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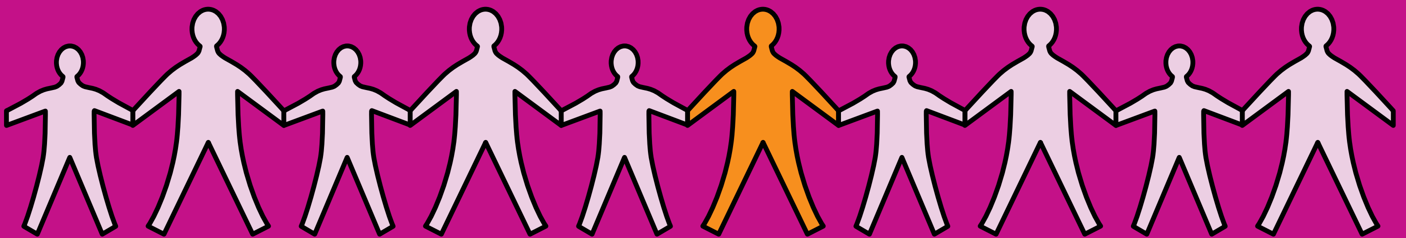
improvement and development agency

Joint strategic needs assessment
Progress so far



part of the **LGA group**

Foreword

Welcome to this new publication from the IDeA's Healthy Communities Programme. As the national lead for Joint Strategic Needs Assessment (JSNA) at the Department of Health I am grateful for this opportunity to read these reflections and local experiences on the JSNA process to date. This booklet illustrates well local perspectives and while by no means a comprehensive account, it comes at a useful time as the future direction of the JSNA is being discussed at national and local levels. It highlights the variety of approaches taken across the country and the huge amount that has been achieved – but also that much more needs to be done to ensure all areas use the JSNA process effectively to improve the health and wellbeing of their population and reduce inequalities.

This document provides a useful prompt to consider where the JSNA as a strategic planning tool should go next. Some will argue that the JSNA should focus primarily on health and social care, but is this appropriate? Certainly the case studies presented here illustrate the potential value in incorporating the wider determinants of health and involving other partners. I think it's helpful to consider to what extent the JSNA can be used as a tool to enable other crucial local partners to engage in health improvement.

A key future challenge for local areas is the new CAA process, and perhaps this is the first test for the JSNA as the link between the needs it identifies and the impact on local strategic decision making and outcomes is explored. Effective engagement of the community and third sector are also challenging areas. To date this kind of involvement in the JSNA process has been quite limited. There is scope to use Local Involvement Networks (LINks) and strengthen existing engagement mechanisms to develop these elements of the JSNA further and the Department of Health is working towards this.

Alongside plans to better support the third sector and community engagement, the Department of Health is also working with the Association of Public Health Observatories (APHO) and the NHS Health and Social Care Information Centre on a project to look at the current core data set with a number of Local Strategic Partnerships to determine how best to make it easier to obtain and use data as intelligence to inform decisions, improve outcomes and reduce health inequalities.

We hope through the learning gained from these projects and through the activities of organisations like the IDeA that the initial experiences in this document can be built upon and the potential of the JSNA maximised.

Fay Haffenden
National JSNA Lead Department of Health

Written by Liam Hughes IDeA National Adviser for Healthy Communities.

Liam's work for the IDeA includes:

- advising the Agency on health and health inequalities
- supporting the Healthy Communities programme and related work streams around partnerships.

Liam Hughes joined the IDeA in September 2006, seconded from his post as Chief Executive of East Leeds Primary Care Trust (PCT). He was subsequently appointed to the substantive post in the IDeA.

As Chief Executive in East Leeds, he led the NHS partnership activities with Leeds City Council and the Leeds Initiative (LSP). He was co-chair of the Healthy Leeds Alliance, also acting as lead commissioner for services for children and young people.

Liam joined the NHS in 2002, after a career in local government. He was Strategic Director for Health, Social Services, Early Years and Youth/ Community Services for the City of Bradford from 1995. Here he lead for the council on Local Agenda 21 and Health Action Zone.

He was the Chief Social Services Officer for Kirklees Metropolitan Borough Council from 1990 and Assistant Director for Community Care from 1985. Before that he held senior roles with the London Borough of Barnet and as a Mental Health Practitioner and Team Leader in the London Borough of Lambeth.

Thanks to the Association of Public Health Observatories, and all those who contributed to the case studies and member comments within the document.

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Introduction

This is one of a series of short papers about the “new landscape” of health and local government which have been published by the IDeA’s Healthy Communities Programme. The Programme is funded by the Department of Health (DH) and supported by the Local Government Association. It aims to build capacity for health improvement and the reduction of health inequalities across local councils and local partnerships. The focus of the programme is on leadership, partnership, community engagement and shared learning for better health outcomes. More information on the programme can be found at www.idea.gov.uk/health.

The joint strategic needs assessment (JSNA)

The JSNA is an important innovation in public policy. It brings together councils, the NHS and other partners to develop common priorities for the improvement of local health and wellbeing. It is a vital element in the new performance framework for local government and health. In the process of undertaking the JSNA, partners are encouraged to work closely together to generate a shared picture of local needs, and then to design systematic interventions that will meet these needs and produce better outcomes for local health. By definition, the JSNA process is about people and the places where they live. Starting with what is known about the population and about current service provision, it seeks to identify gaps in health outcomes with particular attention to the needs of less well served segments of the population. Without doubt, thousands of people have contributed very positively to the process of producing their local JSNA, and they have shown energy and enthusiasm to make the process work well.

This publication looks at the progress that has been made in the first year of the JSNA. It is based on the author’s conversations with over a hundred people across England, although it has no claims to scientific rigour. It presents a wealth of recent experience in the form of local case studies, and looks at some of the emerging issues. The guidance on JSNAs provided by the DH has been relatively flexible about both process and form, and the case studies show that different approaches to handling the task have been taken in different places. The pamphlet examines some of the practical issues facing staff involved in preparing the JSNA, and the tactical decisions that have been taken to deal with them. Some partnerships have been keen to make the JSNA the foundation for all local joint working, while others have given it a more modest place alongside other workstreams. There have also been different approaches to making links between the JSNA and the Local Area Agreement (LAA). The requirements for these elements of the new system were out of phase with each other, but in partnerships that were quick off the mark with their JSNAs it was possible for them to make use of lessons emerging from the JSNA within their LAAs.

The paper also asks, at a more profound level, how far has the JSNA process been able to overcome some of the problems associated with earlier attempts to promote integration between health and local government? In the past there have been some difficulties with joint working and the maintenance of trust between local councils and the NHS (especially when there were financial tensions and lack of clarity about objectives). Where evidence was available that demonstrated sound processes of joint working, it couldn’t always be associated with evidence of better outcomes as a result. This was illustrated by the research summary prepared for the Durham School of Medicine and Health in

association with the IDeA (Research Summary No 1, June 2008). It showed the limitations of the knowledge available about the success of previous partnerships for promoting health improvement – especially the Health Action Zones, the Health Improvement Programmes and the New Deal for Communities. Most of the published studies related to health concentrated on the structures and processes for joint working and not the outcomes the partnerships were achieving. The hope this time around has been that the joint preparation of the JSNA as one element of the new performance framework for local government and health would overcome many of the earlier problems, and make it more straightforward to evaluate outcomes. The research carried out by Birmingham University commissioned by the DH and the Integrated Care Network explores using the JSNA as a mechanism for strengthening interagency relationships. Details of where to find their research findings are provided on page 23 of this booklet.

The ambition

Upper tier councils and PCTs have a responsibility to identify local needs through the JSNA process, to map out the aspirations of local people, and to mobilise efforts to achieve them. The new performance framework of the LAA and the Comprehensive Area Assessment (CAA), underpinned by the JSNA, is a powerful vehicle for achieving these aims and ambitions. The framework and the JSNA binds together the efforts of the local council, the Primary Care Trust (PCT) and the other partners in the Local Strategic Partnership (LSP) to promote better health and wellbeing. The JSNA fits well with the new emphasis on commissioning for improved outcomes in the NHS – the competencies for "world class commissioning" require PCTs to demonstrate vigorous leadership and engagement with their partners, the public and local communities, and assess needs.

JSNA and its links to CAA and LAAs

Rachel Litherland National Adviser Partnerships & Mandy James CAA Programme Development Manager IDeA

Local strategic partnership/ thematic partnerships

Ideally the JSNA is developed through the LSP, as it requires contributions from a range of stakeholders, including statutory partners as well as private and third sector, plus members of the local community. LSPs and their thematic partnerships (eg the health and wellbeing partnership board) have a key role in encouraging partners to engage with JSNA and to own and use the findings to inform the Sustainable Community Strategy's (SCS) shared vision and priorities for place.

By developing the JSNA through the LSP there is a real opportunity to ensure that all of the various thematic needs assessments: Community Safety Strategic Assessment, Children and Young People's Plan, Housing and Spatial Strategies, are seen in the round and for local areas to explore how they can fit them together to strengthen the overall evidence base for place.

This approach also provides a critical mass for data collection and potentially a common platform for information, drawing together the expertise of a number of service areas to assist with the development of the JSNA. This enables a truly joined up needs assessment of place.

From evidence to action

Alongside quantitative data the JSNA should also reflect an understanding of the views of the local population and service users and be used to identify the most important key areas for change. Examples are: health outcomes that are not being met; health inequalities to be addressed; client groups with unmet needs, and services that require change.

Capturing local views, using for example local lifestyle surveys, allows the targeting of specific action with particular age groups or communities of interest or in geographical areas.

This information is important to draw upon in setting LAA targets. It also provides evidence for specific action by age or ethnic group, the need for additional services or access and the differentiation in service delivery by geography.

LSPs will need to ensure a high level commitment across organisations to tackle these needs as expressed in the LAA targets, by ensuring that partners are prepared to move resources to achieve change and that delivery plans are in place and owned.

Commissioning

The JSNA is not an academic process; its purpose is to make changes in the way services are planned and delivered. It is a means to identify changes that are required to service plans and commissioning strategies, to address the issues.

The JSNA should provide key evidence to inform commissioning decisions. The LSP and its thematic partnerships can use the JSNA to evidence strategic shifts of resources to support the delivery of SCS/ LAA outcomes. It will also help commissioners specify outcomes that encourage local innovation, and help providers shape services to address local need.

Role of the JSNA within CAA

The JSNA for the area will be a key piece of evidence for the CAA. It is one of the elements of 'strategic joining' for partners to agree priority needs for the population, develop resource and commissioning plans, and use resources efficiently and effectively.

Many LSPs will develop their own locality self evaluation to ensure that there is a collective understanding of the issues in the area, how well these are being addressed and where there are gaps that need further work. The JSNA should also contribute to a locality's self evaluation and will ensure that a partnership is on track to meet its local priorities, as measured by CAA.

Most people value good health as the foundation for their wellbeing, and this has been reflected strongly in the new LAAs made between local stakeholders. Specific health improvement targets make up nearly half of the total number of targets chosen by LSPs, and many of these are aimed at reducing health inequalities. Arguably, all of the indicators in the national set are potentially health supporting, and can strengthen the building blocks for health and wellbeing.

Top 10 most popular selected indicators

indicator	no. of local areas choosing priority (out of 150)
NI 117 16 to 18 year olds who are not in education, employment or training (NEET)	115
NI 112 Under 18 conception rate	106
NI 154 Net additional homes provided	104
NI 155 Number of affordable homes delivered (gross)	102
NI 186 Per capita reduction in Co2 emissions in the LA area	100
NI 56 Obesity among primary school age children in Year 6	99
NI 16 Serious acquisitive crime rate	98
NI 163 Proportion of population qualified to at least Level 2 or higher	95
NI 123 Stopping smoking	89
NI 1 % of people who believe people from different backgrounds get on well together in their local area	87

A recent Ipsos MORI poll, commissioned by the Healthy Communities Programme, has shown that most councils believe that health improvement is their business, and state that they are active participants in joint work to reduce health inequalities. These are seen as unfair in themselves and as a serious obstacle to local economic growth and regeneration. This expressed commitment runs across the political spectrum and embraces councils of all types – districts, counties and unitaries. This marks a profound recognition by councils and their partners of the importance of combined action for better health and reduced health inequalities in their areas.

Councils are locally rooted organisations. They shape very profoundly how we live. They are political by their very nature, as democratically elected bodies, and they are accountable for making difficult choices on our behalf. They plan how we use space and regulate the nuisance we can cause for each other. They provide practical services to meet basic human needs across the life cycle. They are involved with people literally from the cradle to the grave. They influence many of the building blocks for good health – familiar examples include early years provision, education and lifelong learning; employment, economic development and the protection of living standards (especially during the recession); planning, environment and housing; leisure, sport and culture; social support; and freedom from crime. These examples illustrate the impact of local authorities on the life chances of people as they go about their daily lives in the places where they live.

The consequences of poor health and health inequalities for individuals, families and communities are great. Too many of us are putting our health at risk by the way we live, our patterns of activity and our diet. As a nation, we tend to eat too much and exercise too little, we misuse alcohol and take drugs, and we can be reckless in our sexual behaviours. Too many of us still smoke despite the progress that has already been made to encourage us to quit. Our emotional health is put at risk by how we live and work. Our individual actions are powerfully shaped but not fully determined by our social situations. Poverty makes a big difference. Social class and social status, gender and sexuality, age, ethnicity and race all have a strong impact on our health. We learn from those around us, and our families, peers and neighbours influence our health behaviours. Individually and collectively, we will need to change if we are to avoid burdening ourselves, our children and our grandchildren with unsustainable levels of poor health. The JSNA provides us with a shared tool to better understand and tackle these problems.

"My ambition for the JSNA is that it will be a vital evidence base, not just for commissioning services for health and wellbeing but across other strategic priorities such as regeneration. In Kent, health improvement and economic and social regeneration are inextricably linked – especially in our most deprived areas."

Councillor Graham Gibbens
Cabinet Member for Adult Social Services, Kent County Council

Progress so far

Local authorities, PCTs and their partners have now been working on the JSNA process for over a year. The original Ministerial ambition, set out in the 2007 JSNA guidance, was that the requirement for JSNAs would lead to “stronger partnerships between communities, local government and the NHS”, and provide “a firm foundation for commissioning that improves health and social care provision and reduces inequalities”. The aim was to help partners to identify current and future health and wellbeing needs, review existing services and inform commissioning in the light of evidence. Very specifically, it was anticipated that the JSNA would identify particular groups that were experiencing poor outcomes and where needs were not being met.

The Department of Health recognised the wide variety of arrangements for joint working that had emerged across the country (these were illustrated in the associated IDeA paper entitled *The New Landscape for Social Care and Health*). Rather than specifying a structure to deliver joined-up activity, it focused directly on the required activity. The guidance allowed for local initiative and discretion, building on a nationally defined dataset of key information. It was revealing that the lack of more detailed direction about the form of the JSNA was the cause of both celebration and unease. The approach was in keeping with the “lighter touch” philosophy that had accompanied the new local government performance regime, but many participants sought more clarity. The PCTs in particular were concerned that the creative approach set out in the guidance would be overtaken later by more specific guidance and prescription, but as yet this has not happened.

In most places, of course, the process of developing the JSNA was undertaken as a natural continuation of pre-existing joint planning and commissioning activity. The initial focus was on health and wellbeing from the viewpoint of public health, children`s services and adult social care, and these three directors were named as the prime movers for the process. The involvement of the directors of public health most often in their new role as jointly appointed officers of both the PCT and the local authority was an important new feature, and the JSNA was the first test of the added value they could bring to partnership working.

The wider context for partnerships

The JSNA process has been both a litmus test for the state of local health partnerships and a catalyst for change. In many places improved health outcomes have been underpinned by a long tradition of excellent joint working and an agreed understanding of local needs and aspirations. The five Beacon local authorities for health inequalities in 2008 (Coventry, Derwentside, Greenwich, Sheffield and Sunderland) reflect this picture, as do many other areas with a similar history of strong health partnerships and improving health outcomes. They have shown effective joint leadership, robust joint working, high levels of public and community engagement, skilful use of information and a clear focus on outcomes. They have been both creative and systematic in their approach to health improvement, generating innovations and rolling them out across the area. Many local authorities and PCTs have good reason to be proud of their achievements in working collaboratively for better health outcomes, Wiltshire is a particularly good example.

Wiltshire

Partnership and community engagement

Two elements characterise Wiltshire's approach to JSNA: a high degree of consensus between partners; and the scale of ambition for it to become *the* single assessment tool on which to base all commissioning decisions.

According to Sue Redmond, Director of Community Services: "Wiltshire has a strong culture of partnership working and this undoubtedly helped us to develop JSNA as a broad and inclusive process". The JSNA includes contributions from the voluntary and community sector, the police, the ambulance trust, the fire services, the economic sector and environmental groups. Maggie Rae, Director of Public Health (DPH) underlined this inclusive approach: "Even Wiltshire Wildlife Trust contributed evidence on environmental sustainability and its positive impact on health and wellbeing."

Wiltshire's JSNA emphasises the 'wider determinants of health' such as affordable housing, fear of crime and environmental issues. This helped to engage the voluntary and community sector in a series of workshops to:

- explain the purpose of the JSNA and the critical need for community and voluntary involvement in contributing evidence and agreeing priorities
- share the vision of what the JSNA could be
- identify any gaps in information
- identify other sources of data.

As a result, evidence and research from a number of community and voluntary organisations feature prominently in the final document.

Impact and reach of the JSNA on strategic priorities

In Wiltshire the LAA was signed off at a relatively late stage which meant that the JSNA could be used to inform the LAA priorities. It helped that the LSP partners all agree that the JSNA has great potential for improving outcome-based commissioning. According to Sue Redmond: "The LSP partners and community and voluntary sector are all committed to developing the JSNA as a unified assessment and planning tool on which all strategic plans will be based. We see it as an essential tool to prepare for the transition to unitary status in 2009."

Rather than seeing the JSNA as just another paper exercise, Wiltshire has used the core data set as a common focus for action, especially around collecting data to support the 20 new 'resilient communities' that will be the focus of the new unitary authority.

The JSNA has helped partners to identify new areas of need, including:

- the health and social care needs of members of the armed forces and their families (Wiltshire has a high concentration of soldiers and their families)
- the interrelationship between alcohol-related crime and antisocial behaviour and alcohol related ill-health
- lack of access to NHS dentistry.

It has also already influenced commissioning decisions. For example, an additional £1.4 million has been allocated to dentistry following local concerns over access to NHS dentists.

The LSP partners have agreed that in future, the JSNA will focus far more on local priorities and will be: "developed once and used many times by all local agencies." Partners will agree five priorities on which to focus and build up a far richer and more detailed database. As Maggie Rae points out: "the biggest challenge for us will be to turn the data into real wisdom about our communities."

Addressing challenges

Sue Redmond points out that: "some partners needed convincing that the JSNA would add value to the diverse range of assessments and research already available." The process required a high degree of analytical and research expertise but both Maggie and Sue are confident that the transition to unitary status will strengthen capacity.

Maggie Rae felt that: "in negotiating the LAA targets this time round there was a certain amount of pressure for us to include targets that were not necessarily local priorities. A strong evidence-based JSNA will allow us to be more assertive in promoting our own priorities in future negotiations."

Wiltshire focused on making the JSNA wider than just health and social care, as although health and social care are core to the JSNA it was important that other partners were engaged. Other agencies already doing strategic assessments should be key partners.

Time pressures meant that governance arrangements were given inadequate consideration but this will also be addressed as the process evolves.

Key messages

- "The JSNA must go beyond collating existing data to build a strong and reliable evidence base to inform priorities and commissioning decisions of all LSP partners." Sue Redmond
- "It is vital to involve the director of children's services as a key partner." Maggie Rae
- "Think about language, although health and social care are vital to the JSNA, other agencies such as the police may feel more comfortable with the term 'strategic assessment'. The JSNA and other strategic assessments can be amalgamated." Maggie Rae

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Interviewees:

Maggie Rae, Director of Public Health, Wiltshire PCT and County Council

Sue Redmond, Director of Community Services, Wiltshire County Council

Some places, unfortunately, have had less positive experiences. A number of key enablers have been absent or barriers have presented themselves, these are explored below:

- the preconditions of trust and mutual respect which are necessary for effective partnerships may have been absent
- information about particular dimensions of need may have been missing and evidence about best practice ignored, there can be a deep resistance to adopting new innovations unless developed locally
- community engagement may have been too limited and too rushed to feel real for participants. The timescales for the new LINks programme has often made ensuring proper patient and public engagement in JSNAs difficult
- areas may have encountered difficulties in agreeing a common set of local priorities and deciding what needs to be done first
- finally implementation may have been too limited in scale and lacking in energy or impetus.

The effort to create a common local assessment, to review progress to date and to agree a common set of priorities through the JSNA process, therefore, has illustrated the full range of strengths and weaknesses pre-existing in health partnerships across the country. It has galvanised many of the less advanced local partnerships to work together more successfully and with a renewed sense of urgency

because they now share a common accountability for improvement. The links between the JSNA and the new performance framework for local government and the NHS have provided some powerful motivators and incentives for change, starting at the top. Senior figures from councils and PCTs are now more dependent on one another than ever before. If they fail to make progress towards better outcomes, this will be evident in their Comprehensive Area Assessments.

The processes

The DH guidance makes it clear that the JSNA is better seen as a process of understanding local needs and establishing agreed priorities, rather than as a traditional planning document to be produced at a single point in time and then left unused and unrevised. It is supposed to be a living, organic tool for improvement. Stripped to its kernel, this process involves building up a rich picture of need through triangulation between statistical data, the views and aspirations of local people and the current patterns of provision made by the local partners. It is implicit that the partners will each have their own priorities and preoccupations, and that the iterative process of triangulation will help them to build up a wider appreciation of what needs to be done. The desired outcome from this process, at its most simple, is a common story for local improvement which is then realised in practice.

The core dataset

The core dataset was produced by the Public Health Observatories, and this work has done much to raise awareness in local councils as well as PCTs of the work of these important agencies. Developing the dataset as a working tool has proved to be demanding. It covers a range of fundamental domains:

- demography
- social and environmental context
- lifestyle factors
- burden of ill health
- services
- projections of need.

Each of these is composed of sub-domains. Two kinds of difficulty have emerged. Firstly, for some sub-domains there is too much data and too little translation of it into usable information. Secondly, for other sub-domains the data is incomplete. Despite these difficulties, local partnerships are using information to guide their analysis of local need in an increasingly sophisticated way. The local dataset probably makes its most powerful contribution when it is combined with some form of "market segmentation" tool to map out the population into subgroups of people with similar needs and health risks (e.g. Mosaic and Dr Foster). The Association of Public Health Observatories (APHO) health inequalities intervention tool and the local health profiles have also been extremely helpful.

JSNA – the APHO resource pack

JSNA is all about harnessing the power of data to influence health and wellbeing – which just about sums up the mission of the Public Health Observatories. APHO was therefore delighted to be commissioned by the DH to review the recommended data requirements for JSNA, identify some of the main methodological challenges which analysts would encounter, and produce guidance on how to tackle them. Informed by the responses to DH's JSNA consultation exercise in 2007, the outputs from this project form the five-part **APHO Resource Pack for JSNA.**

Part 1 - The revised **core dataset** is indicative of the data requirement for a comprehensive JSNA. Many of the indicators are drawn from the 198-strong set of National Indicators for local authorities, or the NHS's list of 'Vital Signs'. The core dataset document contains advice on how to obtain and interpret each of them, or else a link to the official definition.

Part 2 - The guide to **statistical validity** introduces confidence intervals and significance testing, and explains how they can help us to draw valid conclusions. It then describes various statistical pitfalls and how to work round them, such as the potential problems posed by small numbers, synthetic estimates, multiple comparisons and league tables.

Part 3 - **Projection methods** reviews the ways in which levels of illness, disability and other characteristics can be forecast for JSNA purposes. It describes two main approaches, identifies suitable tools and software, and highlights websites such as POPPI (www.poppi.org.uk) where ready-made projections can be found.

Part 4 - **Data sharing for JSNA** describes the legal and ethical framework surrounding personal data in general, and health data in particular. It contains good practice guidelines for data sharing protocols and agreements, so that partnerships can reap the benefits of data sharing without compromising confidentiality or security.

Part 5 - The guide to **measuring health inequalities** explores various ways of comparing outcomes or levels of provision between different social groups, allowing any gaps to be identified, quantified, and monitored over time.

Joint Strategic Needs Assessment will always be a major undertaking, but we hope that the APHO Resource Pack will remove some of the obstacles along the way, and help to secure an end product which is both robust and illuminating.

The APHO Resource Pack for JSNA can be accessed via the APHO website www.apho.org.uk/resource/popular.aspx

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For further details please contact Anne Cunningham at the Yorkshire & Humber Public Health Observatory (ac552@york.ac.uk).

The JSNA experience has shown that many areas were initially under resourced and under skilled to handle the preparation and interpretation of data on this scale and with this level of complexity, and some have struggled to catch up. The challenge of data mapping for the JSNA has led many local partnerships to re-examine their capacity and strengthen the information management functions across partnership organisations. Overall there has been a quiet revolution in the development of capacity to manage and use information to produce better outcomes. This has been linked to the availability of good quality evidence, guidance and advice, for example, from NICE and the National Support Teams, which has helped local partnerships to identify how to turn the improvement curve most effectively.

Hammersmith and Fulham

Partnership and inclusion

JSNA is expected to strengthen partnership working but so far it has mainly involved the PCT and the local authority. The PCT has had to depend on considerable input from children's services. It has also acknowledged that much of the public health agenda is delivered via the local authority. Other partner organisations in the LSP and beyond, including the police, ambulance service and the voluntary sector, are being consulted following the publication of the interim report.

Dagmar Zeuner (DPH) and Sandra Husbands (Assistant Director of Public Health) see the JSNA as "painting a picture of the borough's landscape" which is being tested against the perceptions of the public, patients, frontline staff and other partners. There will be several events in different areas with summaries of the report for distribution and key questions for stakeholders. This process will validate the data, identify service gaps and explore diversity issues further. Carole Bell, Assistant Director in Children's Services, feels that the Council's existing consultation processes, for example in children's services, have proved valuable for the JSNA.

needs and priorities – the impact and reach of the JSNA

Carole Bell says: "We hope that JSNA will eventually underpin needs assessment across the board - a 'global picture' which could, for example, better inform the Children and Young People's Plan." But she is doubtful whether it will have a significant impact on commissioning in the short term or is likely to change existing priorities.

The annual public health report has informed the development of the JSNA. The JSNA itself has not produced unexpected revelations but has already started to feed into council planning processes.

Carole Bell notes that: "Well before the JSNA, the Council had spent a lot of time trying to align strategies such as parks, Building Schools for the Future, the Children and Young People's Plan and the community strategy, but the JSNA has concentrated minds and is expected to help the alignment of planning processes." When the LAA comes to be refreshed, it will take account of JSNA data and, in Dagmar Zeuner's words, "serve as the 'proof' of the JSNA process."

Addressing challenges

In Carole Bell's view, some partners were unsure of the JSNA's purpose or impact but, according to Dagmar Zeuner, the 'theory' of JSNA was very appealing to many and there were also high expectations. Sandra Husbands indicated that one of her roles was to manage these expectations, sometimes downwards.

Gaining the commitment of staff at all levels while ensuring expectations are realistic has been a balancing act. According to Sandra Husbands: "They won't 'get it' until they 'get into it'". At times, the process could have become divisive if not for the involvement of staff at operational levels who developed shared understandings on "sometimes mundane matters", such as population projections. As Dagmar Zeuner says: "JSNA is not a glamorous process but asking essential questions about such matters can lead to better planning."

The reality of JSNA proved more daunting than originally envisaged. When people realised the work it would involve, a common question was: "will it tell me anything I didn't know before?". Capacity has been an issue because it was not fully appreciated how resource-hungry the JSNA process would be, particularly for a relatively small organisation like the PCT.

According to Sandra Husbands, the core data set is less useful for needs assessment than for performance monitoring. Most of the information was already being collected, and the annual public health reports provided good information.

It did become clear that, for many things they would like to know, data is not readily available or there are no reliable indicators. Populating the core data set is an ongoing process but has not been a priority.

The national implementation of JSNA has been relatively unchallenged, according to Dagmar Zeuner. Systematic evaluation of the process is essential to ensure it does not become an end in itself.

Key messages

- "Make sure the process is resourced adequately, and don't forget to evaluate" Dagmar Zeuner
- "Joint ownership isn't the same as doing it jointly" Sandra Husbands
- "Get the balance right between children/families and adults" Carole Bell

Interviewees:

Dagmar Zeuner, Director of Public Health, Hammersmith & Fulham PCT

Sandra Husbands, Assistant Director of Public Health, Hammersmith & Fulham PCT

Carole Bell, Assistant Director (Commissioning and Performance), LB Hammersmith & Fulham Children's Services

The scope of the JSNA

There have been different approaches to the scope of the JSNA.

In some places, the aim has been to make the process comprehensive, so that the JSNA will support the whole of the LAA structure and the Sustainable Communities Strategy (as demonstrated by the earlier Wiltshire case study).

In others, especially where there has been substantial regeneration underway, the task of using the JSNA process as the only platform for change has proved unwieldy and demanding. The example of Gateshead, which has taken a measured approach to the scope of the JSNA, illustrates this point very clearly.

Gateshead

Partnership and community engagement

Coming so soon after the reconfiguration of the NHS, in which Gateshead MBC lost co-terminosity with its PCT: "Just getting everyone sitting at the same table was an achievement in itself" according to Maggie Atkinson, Director of Children's Services. That said, it was difficult to involve LSP partners beyond the local authority and the PCT because of the pressure to get the document signed off by the end of February 2008. It will be refreshed in 2009 with earlier and more proactive involvement from other LSP partners. The Director of Children's Services felt that the JSNA needed more involvement from children and young people and the Children's Services Directorate.

Community and voluntary groups and service users were 'under-involved' rather than uninvolved in the data collection. Their comments at a series of 'listening sessions' were influential in shaping the final draft. The JSNA also drew heavily on existing sources of information from the community.

Impact and reach of the JSNA on strategic priorities

The JSNA will be a vital resource in identifying new health and wellbeing priorities. Already, it has identified a number of new priorities. For example:

- information in the JSNA has highlighted older people living in their own homes as an area that needs greater consideration
- JSNA has enabled the PCT and the local authority to be much clearer about how they can improve mental health services in line with 'Our health, our care, our say', the white paper which outlines the vision for community-based, person-centred and integrated health and social care services.

But all the interviewees felt that the JSNA is unlikely to be expanded into a general assessment tool to underpin all strategic plans in Gateshead. They already have existing needs assessments and Margaret Whellans spoke for all the interviewees in saying that: "there is a danger that it will become too unwieldy and process focused rather than a crisp, clear tool to identify priorities for achieving positive health and wellbeing."

As it is, the JSNA built on and brought together a wealth of existing information including:

- the area-based evidence gathered for the health overview and scrutiny committee's review of health inequalities
- the joint Children's Services and PCT needs assessment for children and young people
- detailed data on housing gathered as part of the housing strategy.

In future years Gateshead intends to include more local information gathered from a wider range of sources, in particular the community and voluntary sector.

A prioritising framework developed as part of the JSNA process will provide the LSP and other partnerships with a firm evidence base for identifying strategic health and wellbeing priorities. Alyson Learmonth, the joint DPH sees the JSNA as: "having great potential to help us identify the transfer of resources from acute, hospital-based services to the community. Currently, we have little joint information so the JSNA will be invaluable in informing joint commissioning."

Addressing challenges

Time pressures were mentioned by all the interviewees as a major challenge both in terms of compiling the JSNA and aligning it to planning streams for other key strategies. Margaret Whellans described the initial process as: "putting the cart before the horse" as the LAA targets had already been agreed by the time the JSNA was finalised. In future, the JSNA process will allow more time for discussing the findings and using the information to inform priorities.

Alyson Learmonth describes the core dataset as: "Helpful, if a bit intimidating. Helpful in that it requires a systematic and regular review of data and forces us to ask the same questions over a period of time. A bit intimidating because of the sheer volume of data."

All the interviewees agreed that it needs to place greater emphasis on well-being and ill-health prevention - especially of children and young people - which could be remedied by the Department for Children, Families and Schools giving more prominence to the JSNA.

Both Margaret Whellans and Alyson Learmonth emphasised the need to involve elected members. Future governance arrangements need to involve the Council's Executive and other key partners at all stages: "It is not just a case of getting Cabinet 'sign off'. Elected members and the management boards of other LSP partners need to be involved throughout the process."

Key messages

- "Ownership and 'buy in' from elected members, management boards of PCTs and NHS trusts, and the community, are crucial in ensuring that the JSNA informs priorities and resource allocation" says Margaret Whellans
- Maggie Atkinson advises all partners to ask: "How does this information shape our priorities for investment and commissioning?"
- "The JSNA allows all partners to focus on the changing nature of the population and to plan more accurately and proactively for the future" Alyson Learmonth.

Interviewees:

Maggie Atkinson, Director of Children's Services, Gateshead Council

Alyson Learmonth, Director of Public Health, Gateshead PCT and Council

Margaret Whellans Group Director, Community Based Services, Gateshead Council

The guidance on the JSNA refers specifically to the personal involvement of the directors of public health, children's services and adult social care. The implication is that health improvement is most closely linked to these functional areas of service. However, in places like Blackpool, Sunderland and Greenwich, the local councils have recognised the importance of health improvement for regeneration – good health is both a product of regeneration and a contributor to its success. As a result, the relevant directors have been increasingly more involved with the JSNA. Planning, regeneration, housing and the environment, culture, leisure and sport, and consumer protection all play an important part in the promotion of good health.

Leeds

Partnership and inclusion

JSNA's emergence has been timely for Leeds. It has acted as a vehicle for shared planning systems, for example involving children's services, environment and neighbourhoods, and crime and community safety. But as Sandie Keene, Director of Adult Social Services, says: "Leeds is a large authority with a complex local picture and it has taken time to develop a common vision for health." There is a mature and comprehensive local strategic partnership, with health incorporated into all the programme areas. From the outset, JSNA was seen as much more than health and wellbeing but one of the issues has been "where do you stop?" There were already constructive relationships among the partners on which they could build and a key concern has been to sustain these.

Leeds has held a series of stakeholder engagement and challenge events, though there is a need to involve a greater range of partners. More could be done to address diversity issues to ensure all communities are represented: "the most vocal tend to be heard", according to Lucy Jackson, Head of Public Health Development in the PCT.

Sandie Keene reports that Leeds is also developing a 'Neighbourhood Vitality Index' to provide local communities with examples of what can be measured at local level, and a website to itemise consultations and outcomes.

Needs and priorities – the impact and reach of the JSNA

JSNA has been a catalyst for aligning planning cycles to inform the development of common priorities in future. It will also provide a basis for World Class Commissioning and meeting local authority inspection requirements.

Although LAA targets were set before the JSNA was signed off, the JSNA will help with the LAA 'refresh' process. Lucy Jackson notes that inequality issues have emerged as priorities from the data gathered: "This has reinforced the notion of 'two cities' in Leeds". In response the partners are developing a tool for use by both PCT and Council to assess inequalities and unmet need, and challenge existing priorities. In some cases this has suggested that a particular area of focus should become a higher priority than at present, an example being alcohol as opposed to smoking. Sandie Keene also felt that further analysis of the relative success of various interventions in different communities was needed.

In future the JSNA will develop as a more general needs assessment, building on the integrated processes already established for children's services. A new joint data and information group for the local authority and PCT, and the development of a joint data store to enable better joint use of data, are stages in this process.

Addressing challenges

"Having an externally appointed co-ordinator avoided lengthy internal negotiations about processes", said Sandie Keane. According to Lucy Jackson; "although there was some initial scepticism that JSNA might become 'an industry in itself', it has now become part of the approach to commissioning for both PCT and Council."

It would have been useful if the core dataset was available from the outset. As the core dataset especially uses Office of National Statistics data there is a danger of this being out of date, and it does not, of course, address the needs of groups for whom there is no or little data. Leeds has not over-relied on the core dataset. It has also drawn on a great deal of existing information used, for example, for the DPH's report and Leeds' "Measuring the Gap" inequalities report. They have added information relating to financial inclusion and debt levels, but in some cases neither quantitative nor qualitative data are adequate. It has also proved challenging to break down information to reflect fully the picture in black and minority ethnic communities.

A significant challenge is the work involved in the JSNA process, particularly data analysis and ensuring outcomes are adequately addressed, especially for wellbeing. A lack of 'routine' analytical capacity has been identified.

JSNA work has been carried out through three sub-groups: planning, data and stakeholder engagement. They tended to work in parallel but in Lucy Jackson's view more integrated working between them at an earlier stage would, in retrospect, have been beneficial.

Key messages

- "JSNA is a good means of promoting partnership working across relatively new structures and creating common planning systems" Lucy Jackson
- "It's a worthwhile process but resource-intensive, and a focus on outcomes is essential" Sandie Keane

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Interviewees:

Sandie Keene, Director of Adult Social Services, Leeds City Council

Lucy Jackson, Head of Public Health Development, Leeds PCT

Engaging with communities

The JSNA guidance emphasised the importance of active dialogue with local people, service users and carers. Quoting from the White Paper *Strong and Prosperous Communities*, it proposed community involvement at all stages of the process. Some areas have shown creative and innovative methods for real dialogue around the JSNA, while others have struggled to engage in any depth at all. Some of the issues are explored in the companion publication from the IDeA entitled *Reaching out-community engagement and health*. In due course LINks will be important participants, but they have appeared too late to have made a contribution in their first year. Local government has a long history of community engagement, and has developed a wide range of methods to help local people express their aspirations and take part in local debates. Surveys and focus groups have been widely used. Planning for real, rapid appraisal, future search, open space conferences and aspirational mapping are among the newer approaches that are currently in use. The voluntary and community sector are also a key vehicle for engaging communities as they have strong links with local people at a grass roots level. Margaret Eaton, Chair of the Local Government Association, reinforces the importance of community engagement for local authorities "Community engagement is a key function of local government and

one in which local councillors have a central role. Councillors' wealth of knowledge about needs and aspirations within localities can really enhance an understanding of place and add local interpretation to data gathered."

The curious thing about the JSNA guidance from the viewpoint of local government is that it is silent about the representative role of local councillors in their communities. It implies that local councillors are stakeholders amongst many others to be consulted. This is a viewpoint that also seems to be prevalent in some parts of the NHS. Local authorities are led by their councillors. Locally elected and democratically accountable, they are responsible for improving the places where they live. They are embedded in their local neighbourhoods and have local experience and knowledge based on direct experience of the conditions of life in their area. They are involved in daily discussion and debate about what needs to be done to make improvements. Their collective knowledge and experience is vast. This local intelligence is an important source of information about local needs and aspirations, and it has given added strength to JSNAs when councillors have been more fully involved.

Establishing priorities

In concept, the JSNA process is intended to lead to a set of agreed local priorities for local health and wellbeing. These in turn are to feed into the wider debates about the content of LAAs and the Sustainable Community Strategies. In practice, in 2008, the newstyle LAAs were often at such an advanced stage of preparation that this could not happen properly in the first iteration of the new planning and commissioning cycle. It was therefore a relief for many when the LAAs in that cycle subsequently emerged with nearly a half of their content related to major health indicators.

The JSNA guidance said very little about how the needs established by the analysis of local information were to be turned into priorities for action. As already touched upon Gateshead has developed an interesting approach to informing this process by using a set of questions about impact, effectiveness, inclusiveness, acceptability and resource feasibility. These questions, quite familiar in public health analysis, help to focus attention on those improvements that are likely to make a real difference and show good value for the investment. The Gateshead team made it clear that there is ultimately no technical solution to the task of agreeing priorities. The JSNA is best conceived in terms of presenting options based on the best evidence available for consideration by the twin statutory bodies and the LSP. The process at that stage is political in terms of both interagency debate and local party politics, and the final decision about priorities clearly rest with the council and the board of the PCT.

Some councillors (from authorities of different kinds and in different parts of the country), it has to be said, have felt left out. This is partly as a result of the pace of preparation of the JSNAs in the first iteration, partly as a result of the complexity of the process, and partly as a result of the approach sometimes taken by local managers to introduce them to the process at a relatively late stage. The guidance understandably reinforces both the technical analysis of need, and the importance of professional judgement – especially about the prediction of future trends. It emphasises gap analysis and benchmarking against the English norms. It assumes that as a consequence of this work a consensus will be readily found about priorities. This plays down the question of differing values and views about priorities. These are the stuff of local politics, and can be seen most obviously when the issue of service reconfiguration is raised.

Despite this reservation, the feedback so far on the JSNAs demonstrated that there is most usually a high level of consensus across the political and organisational spectrum about what matters most in a particular place. Local partners have a passion for improving the health and wellbeing of local people, they know their patch well, they identify the same needs and priorities, and they share a common story for that improvement. This passion for health improvement can be seen across the country in councils of all kinds.

"We see the first Manchester JSNA as an important baseline reference document that will help us to commission services effectively and plan for the future. The JSNA is not just about the current situation but also about ensuring we take note of changes to our population and neighbourhoods so that services are in place to meet new challenges and priorities….The JSNA will be key driver for the ongoing development of programmes and services to support our joint efforts to improve the lives of Manchester residents."

Councillor Basil Curley
Executive Member for Adult Services and Health, Manchester City Council

"I see the JSNA as being the vital buffer between the council and its community, and central government – especially when government puts pressure on us to accept targets and priorities that don't reflect our local situation. The JSNA gives us a really robust evidence base with which to assert the priorities that will really make a difference to our community."

Councillor Susan Galloway
Executive Member for Health and Social Services, York City Council

Some conclusions and emerging questions

It is of course, too soon to know whether all this local activity is more likely to improve health outcomes for local populations than previous attempts. The signs are good, and the JSNA story so far is looking positive. The process of analysing local information and establishing joint priorities has brought partners more closely together, and helped to embed the role of the DPH in local government. There has been a sense of rigour about the use of evidence and information that was often missing from previous joint planning. Despite the profound organisational and constitutional differences between PCTs and local councils, they are working together productively on JSNAs and LAAs. They share a common interest in better commissioning which the JSNA, even at this early stage, has often helped to improve. They know that ultimately they will stand or fall together in their Comprehensive Area Assessments. Staff have shown energy and commitment in making the process work well, and despite the limitations of time and attention, many people from the community and voluntary sectors have been involved productively with their local JSNA. So far, so good! On this evidence we should celebrate the success of the JSNA as an important innovation in public policy.

However, there are new challenges. These have become more salient as the implications of the current financial downturn have become more evident. The first of these is the complexity of multi-level working at county level. In the larger two tier counties, the JSNA process has more often been localised and has a focus at district level. Inevitably, therefore, its process has been both a vehicle for the co-ordination of effort between district and county councils and a new battleground for familiar arguments about relative need. How are local partners to rate the needs of seaside towns with the profile of inner city areas versus rural hinterlands with rapidly ageing populations? How will they respond to proposals to invest relatively more in child health or drug treatment as against dementia care and active ageing? These are familiar tensions which will increasingly be played out through the medium of the JSNA as financial pressures and demographic changes bite harder.

Is there also perhaps a more fundamental issue for those working on the JSNA to overcome in terms of turning it from information to actions that have a real impact. This is key to demonstrate the benefit of the JSNA above and beyond existing assessment and planning processes.

The second challenge concerns the impact on health of the new sub-regional agenda. In those metropolitan areas most active in sub-regional initiatives, the integration of health improvement activities has become increasingly important. The Cheshire and Merseyside Public Health Network (ChaMPs) and the Greater Manchester Health Commission are impressive examples of collaboration that show the benefits of sharing the learning from the individual JSNAs widely around the sub-regions. The point about these examples is that they have introduced new levels of complexity over and beyond the experience of the individual unitary authorities and local PCTs. It can be a challenging task to mobilise partnerships on this scale and ensure they continue to be productive when individual organisations face difficult internal pressures. However where this is done effectively there is the potential to greatly reduce duplication of effort and meet the needs of communities more effectively, by recognising that they often don't fit neatly within organisational boundaries.

The third concerns the decision-making processes and governance arrangements within local partnerships. In many places there is a high level of mutual trust and confidence, and problems are readily brought to the surface for joint resolution. In some, the foundations for effective partnerships are still fragile, and difficult subjects are avoided rather than being debated and resolved. The relative financial standing of the PCTs and their ability to invest in public health have been important factors in shaping the partnership challenges, along with the financial pressures on adult social services and other parts of the council. As the economic downturn bites even more over the next two or three years, the maturity of local health partnerships will be sorely tested in terms of their governance. The JSNA will be an important point of reference about local needs and priorities, which will show up strengths and weaknesses in partnership working.

Finally there is no specific mechanism for conflict resolution between local partners in cases where they cannot agree on priorities or want to revise them. In the past, successful partners have learned how to fall out with each other about specific issues and still maintain trust. They have kept up the momentum for improvement and limited the damage caused by retrenchment. However, the see saw example of continuing care and the historical experiences of financial pressures in the NHS have shown us that partnerships can be very fragile despite the best intentions of partners.

The new performance framework involves judgements about both the success of individual organisations and their collective efforts for their locality. Will this provide strong enough motivation for local leaders to handle difficult issues in a mature way? Will the JSNA priorities which have been jointly agreed really be delivered when budgets are more constrained? There is a challenge for Health Overview and Scrutiny Committees to examine progress and promote debate about the delivery of JSNA priorities and the state of local health partnerships on a regular basis.

These questions focus on the journey ahead and they are matters of concern for those leading the JSNA process. But despite these concerns we can celebrate the success of the JSNA process and the commitment from staff in local government, the NHS and the community and voluntary sector in working together to improve the health of local people.

Additional information, resources and links

Links to the following documents referenced in this booklet can be found on the IDeA website http://www.idea.gov.uk/idk/core/page.do?pageId=9499872

The IDeA's companion publications are:

The New Landscape in Social Care and Health (October 2007)

Reaching out – community engagement and health (August 2008)

Communities and Local Government (CLG)
Strong and prosperous communities (October 2006)

Department of Health
JSNA guidance (December 2007)

Department of Health
World class commissioning assurance toolkit

Durham University
Partnerships in public health: A healthy outcome? Summary findings of a systematic literature review (July 2008)

IDeA
Healthy Communities Ipsos MORI survey (December 2008)

Integrated Care Network
Implementing joint strategic needs assessment: pitfalls, possibilities and progress (June 2008)

Joint strategic needs assessment quality assurance toolkit (May 2008)

For more details on the Beacon scheme visit:

www.beacons.idea.gov.uk

The Local Government Association is the national voice for more than 450 local authorities in England and Wales. The LGA group comprises the LGA and five partner organisations which work together to support, promote and improve local government.

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