the best ways to reach out to these groups. This approach challenged assumptions and found pockets of people living in deprivation in otherwise affluent areas and helped lead to changes in the approach to initiatives.

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Case Study – Oxfordshire’s ‘Rural Share of Deprivation’

The development of Oxfordshire’s ‘Rural Share of Deprivation’ has provided evidence of significant pockets of deprivation in rural areas, which were potentially hidden by a traditional focus on the urban Index of Multiple Deprivation (IMD) ‘hotspots’. Significant numbers of excluded people were identified in rural areas, with 15% of incapacity benefit claimants and 19% of household below the poverty line living in rural areas. The median age in rural areas was found to be nearly 6 years older than urban areas. The work identified that social care needs in rural areas are significant and growing fast, due to the increasingly ageing population.

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Comments from JSNA areas:

- ‘The JSNA has helped to join up the strategic approach and enabled key partners to align their individual organisation strategies with one another.’
- ‘The JSNA has become the central document to support all strategic planning, both for strategic partnerships and individual organisations.’
- ‘The JSNA has helped to demonstrate that health is an important outcome for local authority work and that it could be used to justify and support many of their work streams.’
- ‘The JSNA process has highlighted the need for better strategic links and integrated planning between health and social care in order to tackle common issues.’

Strategic commissioning

All JSNA areas (n=14*) reported that the JSNA had informed strategic commissioning decisions. Some JSNA areas found it easier than others to align the JSNA work with commissioning cycles, therefore allowing it to become fully integrated in the commissioning process. The need to engage commissioners in the JSNA process from the beginning was highlighted, as ‘ownership’ of the JSNA enabled the findings to inform commissioning decisions. Two representatives said that the JSNA had such a high profile and

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* Data missing for one JSNA area.
acceptance that ‘if it wasn’t in the JSNA, it was not a commissioning priority’ and that it had become generally accepted that funding followed the JSNA.

Six JSNA areas reported undertaking joint commissioning as a consequence of the JSNA, although it was recognised that JSNAs supported the practice. Two JSNA areas reported that they had established pooled budgets, one of which is undertaking a pilot to explore the possibilities of linking Personal Health Budgets with adult social care Personal Budgets. One JSNA steering group was a subgroup of the Joint Commissioning Board and could therefore influence joint commissioning directly. It was clear that the practice of joint commissioning was still becoming established and some JSNA areas were just starting to explore the possibilities of joint commissioning a range of community health and social care provision.

Comments from JSNA areas:
- ‘JSNA has allowed us to commission services in a more systematic way.’
- ‘JSNA has helped to standardise the approach to commissioning across health and social care, which supports joined up work.’

Case Study – Intelligent Commissioning Model in Brighton and Hove City Council

Brighton and Hove City JSNA area found that the JSNA work supported the City Council's move to an ‘intelligent commissioning’ model, introduced as part of the transformation programme. Intelligent commissioning is about creating services that focus on the needs of the local residents, which is exactly what JSNA is aiming to achieve. In order to support the new intelligent commissioning model, the City Council had to restructure senior management. The new structure involved creating a Strategic Leadership Board, Commissioning Group, Finance Unit, Delivery Units and Support Units. As well as changes in the structure of the City Council, the move to intelligent commissioning required a culture shift within the council. It was acknowledged that the JSNA work had paved the way for the introduction of the new model and provided an important source of information on which to base future commissioning decisions.

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Case Study – Joint Commissioning for Dementia in Kent

The Kent JSNA area undertook a JSNA for older people, focusing on the ageing population. The JSNA identified that there will be an increase in the need for domiciliary care, due to increasing disease morbidity. They focused on preventable diseases and used economic modelling to quantify the savings gained from investing in prevention. Their findings formed a powerful commissioning message, as they illustrated that massive savings could be made by tackling preventable diseases. The JSNA focused the PCT’s strategic commissioning plan on long term conditions and identified the need to embed prevention. Several initiatives came out of these findings, for example the PCT commissioned BUPA to provide health coaching to support patients with long term conditions in general practice. The JSNA informed the county council’s strategy for later life/dementia and led to a better understanding of personal care, which supported the increase in provision of domiciliary care. The JSNA also identified failings in the commissioning process across the local authority and PCT. This resulted in a new joint commissioning post to focus specifically on commissioning for dementia across health and social care. The joint commissioning post has enabled ‘true’ joint commissioning and allowed significant improvements in dementia care.

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Case Study – Joint Commissioning for Mental Health Services in East Sussex

The PCTs and the County Council’s Adult Social Care Department have for several years had a joint approach to strategic commissioning. The Joint Commissioning Strategy for Mental Health Services (2008-11) is an example of how clinical engagement and service user engagement (cited by the Sainsbury Centre as an example of national best practice) have reinforced a strategic approach rooted in needs assessment and the evidence base for clinical effectiveness, to deliver a range of modernised services including day opportunities and mental health in primary care teams focused on prevention, early intervention, recovery and social inclusion, configured to reflect local need.

A mental health comprehensive needs assessment was used to form the basis of the Commissioning Strategy, which was important in setting the context and prevalence of different mental health problems in the local population. Together with a review of models of best practice, this was used to scrutinise existing service provision, identify gaps and determine overall priorities for development and/or investment.

The inclusion in the needs assessment of psychiatric morbidity weightings showing geographical variations was used to calculate what would be ‘fair shares’ allocations reflecting needs, which in turn were used in re-designing day services, primary care services and rolling out expanded psychological therapies, by allocating resources to reflect where psychiatric needs could be expected to be greatest. These weightings were also used to assist the local Mental Health Foundation Trust to re-draw its boundaries for Community Mental Health Teams and the deployment of Consultant ‘patches’, again to ensure resources reflect underlying need.

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Service development and delivery
There was evidence that JSNAs have informed service development and delivery both across ‘joint’ services as well as services within individual organisations. All JSNAs areas (n=15) reported that their JSNA had influenced service development and delivery in some way. In many JSNA areas the JSNA had enabled them to identify key areas for service development and this was felt to have led to improvement in local services. The JSNA was identified as providing useful evidence for individual business cases to support service development.
**Case studies - Service Development**

- Surrey JSNA area developed their smoking cessation services by targeting populations of high smoking prevalence and focusing on areas with unmet need. The JSNA provided the evidence to identify where services should be targeting and provided a vehicle to engage in joint working at a district level. Development of the smoking cessation service enabled them to achieve their smoking cessation targets.

- West Sussex JSNA area identified unmet need in young families in areas of high deprivation. The PCT decommissioned their existing health visiting service and re-commissioned a new service, redistributing resources to increase coverage in areas of deprivation. Health visitors from rural affluent areas were moved to support health visitors working in deprived areas, thereby reducing the size of individual case loads and enabling greater support for young families in deprived areas.

- Buckinghamshire JSNA area identified domestic violence as an important issue in their area. They decommissioned services, such as some preventative services included in the youth offending service, to enable them to divert funds and commission more services to tackle domestic violence and support victims.

- Oxfordshire JSNA area has several examples of how JSNA has been used in service development and delivery.
  - JSNA findings were used by Oxfordshire PCT Trust Board to help determine the location of a new walk-in, GP led health facility.
  - The Community Development for Older People is directing additional resources into six wards which the JSNA identified as having the greatest need.
  - South Oxfordshire, Vale of White Horse and West Oxfordshire district councils have used joint analysis of housing needs to develop their Extra Care Housing provision.

**Comment from one JSNA area:**

‘The JSNA has encouraged us to analyse data in more innovative and interesting ways which adds value, such as using social marketing and ‘forecasting’, which has supported us in targeting services and developing robust services for the future.’
Role of the third sector
There was limited evidence of third sector involvement in the utilisation of JSNA findings across the region. One JSNA area was working closely with Age Concern to provide on-going support to Age Concern’s analysis of the needs of Older People.

Case Study – Community Link Worker in Kent

Eastern and Coastal Kent NHS, West Kent NHS, Medway NHS, Kent County Council and Medway Council undertook a Joint Strategic Needs Assessment focusing on mental health. The JSNA identified Thanet district as an area of deprivation with poor housing provision and the greatest need for mental health services. It is recognised that people with mental health issues are at increased risk of homelessness and stakeholders were concerned that the needs of those with mental health were not being met. Kent County Council and Eastern and Coastal Kent NHS worked together with the local homeless charity, Porchlight, to set up a Community Link Worker Project pilot in Thanet. The Community Link Worker is provided by Porchlight and works in partnership with three local GP surgeries in Thanet to assist people with low level mental health needs. GP’s identify people at risk and refer them to the Community Link Worker for support with practical issues, such as housing advice, debt counselling and budget management, that often accompany or trigger mental health difficulties. The Community Link Worker can support each person for up to eight weeks and help them to access specialist services, as well as promoting social inclusion through access to everyday services, such as libraries and education.

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Dissemination of JSNA findings
A wide range of methods were used across the region to disseminate JSNA findings. LINks was a common channel used to disseminate findings to the public, service users and carers. Dissemination was described by some JSNA areas as an ongoing process, involving presentations to key stakeholders. These individual presentations allowed them to tailor the information and present data at the relevant level for different stakeholders, such as district level for district LSPs and practice level (or aggregation of practices) for Practice Based Commissioning (PBC) groups in order for the findings to be meaningful to each stakeholder. One JSNA area had a rolling programme of presentations which coincided with local commissioning cycles.
Other methods of dissemination include:

- Key stakeholders sent the JSNA report/summary electronically via e-mail or sent hard copies for reference
- Stakeholder meetings or workshops to discuss findings and implications
- Local radio and press releases to inform the general public
- JSNA report/summary available on organisation websites

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**Case Study – Health and Social Care Maps in Kent**

NHS Eastern and Coastal Kent have developed health and social care maps to support GP commissioning in their area. These data tools describe specific parts of East Kent in both statistical and geographic terms so that local need can be more readily understood for the purposes of commissioning – specifically for PBC groups and potential GP Commissioning Consortia. Other non-NHS agencies are also using this resource.

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**4.3 Joint learning**

Similar challenges and barriers were identified across the region, but there were many positive outcomes from the JSNA process.

**Challenges**

An issue of ownership was identified as a challenge. It was recognised that JSNA sat more comfortably with ‘health’ partners initially and that many JSNAs were initially led and driven by the PCT. Lack of engagement by local authorities at a senior level was a barrier which had to be overcome in some JSNA areas, in order to ensure joint ownership of the JSNA. It was acknowledged by some LA representatives that a population ‘need’ based approach to commissioning required a culture shift and the challenge of changing their current practice.

Issues with data sharing and data sources were common barriers. It was highlighted that often information recorded in social care reflected performance, which is not always the most useful data. It was noted that it can be difficult to analyse LA data at a district level or below, due to the way the data are recorded. The robustness of data provided by wider partners was often an issue and some JSNA areas felt that further work to strengthen data sources was required. Data sharing issues were raised, for example local
authorities and PCTs have different protocols for dealing with small data sets and consider a different level of suppression\textsuperscript{*} appropriate to protect data confidentiality. It was suggested that national data sharing guidance to enable a uniform public sector approach to data sharing would support the JSNA work.

Lack of resources was identified as a challenge, in particular the availability of specialist analytical expertise. Some of the JSNA areas who had commissioned consultants to undertake the JSNA said they would not do so again. Using external consultants to undertake the work can prevent the development of local ‘in house’ skills, especially as JSNA is not just a one off project but an ongoing process. It was suggested that national or regional analytical support would be useful, particularly with areas of the core dataset that were obtained from national data. It was suggested that if national or regional analysts could provide trends/comparisons for the whole region by local authority or district areas, it would reduce their workload locally.

Issues were raised with the recommended structure of the recommended national core data set. The main problem identified was that the current format of domains made the data difficult to use and translate into useful information for commissioners. One JSNA area found the core data set so complex and confusing that it had a detrimental impact on the partnership and led to disengagement of partners in the JSNA. It was suggested that the core data set would be more useful if organised by topic areas (e.g. obesity and smoking) or specific groups (e.g. children and older people), rather than its current format. A few JSNA areas felt that national data guidance should provide high level headings, which allow JSNA areas the flexibility to make the data set locally relevant.

Several barriers to joint commissioning were identified, such as the fact that local authority and PCT commissioning cycles are not aligned, there are different budget accountabilities and the JSNA has to compete against other priorities at the level of stakeholders.

Meaningful engagement with stakeholders was identified as a challenge, particularly with large two tier local authorities, due to the complex geographical area and multiple stakeholders. Some JSNA areas recognised that they had not engaged fully with third sector agencies. The availability and capacity of key stakeholders was identified as a barrier to meaningful engagement. It was recognised that successful and representative public engagement could be difficult to achieve, but that more needed to be done to allow patients, carers and the general public a ‘voice’.

**Successes**
JSNA was identified as a vehicle to break down cultural barriers and the use of different language across health and social care. It was highlighted that having this joint source of intelligence reduced issues regarding duplication

\textsuperscript{*} Suppression means that data is not published if it could breach confidentiality, for example if a data set is too small and individuals could be determined from the data set.
and validity of data. The JSNA provided common evidence from joint intelligence, allowing partners to start ‘on the same page’. One JSNA area felt that the JSNA had facilitated a common understanding of respective priorities and led to a mutually agreed focus and process for the JSNA.

Sharing of resources, such as a shared data repository, joint appointments and integrated teams are other successes to come out of JSNA. One JSNA area acknowledged that partnership working was not particularly strong prior to JSNA, but the JSNA had highlighted the need to develop more robust joint processes to facilitate and support joint working. They are currently developing joint appointments and integrated teams to take this agenda forward.

An important outcome for the JSNA in one area was that it had led to identification of gaps in intelligence. As a result of actively searching for specific data to inform the JSNA, it became apparent that there was a lack of data for looked after children who are placed in the county by other local authorities. Once this was identified, a systematic process was put into place to ensure that important data were collated. The availability of these data will support better health and social care for vulnerable children being placed in the area.

Comments from JSNA areas:

- ‘JSNA supports joint working and there is greater impact in working collectively and using the same care pathways.’
- ‘JSNA has standardised the approach to commissioning across the local authority and PCT and supported joined up work.’
- ‘JSNA has provided an infrastructure of evidence for commissioners to use.’
- ‘The JSNA process has enabled a shared understanding of health inequalities and the wider determinants of health.’
- ‘JSNA has led to a better understanding of each other paradigms.’
- ‘People were now committed to the JSNA and resources have been aligned behind it.’
- ‘JSNA will provide useful evidence to support difficult decisions, which are inevitable in the current financial climate.’
5. Discussion
This review captures the JSNA journey across the region and demonstrates that the process is still developing. There are five key issues raised by this review that require further discussion: leadership and governance; JSNA process; engagement and ownership; strategic planning and commissioning; and future challenges.

Leadership and governance
It was interesting to note that many of the representatives who responded to take part in this review were based in a PCT and that two local authorities who did not take part in the review referred us to their PCT colleagues for information on JSNA. This does support the perception that ‘health’ has led the JSNA work. Whether it is that ‘health’ feel more comfortable with a population ‘need’ based approach or whether they are more experienced in data analysis – the review did not identify the answer to this. But it is, however, an interesting finding and maybe something that JSNA areas need to consider with the Coalition Government’s plans for local authorities (LAs) to lead JSNA. It would be important to establish in the coming months, how confident LAs feel to take the reins of the JSNA and start to transfer any skills or knowledge over to the LA to ensure continuity and embed the JSNA work in LA core business. This will be supported by the joint appointment of the Director of Public Health across the local authority and the proposed new public health service, Public Health England.

There is also the issue of strategic leadership of JSNA. The review highlighted that only one JSNA area describes the strategic partnership group or LSP as leading the process and two thirds of JSNA areas (67%, n=15) determine their focus and priorities with little evidence of a strategic steer. Strategic leadership is important for the JSNA, as it should represent a complete local picture of need, taking into account data and views from wide stakeholders. JSNA areas will need to address how to strengthen the strategic leadership role and the Coalition Government has set out that this will be through new health and wellbeing boards. It is proposed that the health and wellbeing boards will develop a joint health and wellbeing strategy, based on the JSNA, which will provide an overarching framework within which a locality can develop specific commissioning plans. The strength of having a joint source of evidence from which to base all local decision making and the power of collaboration to address the key issues must be recognised for the JSNA to reach its full potential. This ‘whole systems’ approach to health and wellbeing, such as supported by the ‘Total Place’ initiative can be both effective and efficient, particularly in addressing prevention of long term ill health and disability.

Practice Based Commissioning Groups (PBC groups and GP consortia) have been identified in the Coalition Government’s proposals as key stakeholders in future JSNAs. The recent Public Health White Paper states that, ‘GP consortia, local authorities and Directors of Public Health will each have an equal and explicit obligation to prepare JSNA through health and wellbeing boards’. As this review was started prior to the Coalition Government, we did not include specific questions to identify engagement with PBC groups.
However, our findings suggest that they were mainly involved in the dissemination stage of the JSNA process. This lack of engagement will need to be addressed in the coming months, as GP consortia will need to be fully engaged in the future JSNA process.

**JSNA process**

There is wide variation in the approach taken across the region and it became clear that JSNA means different things to different people. It was also apparent that JSNA is still evolving and that many JSNA areas have been developing and refining their JSNA process since its introduction in 2008.

JSNA is a process not a finite product, although the JSNA report or summary documents should be a product of this process. It was clear that individual JSNA areas have had to shape the JSNA process into a structure that would work for them locally. There was an apparent tension between identifying ‘high’ level need, to determine strategic priorities, and ‘low’ level need, to influence commissioning of specific services. The ‘breadth’ verse ‘depth’ approaches can be conflicting, but some areas addressed this with a combination of core data set analysis (to identify key strategic priorities) and specific needs assessments (to drill down into specific issues/service areas to inform commissioning). In this way, the service/issue specific needs assessments provide the evidence to support health and social care commissioning (see diagram below).

**Diagram 1: JSNA umbrella model**

We recognise that this model may be more of a challenge for complex two tier authorities, due to the multiple stakeholders and relatively large geographical area covered. There is evidence that many JSNA areas undertook specific needs assessments to drill down into issues raised by the JSNA, but did not include this work under the umbrella of JSNA. This shows the work is being undertaken and maybe the model is just about the JSNA process including
co-ordination and joining up of these needs assessments to feed into the strategic perspective, rather than starting a new stream of JSNA work.

There is a question as to whether the JSNA provides the right information for commissioners. It was also suggested by one respondent that some commissioners may not possess the skills and knowledge to use the JSNA data to its full potential. These issues were also raised in a recent briefing published by the North West Joint Improvement Partnership. Commissioners must be fully engaged in the JSNA process, both so that their requirements can be included in the JSNA and so they can understand the findings. This includes GP consortia who should be active participants in JSNA.

We would recommend that the product of JSNA is seen as a separate document to the Annual Public Health Report. Although Annual Public Health Reports (APHRs) have similar overarching goals to the JSNA (to improve health and wellbeing of the local population), the APHR should be a platform for the Director of Public Health to advocate independently for improving the health and wellbeing of the local population.

Engagement and ownership
The review highlighted that there had generally been poor engagement with the third sector, User Led Organisations, patients, public and carers throughout the JSNA process. It was also evident that two tier local authorities had found it a challenge to engage district and borough councils in the JSNA. These findings support previous work undertaken by DHSE on JSNA, which examined the extent to which housing needs were covered in the JSNA. Mechanisms for engagement of district and borough councils should be explored, such as appointing JSNA champions, to ensure ownership of the JSNA.

The third sector, User Led Organisations, and district and borough councils are all key stakeholders for the JSNA. These partners have information and influence over some of the wider determinants of health, such as housing, and have strong links with the public voice. A recent report by the Northern Housing Consortium also found that engagement with wider partners was variable across different JSNA areas in the north of England and identified that successful engagement was influenced by strong leadership and governance structures, which support close links between housing and health and social care. The importance of strong leadership and ownership of the JSNA were also identified by a recent report focusing on JSNA and vulnerable adults, housing and support. The report identified the need for clear leadership and governance structures with clarity of roles and responsibilities for all stakeholders, so wider partners were able to understand where they ‘fit into the local JSNA process’.

There are mutual benefits of engaging third sector agencies and User Led Organisations in the JSNA process, such as data sharing. These wider partners often have access to local data that is not available from any other source, such as capturing data regarding marginalised groups and those with
specialist or complex needs (e.g. homeless). In turn, the JSNA can be a useful resource to inform third sector work, such as to support them putting together business cases for new funding or for their own strategy development and service planning. Dissemination of the JSNA findings to the third sector and engaging them in planning the solutions to tackle the issues raised by the JSNA is a key step in the JSNA process. Working collaboratively is likely to be more effective than working separately and will have the greatest impact on local health and wellbeing.

Engagement through established networks, such as LINks and district or borough council networks was limited. It is important that the use of existing networks is maximised, particularly for JSNAs that cover large geographical areas, as networks will enable engagement with a wide range of smaller organisations or communities and ensure their voice is heard. The recently updated ‘Carers Strategy’\(^6\) states that the JSNA should routinely engage with carers of all ages to ensure the needs of carers in the local population are adequately identified. Issues of engagement with the third sector were considered in a recent briefing paper published by the National Association for Voluntary and Community Action (NAVCA)\(^7\), which emphasises the importance of developing, strengthening and maximising the use of local networks to support engagement of voluntary and community groups in the JSNA.

Our review identified some barriers to successful engagement with third sector and User Led Organisations, such as capacity issues. A recent briefing paper by the Voluntary Organisation Disability Group\(^8\) considered how the role of the voluntary sector and community engagement could be more effectively embedded in JSNA. It was suggested that capacity issues could be addressed by offering in-kind support, such as setting up data collection systems and interpreting data or including participation in the JSNA in contracts with the voluntary sector.\(^9\) Other recommendations included the need to promote a better understanding of JSNA and the importance of establishing a clear role for the third sector.

We did identify some examples of successful public engagement (see case studies), but more work needs to be done to develop and strengthen channels for consultation and feedback so the public can voice their perspective of ‘need’. New proposals, such as HealthWatch\(^3\) and the Big Society\(^4\) could help strengthen the voice of the public and support them to contribute to the JSNA work.

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\(^3\) HealthWatch is proposed to replace the Local Involvement Networks (LINks) and would continue to promote patient and public involvement in local health and social care services. It is envisaged that HealthWatch will also take on additional roles, including providing an NHS complaints advocacy service and supporting individuals to exercise choice, such as helping them choose a GP practice.

\(^4\) Big Society is a vision by the Coalition Government to empower local people and communities to form a strong society, taking the power away from the politicians and giving it to the people.
**Strategic planning and commissioning**

It was recognised that JSNA was a tool to support joint working and there were examples of how some JSNA had led to joint commissioning, but it was clear from the review that joint commissioning is still at an early stage in many JSNA areas. This is likely to be due to the potential barriers to joint working, several of which were identified by the review, such as lack of alignment of commissioning cycles between local authority and PCTs, different budget accountabilities and competing priorities. The proposed changes to health and social care will influence these issues and should support integrated commissioning. The local authority will be working with new partners, such as GP consortia, therefore potential barriers to any future joint commissioning should be identified early and addressed.

**Future challenges**

The proposed changes to the structure of health and social care will present many new challenges for JSNA. It will be important for JSNA areas, particularly local authorities, to consider whether their current JSNA process will support delivery of the White Paper proposals, particularly with regards to GP commissioning consortia. The review highlighted that very few JSNA areas had undertaken an evaluation of their JSNA, other than as part of their World Class Commissioning assessment. An evaluation of the current state of JSNA is imperative, as it will enable JSNA areas to plan their local transition.

Although not identified as an issue from the field work for the study, the introduction of Personal Budgets in adult social care and Personal Health Budgets within the NHS may present a challenge to the JSNA. The current JSNA guidance emphasises that the JSNA should focus on population need stating that ‘Needs assessment is an essential tool for commissioners to inform service planning and commissioning strategies. For the purpose of a JSNA, a clear distinction should be made between individual and population need. JSNA examines aggregated assessment of need and should not be used for identifying need at the individual level’. As increasing numbers of people start to organise their own care and support, health and social care commissioners will have a role to play in aggregating these individual purchasing decisions in order to help shape the provider market. Such information may also be relevant for the JSNA. This is an area that requires further consideration.

Local authorities will have to build new partnerships, particularly with GP consortia and the new NHS Commissioning Board. Local authorities will also have to establish and lead the new health and wellbeing boards. The work that has been undertaken in JSNA areas so far will be a strong platform for local authorities to continue the ‘need’ based approach. It is important that local authorities use what they have learnt from the JSNA work, especially their increased awareness of the ‘health’ perspective, to their advantage so future partnerships benefit from this ‘head start’.

The JSNA process has come a long way since its introduction and there are many examples of good practice across the region. The work that has been
undertaken so far to develop and embed JSNA should provide strong foundations for the future changes in health and social care policy.

6. Recommendations for developing JSNA across the region

a) Leadership and governance
1. Establish clear lines of accountability and governance throughout the JSNA process
2. Strengthen strategic leadership of JSNA process, including input from third sector agencies and community representatives
3. PCT to support the LA to start leading the JSNA work, if not already, to enable smoother transition with future changes in health and social care and embed JSNA in core LA practice
4. Ensure better use of scarce analytical resources

b) JSNA process
5. Ensure that priorities and focus for JSNA is negotiated with wider partners, for example through the LSP
6. Be inclusive – involve both health and social care commissioners, third sector agencies and User Led Organisations at all stages of the JSNA process
7. Be creative with the structure of the core data set, such as arranging by themes or topic areas – make it work for you locally
8. Supplement the core data set with locally agreed data
9. As well as analysis of the core data set, the JSNA process should include a system for collating health and social care needs assessments to provide an evidence base for local commissioning decisions
10. Establish a regional intelligence resource with analysis of a sub-core data set, to prevent duplication and support consistency
11. Evaluate JSNA work in order to improve current process
12. JSNA and APHR should be separate, though clearly related reports

c) Engagement
13. Develop channels for consultation and feedback so the public can voice their perspective of ‘need’
14. Develop engagement strategy for JSNA work, including engagement with district and borough councils (in two tier authorities)

d) Strategic planning and commissioning
15. Establish joint processes across health and social care, such as alignment of planning process and commissioning cycles
16. Encourage and develop integrated teams and joint appointments
17. Have a JSNA champion to maintain a high profile for JSNA and push the agenda forward
18. Strengthen communication channels between strategic leads, analysts and commissioners
### Appendix 1: JSNA areas mapped to local authorities and PCTs

<table>
<thead>
<tr>
<th>JSNA area</th>
<th>PCT</th>
<th>Local Authority</th>
<th>Number of District/Boroughs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Berkshire East</td>
<td>NHS Berkshire East</td>
<td>Bracknell Forest</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td>(undertakes three separate JSNAs for each unitary authority)</td>
<td>Slough</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Windsor and Maidenhead</td>
<td>N/A</td>
</tr>
<tr>
<td>Berkshire West</td>
<td>NHS Berkshire West</td>
<td>Reading</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td></td>
<td>West Berkshire</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Wokingham</td>
<td>N/A</td>
</tr>
<tr>
<td>Brighton and Hove City</td>
<td>NHS Brighton and Hove City</td>
<td>Brighton and Hove City</td>
<td>N/A</td>
</tr>
<tr>
<td>Buckinghamshire</td>
<td>NHS Buckinghamshire</td>
<td>Buckinghamshire</td>
<td>4</td>
</tr>
<tr>
<td>East Sussex</td>
<td>NHS East Sussex Down and Weald and NHS Hastings and Rother</td>
<td>East Sussex</td>
<td>5</td>
</tr>
<tr>
<td>Hampshire</td>
<td>NHS Hampshire</td>
<td>Hampshire</td>
<td>11</td>
</tr>
<tr>
<td>Isle of Wight</td>
<td>NHS Isle of Wight</td>
<td>Isle of Wight</td>
<td>N/A</td>
</tr>
<tr>
<td>Kent</td>
<td>NHS West Kent NHS Eastern and Coastal Kent</td>
<td>Kent</td>
<td>12</td>
</tr>
<tr>
<td>Medway</td>
<td>NHS Medway</td>
<td>Medway</td>
<td>N/A</td>
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<tr>
<td>Milton Keynes</td>
<td>NHS Milton Keynes</td>
<td>Milton Keynes</td>
<td>N/A</td>
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<tr>
<td>Oxfordshire</td>
<td>NHS Oxfordshire</td>
<td>Oxfordshire</td>
<td>5</td>
</tr>
<tr>
<td>Portsmouth City</td>
<td>NHS Portsmouth City Teaching PCT</td>
<td>Portsmouth</td>
<td>N/A</td>
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<tr>
<td>Southampton City</td>
<td>NHS Southampton City</td>
<td>Southampton</td>
<td>N/A</td>
</tr>
<tr>
<td>Surrey</td>
<td>NHS Surrey</td>
<td>Surrey</td>
<td>11</td>
</tr>
<tr>
<td>West Sussex</td>
<td>NHS West Sussex</td>
<td>West Sussex</td>
<td>7</td>
</tr>
</tbody>
</table>
### Appendix 2: Semi-structured questionnaire

**Name:**  
**Role:**  
**Organisation:**  
**Relationship to JSNA:**

#### Process: How are JSNAs undertaken?

<table>
<thead>
<tr>
<th>Prompts: (tick as covered)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Who leads the JSNA project? (Health, LA, partnership group, including post/title/seniority/reporting arrangements)</td>
<td></td>
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<tr>
<td>Does the JSNA have a project manager and dedicated staff?</td>
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<tr>
<td>What are the governance arrangements and lines of accountability for JSNA project?</td>
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<tr>
<td>What format did your JSNA take?</td>
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<tr>
<td>What best practice guidance is used to inform the work?</td>
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<tr>
<td>Which stakeholders are involved?</td>
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<tr>
<td>Were the general public involved/engaged in the process?</td>
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<tr>
<td>How are JSNA focus and priorities defined?</td>
<td></td>
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<tr>
<td>Did the JSNA include the full core dataset?</td>
<td></td>
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<tr>
<td>Is there a local delivery plan or equivalent?</td>
<td></td>
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<tr>
<td>How often are JSNAs undertaken or are they part of an on-going cycle?</td>
<td></td>
</tr>
<tr>
<td>How, if at all, are JSNAs monitored and evaluated in terms of process, informing strategic frameworks, outcome, etc.?</td>
<td></td>
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</tbody>
</table>

#### Utilisation: How does the JSNA improve local planning, commissioning, service delivery and joint working?

<table>
<thead>
<tr>
<th>Prompts: (tick as covered)</th>
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</thead>
<tbody>
<tr>
<td>What are the direct outcomes of the JSNA?</td>
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<tr>
<td>Did the JSNA identify unmet need and inequalities? Please evidence or give examples</td>
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</tr>
<tr>
<td>How are the JSNA findings used to inform the strategic planning and commissioning for social and health care provision? Please evidence or give examples</td>
<td></td>
</tr>
<tr>
<td>Were clear and agreed joint priorities for local action derived from the JSNA? Please evidence or give examples</td>
<td></td>
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<tr>
<td>Did JSNA directly inform the LAA process? Please evidence or give examples</td>
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<tr>
<td>Have JSNA findings improved strategic linkages and integrated planning? Please evidence or give examples</td>
<td></td>
</tr>
<tr>
<td>Can you give examples of JSNA informing local commissioning and policy making e.g. PCT operational plans/LA commissioning strategies</td>
<td></td>
</tr>
<tr>
<td>How has JSNA contributed to WCC competencies?</td>
<td></td>
</tr>
<tr>
<td>Can you give an example where JSNA has been instrumental in informing a development or in commissioning/decommissioning a service?</td>
<td></td>
</tr>
<tr>
<td>How were the JSNA findings disseminated to other key stakeholders (whom)?</td>
<td></td>
</tr>
<tr>
<td>Is there a process of public consultation and dissemination?</td>
<td></td>
</tr>
</tbody>
</table>

#### Joint learning: Barriers, challenges, opportunities, examples of good practice, etc.

<table>
<thead>
<tr>
<th>Prompts: (tick as covered)</th>
<th></th>
</tr>
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<tbody>
<tr>
<td>What worked well for you?</td>
<td></td>
</tr>
<tr>
<td>What barriers and challenges did you have to overcome during the JSNA process?</td>
<td></td>
</tr>
<tr>
<td>What would you do differently next time?</td>
<td></td>
</tr>
<tr>
<td>What does your local partnership need to do to improve (if at all) utilisation of JSNAs?</td>
<td></td>
</tr>
<tr>
<td>What support do LAs/PCTs/partnership groups require in terms of integrating other strategic planning with JSNAs?</td>
<td></td>
</tr>
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</table>
Appendix 3: JSNA Peer Review Benchmark

Joint Strategic Needs Assessment Peer Challenge

Benchmark

May 2010
Introduction

Section 116 of the Local Government and Public Involvement in Health Act (2007) places a duty on upper tier local authorities and Primary Care Trusts (PCTs) to undertake Joint Strategic Needs Assessment (JSNA). Department of Health Guidance defines JSNA as the process that will identify the current and future health and well being needs of a local population, informing the priorities and targets set by Local Area Agreements and leading to agreed commissioning priorities that will improve outcomes and reduce health inequalities.

The duty to undertake JSNA commenced on 1st April 2008 and the majority of local authorities and PCTs are either in the process of refreshing/reviewing their JSNA or developing their second generation JSNA.

Several local authorities and Primary Care Trusts (PCTs) have approached the Healthy Communities Team to undertake an external challenge of their JSNA. This benchmark has been produced to support the JSNA peer challenge process.

The peer challenge is a constructive and supportive process with the central aim of helping councils and their health partners to embed a strong and effective JSNA process. It is not an inspection nor does it award any form of rating category. It is undertaken from the viewpoint of a ‘critical friend’, holding a mirror up to the council and health partners. The peer challenge will help councils and primary care trusts to assess the effectiveness of their current JSNA process and to identify those areas in which it could improve.

The peer challenge involves an assessment against the JSNA benchmark which draws on statutory JSNA Guidance produced by the Department of Health and explores:

1. **The process of undertaking the JSNA**: looks at governance and leadership; partnership arrangements; community and wider stakeholder engagement; and alignment with key strategies and plans
2. **The format and content of the JSNA**: examines the data covered in the JSNA and accessibility
3. **Using the JSNA**: recognises that a powerful JSNA is one that influences commissioning decisions, priorities and supports the achievement of positive outcomes for local communities,

The peer challenge is undertaken by a team including Local Government Improvement and Development member and officer peers, who, undertake a “critical read” of the JSNA, assessing the extent to which there is ‘read across’ between the JSNA and key strategies and plans. This is followed up by a series of face to face or phone interviews and focus group discussions with key stakeholders, including:

Executive member/portfolio holder for adult and health
Scrutiny lead for health and wellbeing
PCT Board Chair

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Chief Executive of the Council

Director of public health
Director of children’s services
Director of adult services
Director/lead for partnerships

Commissioning leads from local authority and PCT

Research and data analysts

Voluntary and community sector groups
LINks

Other individuals and organisations as agreed prior to commencing the peer challenge

This benchmark has been produced to support peers in carrying out the JSNA peer challenge. It is not wholly a technical document. Instead, it provides some broad headings / themes for peers to use as “pointers” to help with assessing JSNAs. What is more important is that the peer challenge draws on the expertise, knowledge, experience and perspectives of peers.

For more information about JSNA peer challenge, contact Lorna Shaw by phone (07917 831 745) or email: lorna.shaw@local.gov.uk
The content of the benchmark

The benchmark focuses on 3 key areas:

1. Undertaking the JSNA
2. The content of the JSNA
3. Using the JSNA

1. **Undertaking the JSNA** – this focuses on the *process* of developing the JSNA and covers the following key elements:

   - Leadership and ownership
   - Linkage of the JSNA with key local plans and strategies
   - Partnership working between the trio of Directors of Children’s Services, Public Health and Adult Social Care in undertaking the JSNA
   - Involvement and engagement
   - Resourcing the JSNA process
   - Performance and risk management

2. **The Content of JSNA** - Clearly, JSNA is not about the production of a document but about local authorities, NHS and other key partners, working together to establish an over-arching, evidence-based consensus on local priorities for health and wellbeing. This section focuses on:-

   - Data and intelligence
   - Format of the JSNA

3. **Using the JSNA** – Ultimately, the JSNA is about delivering better health outcomes, reducing health inequalities and making a difference to the health and well being of local communities; key to this is the extent to which the JSNA informs prioritisation and how priorities, in turn, translate into commissioning requirements. This section focuses on understanding the impact of JSNA on:

   - Commissioning and decision making
   - Addressing the wider social determinants
   - Delivering better health outcomes for local communities
### Section 1: Undertaking the JSNA

<table>
<thead>
<tr>
<th>Key element</th>
<th>Ideal JSNA</th>
<th>Probes</th>
<th>Key documentation and Evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Leadership and ownership</td>
<td>1.1 The JSNA is embedded in Council and PCT decision making arrangements (e.g. Cabinet and PCT Board).</td>
<td>- The JSNA is “owned” by the key decision makers.</td>
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<tr>
<td></td>
<td>1.2 The JSNA is integrated within the LSP’s wider strategic priorities and ambitions for the area as reflected in the Sustainable Community Strategy.</td>
<td>- The JSNA is rooted in Council and PCT/NHS systems, processes and services (e.g. spatial planning, hospitals, etc) beyond the ‘usual suspects’ of health and social care.</td>
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<tr>
<td></td>
<td>1.3 The JSNA reflects the specific contributions of the LSP and thematic partnerships in achieving the priorities</td>
<td>- The JSNA identifies how the LSP / thematic groups have shaped it.</td>
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</tr>
<tr>
<td></td>
<td>1.4 The JSNA is owned by the leaders and employees across the Council and by its partner organisations</td>
<td>- The JSNA identifies how the LSP/thematic groups will contribute to realising the priorities.</td>
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<tr>
<td></td>
<td>1.5 The Council exercises its community leadership</td>
<td>- There is evidence of dedicated resources to undertake the JSNA</td>
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<td>Key element</td>
<td>Ideal JSNA</td>
<td>Probes</td>
<td>Key documentation and Evidence</td>
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<tr>
<td>role in ensuring that the JSNA is widely understood and owned by all partner organisations.</td>
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<tr>
<td>Strategy and Plan alignment</td>
<td>1.6 There is strategic alignment and linkage of the JSNA with a range of key local strategies and plans</td>
<td>- The extent to which the JSNA aligns with key local strategies and plans, including the Sustainable Community Strategy, Children and Young People's Plan, Local Area Agreement, Local Development Framework, Housing Strategy, Safeguarding Policies and strategies supporting vulnerable adults, commissioning strategies, etc.</td>
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<td></td>
<td>1.7 The JSNA demonstrates a clear understanding of the current and future health and well being needs of the population, over both the short term (three to five years) to inform Local Area Agreements, and the longer term future (five to ten years) to inform strategic planning.</td>
<td>- As a minimum, the JSNA aligns with three-yearly LAA planning cycles.</td>
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<td>1.8 The JSNA makes clear linkages to the Equalities</td>
<td>- There is a clear planning cycle in place for updating the JSNA in response to</td>
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<tr>
<td>Key element</td>
<td>Ideal JSNA</td>
<td>Probes</td>
<td>Key documentation and Evidence</td>
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<tr>
<td>Partnership working</td>
<td>1.9 There is joint and co-ordinated ownership of the JSNA by key partners</td>
<td>- The JSNA has been undertaken jointly by the Directors of Public Health, Adult Social Services and Children’s Services working in collaboration</td>
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<tr>
<td></td>
<td>1.10 The process of developing the JSNA has been inclusive and includes partners other than health and social care, e.g. third sectors, ALMOs, etc.</td>
<td>- The JSNA articulates how partners have contributed to it and how the JSNA will shape their own actions.</td>
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<tr>
<td></td>
<td>1.11 The role and contribution of the third sector in delivering the JSNA priorities is clearly understood and reflected.</td>
<td>- The JSNA is used as part of a debate with the LSP and local communities about “what needs to be done around here”.</td>
<td></td>
</tr>
<tr>
<td>Involvement and Engagement</td>
<td>1.12 The JSNA process actively engages with communities, patients, service users, carers, and providers including the third and private sectors to develop a full</td>
<td>- There is effective community and third sector engagement in all stages of the JSNA process – identifying needs, determining priorities, service delivery, and</td>
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<tr>
<td>Key element</td>
<td>Ideal JSNA</td>
<td>Probes</td>
<td>Key documentation and Evidence</td>
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</table>
| understanding of needs, with a particular focus on the views of vulnerable groups. 1.13 Local people understand and support the priorities for their communities as set out in the JSNA | evaluating outcomes  
- The extent to which local authorities and PCTs are working together to engage communities  
- A variety of different approaches and mechanisms are used to encourage the widest range and diversity of voices to be heard  
- Local people understand and support the priorities for their communities as set out in the JSNA  
- The JSNA has been taken to Health Scrutiny  
- LINks have been involved in the process of developing the JSNA and their views have been integrated into the JSNA  
- Specific attention has been paid to accessing groups who are |
<table>
<thead>
<tr>
<th>Key element</th>
<th>Ideal JSNA</th>
<th>Probes</th>
<th>Key documentation and Evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Resourcing the JSNA</td>
<td>1.13 There is evidence that the PCT and local authority have organised an appropriate response through effective resourcing of the JSNA project</td>
<td>- Resources in the form of, for example: dedicated team, JSNA programme manager</td>
<td></td>
</tr>
</tbody>
</table>
| Performance and risk management | 1.14 The JSNA process incorporates a robust joined up risk management process  
1.15 There is a defined performance monitoring framework which includes key elements of JSNA progress | - There is evidence of risk management process in place and working effectively  
- Management information is used to monitor progress against performance targets and is fit for purpose  
- Performance indicators and targets are prioritised and linked to JSNA, PCT and council strategic objectives |                                |
Section 2: The Content of JSNA

<table>
<thead>
<tr>
<th>Key element</th>
<th>Ideal JSNA</th>
<th>Probes</th>
<th>Evidence</th>
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</thead>
<tbody>
<tr>
<td>Data and intelligence</td>
<td>2.1 The JSNA addresses those outcomes described in both the National Indicator Set for local authorities and local authority partnerships, and the priorities / “vital signs” referred to in <em>The NHS in England: The Operating Framework for 2010/2011</em> 2.2 The JSNA contains relevant, accurate information, gathered from a variety of sources, partners and directions. 2.3 The information contained in the JSNA is accessible, easy to understand and is shared across the whole council and its partners. 2.4 The JSNA articulates how information is gathered and how decisions are made on the basis of the information available.</td>
<td>▪ The JSNA is based on high quality data including National Dataset, locally relevant information and insight from local communities into their needs  ▪ The data tells the story about the “people and place”  ▪ There is locally agreed standards on data quality for inclusion, risks attached to using available data is identified.  ▪ The data and intelligence in the JSNA provides a robust local test of whether a fair and equitable approach is being taken to meet the health and well being needs of local people.  ▪ Demography, epidemiology, and linked analyses are well presented and explained  ▪ The data balances both quantitative and qualitative information  ▪ The JSNA identifies relevant best practice, innovation</td>
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<tr>
<td>Key element</td>
<td>Ideal JSNA</td>
<td>Probes</td>
<td>Evidence</td>
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<tr>
<td>and research to inform how needs will best be met.</td>
<td></td>
<td>- The JSNA addresses the health of mobile and transient populations, particularly where there is “churn”, areas with high student populations and people living in housing in multiple occupations.</td>
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<td>- The JSNA demonstrates an understanding of the causes of poor health and death of people aged 50 and under and effective interventions, based on evidence of “what works”</td>
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<td></td>
<td>- The JSNA actively identifies cases/people who are at risk of dying prematurely</td>
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<tr>
<td>Format</td>
<td>2.5 The published findings of the JSNA is a concise summary of the main health and wellbeing needs of the local community as opposed to a large, technical document.</td>
<td></td>
<td>- There is a clear and easy to follow structure</td>
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<tr>
<td></td>
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<td>- The JSNA is accessible to the public; it reflects community involvement</td>
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<td></td>
<td>- A web-based version of the JSNA</td>
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<td>- There is a clear</td>
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</tr>
<tr>
<td>Key element</td>
<td>Ideal JSNA</td>
<td>Probes</td>
<td>Evidence</td>
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<td></td>
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<td></td>
<td>shared understanding that JSNA is a progressive and iterative ongoing process</td>
</tr>
</tbody>
</table>
### Section 3: Using JSNA

<table>
<thead>
<tr>
<th>Key element</th>
<th>Ideal JSNA</th>
<th>Probes</th>
<th>Evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Commissioning and decision making</td>
<td>3.1 The JSNA identifies the outcomes that commissioning bodies want to achieve on behalf of communities based on robust analysis to enable priorities to be determined.</td>
<td>■ The JSNA process has engaged Commissioning Officers</td>
<td></td>
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<td></td>
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<td>■ The specifications required of the JSNA process from commissioners are clear and explicit.</td>
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<td></td>
<td>■ Decision making processes in defining and agreeing priorities are transparent and undertaken in partnership</td>
<td>■ There is evidence that steps have been taken to ensure commissioning managers and officers are aware of the JSNA and are using the information to develop commissioning and service plans</td>
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<td></td>
<td></td>
<td>■ The JSNA has helped commissioners to engage in outcomes-based commissioning</td>
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<td></td>
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<td>■ Commissioners are able to identify examples of where things have changed because of JSNA</td>
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<td></td>
<td></td>
<td>■ The extent to which the JSNA has informed commissioning decisions / led to agreed commissioning priorities,</td>
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<tr>
<td>Key element</td>
<td>Ideal JSNA</td>
<td>Probes</td>
<td>Evidence</td>
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<tr>
<td>There are evident connections with the LAA targets and priorities</td>
<td>▪ There are evident connections with the LAA targets and priorities</td>
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</tr>
<tr>
<td>The JSNA informs World Class Commissioning</td>
<td>▪ The JSNA informs World Class Commissioning</td>
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<tr>
<td>There is a systematic way of generating options and choosing priorities using existing tools such as Ready Reckoner, Calibration and key information inside the area.</td>
<td>▪ There is a systematic way of generating options and choosing priorities using existing tools such as Ready Reckoner, Calibration and key information inside the area.</td>
<td></td>
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</tr>
<tr>
<td>3.3 The JSNA is Marmot-proof, i.e. addresses the preconditions for good health, such as housing, education, etc.</td>
<td>▪ The JSNA reflects ‘upstream’ interventions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Marmot and the wider social determinants</td>
<td>3.3 The JSNA is Marmot-proof, i.e. addresses the preconditions for good health, such as housing, education, etc.</td>
<td></td>
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</tr>
<tr>
<td>Impact on health outcomes and making a difference</td>
<td>3.4 There is evidence of the impact of JSNA in reducing health inequalities and delivering better outcomes for local communities</td>
<td></td>
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<tr>
<td></td>
<td>▪ The JSNA clearly identifies health inequalities</td>
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</table>
### Appendix 4: Core Dataset for Joint Strategic Needs Assessment

<table>
<thead>
<tr>
<th>Domain</th>
<th>Sub-domain</th>
<th>Sub-sub-domain</th>
<th>Indicator</th>
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<tr>
<td>Demography</td>
<td>Population numbers</td>
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<td>Estimated and projected population by age-band and gender</td>
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<tr>
<td></td>
<td>Births</td>
<td></td>
<td>Current births</td>
</tr>
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<td>Ethnicity</td>
<td></td>
<td>Estimated population by ethnic group</td>
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<tr>
<td></td>
<td>Disability</td>
<td></td>
<td>Estimated number of disabled people, overall and/or by impairment group</td>
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<tr>
<td></td>
<td>Religion</td>
<td></td>
<td>Estimated population by religious group</td>
</tr>
<tr>
<td></td>
<td>Migrant population</td>
<td></td>
<td>Estimated population by migrant status</td>
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<tr>
<td></td>
<td>Local area</td>
<td></td>
<td>Number of households</td>
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<td>Breakdown of area into constituent communities/neighbourhoods</td>
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<td>Deprivation band</td>
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<td>ONS classification</td>
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<td>Social marketing categories</td>
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<td>Urban/rural classification</td>
</tr>
<tr>
<td>Social and environmental context</td>
<td>Poverty</td>
<td></td>
<td>Proportion of children in poverty</td>
</tr>
<tr>
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<td>Living arrangements</td>
<td>Housing</td>
<td>Housing tenure</td>
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<td>Overcrowding</td>
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<td></td>
<td>Adults with learning disabilities in settled accommodation</td>
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<td></td>
<td>Adults in contact with secondary mental health services in settled accommodation</td>
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<td>Living alone</td>
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<td>Central heating</td>
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<td></td>
<td></td>
<td>Transport</td>
<td>Access to car or van etc</td>
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<td>Employment</td>
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<td>Overall employment rate</td>
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<td>Working age people on out-of-work benefits</td>
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<td>Working age people claiming out-of-work benefits in the worst performing neighbourhoods</td>
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<td>Adults with learning disabilities in employment</td>
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<td>Adults in contact with secondary mental health services in settlement</td>
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<tr>
<td>Environment</td>
<td>Unemployment</td>
<td>Claimant count</td>
<td>Other</td>
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<tr>
<td>Voice</td>
<td>Isolation</td>
<td>Access to services</td>
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<td>Smoking</td>
<td>Modelled and/or recorded smoking prevalence</td>
<td>Quit rates</td>
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<tr>
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<td>Eating habits</td>
<td>Modelled and/or recorded eating behaviour</td>
<td>Prevalence of breastfeeding at 6-8 weeks from birth</td>
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<td>Alcohol-harm related hospital admission rates</td>
<td>Modelled and/or recorded drinking behaviour</td>
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<td>Physical activity</td>
<td>Participation in sport and active recreation</td>
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<td>Teenage pregnancy</td>
<td>Under 18 conceptions</td>
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<td>Under 16 conceptions</td>
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<td>Modelled and/or recorded hypertension</td>
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<td>Obesity</td>
<td>Obesity among primary school age children in Reception Year</td>
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<td>Obesity among primary school age children in Year 6</td>
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<td>Burden of ill-health</td>
<td>Miscellaneous</td>
<td>All causes</td>
<td>All-Age All-Cause Mortality</td>
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<td>Life expectancy</td>
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<td>Main causes of death</td>
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<td>Hospital admissions – top 10 causes</td>
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<td>Self-reported measure of overall health and wellbeing</td>
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<td>Healthy life expectancy at age 65</td>
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<td>Causes considered amenable to healthcare</td>
<td>Mortality rate from causes considered amenable to healthcare</td>
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<td>Due to smoking</td>
<td>Deaths attributable to smoking</td>
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<td>Condition</td>
<td>Type</td>
<td>Measure</td>
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<tr>
<td>Diabetes</td>
<td>General</td>
<td>Modelled v. recorded prevalence</td>
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<td></td>
<td>Estimated excess deaths among people with diabetes</td>
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<td>Circulatory</td>
<td>General</td>
<td>Mortality rate from all circulatory diseases under 75</td>
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<td>Modelled v. recorded prevalence</td>
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<td>Hospital admission rate for MI (proxy for incidence)</td>
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<tr>
<td>Stroke</td>
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<td>Admissions for cardiac revascularisation</td>
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<td></td>
<td></td>
<td>Mortality</td>
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</tr>
<tr>
<td></td>
<td></td>
<td>Hospital admission rate for stroke (proxy for incidence)</td>
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<tr>
<td>Cancer</td>
<td>General</td>
<td>Mortality rate from all cancers under age 75</td>
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<td>By site</td>
<td>Cancer registrations</td>
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<td>Respiratory</td>
<td>COPD</td>
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<td>COPD modelled v. recorded prevalence</td>
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<td>Infectious</td>
<td>STIs &amp; HIV</td>
<td>KC60 GUM STI data, particularly gonorrhoea</td>
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<td>New diagnoses of HIV/AIDS</td>
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<td>Late diagnoses of HIV/AIDS</td>
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<td>Uptake of Chlamydia screening in under-25s</td>
<td></td>
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<tr>
<td>Dental health</td>
<td>Decay</td>
<td>% dmft in 5-year olds</td>
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<td>Mental health</td>
<td>Dementia</td>
<td>Prevalence of dementia</td>
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<td></td>
<td>Suicide</td>
<td>Suicide and injury of undetermined intent mortality rate</td>
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<tr>
<td></td>
<td>Mental illness</td>
<td>Mental illness needs indices and prevalence rates</td>
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<tr>
<td>Trauma</td>
<td>Falls</td>
<td>Hospital admissions for fractured proximal femur (proxy for incidence)</td>
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<tr>
<td></td>
<td>Road accidents</td>
<td>People killed or seriously injured on roads</td>
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<td>Children killed or seriously injured on roads</td>
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<td>Injuries</td>
<td>Hospital admissions caused by unintentional and deliberate injuries to children and young people</td>
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<tr>
<td>Musculo-</td>
<td>Arthritis</td>
<td>Admissions for hip and knee</td>
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<thead>
<tr>
<th>Services</th>
<th>Social care</th>
<th>Numbers</th>
<th>replacement</th>
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<td>Physical disability, frailty and sensory impairment</td>
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<td>1) Number of clients</td>
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<td>2) Number receiving services in community</td>
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<td>Learning disability</td>
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<td>Mental health</td>
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<td>1) Number of clients</td>
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<td>2) Number receiving services in community</td>
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<td>Vulnerable people</td>
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<td>2) Number receiving services in community</td>
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<tr>
<td>Standard of service</td>
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<td></td>
<td>Timeliness of social care assessment and packages</td>
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<td></td>
<td>People supported to live independently through social services</td>
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<td>Carers receiving needs assessment or review and a specific carer’s service,</td>
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<td>or advice and information</td>
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<td></td>
<td>Adults and older people receiving direct payments and/or individual budgets</td>
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<td>per 100,000 population aged 18 and over</td>
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<td>Health services</td>
<td>Maternity</td>
<td>Early access for women to maternity services</td>
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<td>Dental health</td>
<td>Number of people accessing NHS dentistry</td>
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<td>Preventative screening</td>
<td>Proportion of children who complete immunisation by recommended ages</td>
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<td>Uptake rates for flu jab</td>
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<tr>
<td>Category</td>
<td>Description</td>
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<tr>
<td><strong>Proportion</strong></td>
<td>Proportion of women aged 47-49 and 71-73 offered screening for breast cancer</td>
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<td><strong>Sexual health</strong></td>
<td>Offer of an appointment at a GUM service within 48 hours</td>
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<td>Long acting reversible contraception methods</td>
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<td>Access to NHS funded abortions before 10 weeks gestation</td>
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<td><strong>Mental health</strong></td>
<td>Proportion of people with depression and/or anxiety disorders who are offered psychological therapies</td>
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<td><strong>Long-term conditions</strong></td>
<td>Proportion of people with long-term conditions supported to be independent and in control of their condition</td>
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<td><strong>Voice</strong></td>
<td>The extent to which older people receive the support they need to live independently at home</td>
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<td>User reported measure of respect and dignity in their treatment</td>
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<td>Self-reported experience of social care users</td>
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<td><strong>User perspective on health care</strong></td>
<td>National Patients Survey Programme findings for local institutions</td>
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<td>Parental experience of services for disabled children</td>
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References

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