

Joint Strategic Needs Assessment:

Data Inventory



Foreword

With Joint Strategic Needs Assessment (JSNA) taking on an enhanced role in the future, it is more important than ever to ensure that the JSNA is supported by robust data to enable effective planning, prioritisation and commissioning decisions that serve the whole population.

This publication accompanies 'JSNA: a springboard for action' produced by the Healthy Communities Programme¹. It is primarily targeted at members of health and wellbeing boards, clinical commissioning groups and local councils, to assist them in considering the factors that affect health and wellbeing and identifying some of the key data and information that local areas may find appropriate in building a picture of current and future needs. It is not intended to be prescriptive but instead offers a broad range of information that local areas can usefully draw on in designing their JSNA.

It comes at a time when the government has published its response to the listening exercise on the health reforms. The proposals includes a stronger role for health and wellbeing boards in promoting joint commissioning and integrated provision between health, public health and social care. The JSNA will be an important component in this process, providing the local story of health and wellbeing needs and assets, which in turn will set the direction for the Joint Health and Wellbeing Strategy.

I trust that, as health and wellbeing boards become established and new partners, not previously engaged in JSNA, gain awareness of the important contribution that it can play in the broader goals to improve health outcomes and tackle health inequalities, they will find this publication a useful and helpful resource.

A handwritten signature in black ink, appearing to read 'David O. Rogers', with a horizontal line underneath.

Councillor David Rogers – OBE
Chairman, Local Government Group
Community Wellbeing Board

¹ <http://www.idea.gov.uk/idk/aio/27014541>

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Introduction

Joint strategic needs assessment (JSNA) is a core function of health and wellbeing boards. To be fit for purpose, JSNAs should support strategy and commissioning by providing “an objective analysis of local, current and future needs for adults and children, assembling a wide range of quantitative and qualitative data, including user views”².

This data inventory offers practical help to councils, clinical commissioning groups and other members of health and wellbeing boards. It is a tool to generate ideas for the JSNA rather than a checklist of data requirements. There is no expectation that JSNAs would contain all (or even most) of the information in this document; instead it acts as a resource that can be adapted to suit local requirements. The inventory tries to offer a balanced range of information on health and wellbeing in its broad sense. It covers both physical and mental health for children and adults, and includes both quantitative and qualitative data. The inventory therefore creates a framework for telling a local story and for agreeing priorities for action.

JSNA data should reflect the stated objectives of the JSNA process locally and should offer practical support to the health and wellbeing board (HWB) in developing its joint strategy. To be an effective part of the strategy and commissioning process, JSNAs will need to quantify local physical and mental wellbeing needs in a way that has practical value to those who set priorities and commission services.

This data inventory was commissioned by the Department of Health (DH) and it links to the JSNA guide also published by LGID³. Although it is not official guidance, this inventory expands on the previous JSNA Core Dataset published by the DH in 2008.

² Department of Health. ‘Liberating the NHS: Legislative framework and next steps’. DH 2010.

³ Local Government Improvement and Development. ‘JSNA Best Practice Guide’ LGID 2011.

Structure and coverage

The data inventory is organised around the six domains shown below. This follows a simple pathway that starts with the population, runs through some of the factors that affect health and wellbeing, looks at health and wellbeing status and its impact on services, and ends with priorities for local action. These six domains are accompanied by two common themes that run through the whole document: local views and inequalities.

Each domain in the inventory begins with an introduction including some questions that local partners may want to ask. These are followed by sections listing potentially useful information to help answer these questions.



The inventory effectively offers local health and wellbeing boards a menu of indicators that they may wish to include in a JSNA. This is not meant to be exhaustive and local boards will want to replace or supplement the information with other data they consider appropriate. Similarly, JSNAs may give equal coverage to a broad range of topics or alternatively may focus on a limited number of issues in more depth.

Commissioning decisions are made by different bodies that serve different populations (for example upper tier councils, district councils, clinical commissioning groups and the NHS Commissioning Board). All data listed in this inventory is available at upper tier council level but the document also highlights examples where smaller area information is available. This can provide a more in-depth profile of the similarities and contrasts within local populations. The inventory also refers to sources of data on many occasions but these are kept at a high level as the specific references are subject to change over time.

While some of the data items relate to specific population groups, many others relate to the whole community. However it will often be possible to break this data down into specific age groups, localities, GP practices or ethnic groups, for example. This will bring extra depth to the JSNA and help understand whether some groups have particular needs that might otherwise be hidden.

There is some overlap between the content of the data inventory and the NHS, social care and public health outcomes frameworks. While this is deliberate, the two processes have different roles. While the JSNA is about local understanding of local needs, the outcomes frameworks are part of a national accountability mechanism. There will also be differences in the timing, level of detail and presentation of data across the two processes. Public health directors will also want to consider how JSNA data can link to their annual public health report which may be an opportunity to delve into a specific topic in more detail.

Using the inventory

The inventory is aimed at both policy-makers and analysts. Members of health and wellbeing boards and other policy-makers may want to focus on the questions at the beginning of each domain and then to consider domain six (priorities for action) in more depth. This would help to set the agenda for the JSNA and help ensure that information is fit for purpose. Information would be gathered with the aim of answering specific questions and presented in a format that gives practical help to the commissioning process.

The rest of the inventory will be of more help to analysts charged with developing the main content of the JSNA. Guided by an overall steer from the health and wellbeing board, analytical skills can be used to address questions such as:

- Is the data reliable and ‘correct’?
- How do we compare with other places (including peer groups)?
- What are the differences within our community?
- Are any differences statistically significant or just the result of normal variation?
- What are the trends over time?
- What will happen if current trends continue?

However, the gathering and interpretation of JSNA data also requires different perspectives and needs the involvement of a wider range of people. This is when a statistical profile becomes a local narrative with deeper meaning. Having had access to some initial data, members of health and wellbeing boards

and others may want to ask questions such as:

- What are the **causes** of the local position?
- What do local people **feel** about the situation?
- What other information do we need to **understand** what’s really happening?
- What does the **future** look like under different scenarios?
- How can we use JSNA data to set **priorities** and allocate resources?

The audience for JSNA is expanding. It includes clinical commissioning groups and individual GP practices as well as bodies such as councils, public health teams and voluntary sector groups that have been involved in JSNA for some time. The increased number of commissioning bodies and sometimes complex geographical boundaries means that data will need very careful analysis and presentation. Mapping packages and other techniques can be used to overlay different types of information and to illustrate the relationship between them.

Finally, users will be aware that indicators and information sources are themselves changing as the public sector evolves. The government has for example published a ‘single data list’ of national requirements relating to the Department for Communities and Local Government (DCLG) and it is likely that other government departments will adopt a similar approach. As this inventory is intended to be a source of ideas rather than a specific checklist, we hope that its overall structure and meaning will be relevant for some time to come.

Domain one: Population

A detailed understanding of the local population is vital to needs assessment. Population size and structure is a fundamental driver of need and demand. It also forms the basis against which other data can be analysed, helps to identify inequalities and is a key building block in modelling service requirements. JSNA data should paint a picture of the local area, its characteristics and the diversity within it. Some key questions that the JSNA might address include:

- How many people live here, who are they and what are their characteristics?
- What are the different populations that should be used for commissioning services?
- How many people are in groups that have complex or additional needs?
- What (if anything) is special about the local population that might require a different approach to local services?
- How is the population changing over time?
- What is the population expected to look like in three, five and 10 years' time?

1.1 Age and gender

Current local authority population by five year age group and gender, and trends (see note a)

Population data for the smaller geographical areas used for planning local services (for example, super output areas, council wards and larger locality populations that are the basis for local community services)*

Clinical commissioning groups registered populations by five year age group and gender, with degree of fit with the local authority and trends

Populations of each GP practice by age group and gender, and trends

Clinical commissioning groups designated geographical populations by five year age group and gender, with degree of fit with the local authority (b)

Estimated unregistered population within the local authority and in each clinical commissioning group.

Population projections for the local authority (particularly for three, five and 10 years ahead), by age group and gender (c)

Projections of the number and type of households

1.2 Ethnicity

Population estimates by ethnic group and age group* (d)

Level of recording of ethnicity among local GP practices (e)

Registered school population by ethnic group (f)

Languages spoken by children in local schools (f)

1.3 Migration

Migration into and out of the local authority

Foreign National Insurance registrations (g)

New GP registrations from overseas (h)

New school registrations

Country of origin of birth mother (i)

1.4 Births and deaths

Number of births each year*

Crude birth rate*

General fertility rate*

Birth rate for different age groups*

Number of deaths each year, by age group* (j)

All age all-cause mortality rate* (k)

1.5 Population groups that may have specific needs

Actual or estimated number of people in other specific populations that may face greater risks or who may have different types of need. Examples are set out below but this list is not exhaustive:

- carers (including young carers)
- children on the child protection register
- children with statements of special educational needs
- former services personnel
- Gypsies and Travellers
- homeless people
- lesbian, gay and bisexual people
- looked-after children and those leaving care
- migrant workers and their children
- offenders (including those in prison)
- older people living alone
- people with disabilities
- refugees and asylum seekers
- sex workers
- students
- teenage parents and their children
- unemployed people
- young people who are not in education, employment or training.

See also note (l)

Local views

The diversity of the population as described above can be reflected in a wide range of local views on health and wellbeing as a whole. These can set the scene for more targeted and in-depth work on particular topics.

While some quantitative and qualitative methods can seek to gain the views of the general population, there also is a need to hear the voice of specific groups. These can include people in different localities, GP practice lists, age groups, ethnic groups or groups that may be vulnerable (including those who do not readily access healthcare and may require outreach) or who may have complex or different types of need.

A wide range of methods are available and include meetings, interviews, surveys, advocacy groups, reports and representation from local HealthWatch (building on the work of LINKs), user representatives, and online methods. The 'information revolution' in the NHS is one stream of work concerned with opening up access to information and enabling more participation from users and the wider public.

Inequalities

Small area data on population structure can be a starting point in analysing inequalities. Differences in health and wellbeing outcomes may simply be the result of basic population characteristics (for example, age profile) or may result from other more inequitable conditions. Standardisation of data (for example by age and gender) is therefore important.

Differences in the socio-economic status or ethnic composition of populations may contribute to inequalities in prevalence or outcomes and therefore merit deeper analysis. While small geographical area data is readily available, analysis of GP practice and clinical commissioning group populations is more challenging. For example, the level of ethnic group recording by GP practices varies widely.

Vulnerable groups tend to have higher utilisation of health and social care services and differences in numbers in some specific groups may help explain variations in resource use within a local area.

One group that can have high levels of need is those who are not registered with general practitioners. Missed opportunities for prevention and early intervention can lead to worse outcomes and increased levels of emergency hospital admissions. This represents a cost to clinical commissioning groups (and other services) that could potentially be reduced if people were helped to engage with primary care services.

Domain one – notes

***Note:** Throughout the inventory an asterisk denotes examples of where data is normally available, or can be calculated, on a small area (MSOA) level. These examples are not exhaustive and are subject to change over time as information systems evolve. Some of the information will also be available by GP practice and this has also been indicated in places.

- (a) Office for National Statistics (ONS) mid-year estimates at local authority (LA) level are produced annually. ONS experimental estimates for broad age groups are available at lower layer

- super output area (LSOA) and middle layer super output area (MSOA) level. A jointly agreed set of population data used across local agencies can reduce duplication and promote joint-working.
- (b) There may be considerable differences between clinical commissioning group and local authority populations depending on the number and location of constituent GP practices.
 - (c) ONS population projections look 25 years ahead at LA level and 'components of change' data quantify the relative roles of births, deaths and migration. Councils often produce their own projections taking other local factors such as housing developments into account.
 - (d) ONS experimental statistics on ethnic group populations are available at LA level, while some councils also produce local data. 2011 census results will provide an up to date picture at output area (OA) level.
 - (e) Ethnicity recording in primary care is improving but coverage is still variable. Where good quality data exists it can be used as one factor in analysing differences in health status and in acute and mental health service utilisation rates across GP practices and commissioning groups.
 - (f) Local education authority (LEA) information on school populations by ethnic group and languages spoken is normally updated annually following schools census returns made to the Department for Education (DfE) and gives a detailed picture based on aggregated school data rather than place of residence.
 - (g) Information on foreign National Insurance registrations is available from the Department for Work and Pensions.
 - (h) 'Flag 4' data on GP patient registers identify in-migrants registering with a GP. These are available at LA level.
 - (i) Available from birth files
 - (j) Absolute numbers of deaths can highlight the scale of the task in reducing premature mortality. Data can be entered into a life expectancy calculator to model the effect of specific improvements.
 - (k) This overall indicator of mortality sets the scene for more detailed analysis in section 4. It is available as directly standardised rates (often per 100,000 population) or indirectly standardised rates (standardised mortality ratios). Both can be obtained or calculated on a small area basis and the latter are particularly useful in comparing different populations.
 - (l) While some of this information can be derived from routine official sources, much of the data will need to be derived from a range of sources that together will help to build up a coherent picture. These may include voluntary sector organisations (including those that work with specific groups), user/advocacy groups, local services (for example, social care, general practice, and specific targeted community services that may have gathered specific information), and estimates derived from national research. Data on size and trends can help to calculate future service requirements.

Domain two: Social and place wellbeing

This domain is about wellbeing in its widest sense. Individual and community experience is affected by many different factors that together contribute to social and place wellbeing. This domain should draw on data from a wide range of perspectives including learning and skills, the economy, housing, the environment, crime and disorder and other issues. It reflects the new position of public health as a council-led function that links closely with these 'wider' determinants of health and wellbeing. Key questions include:

- What are the social, economic and other factors that promote wellbeing?
- What are the social, economic and other factors that damage wellbeing?
- How are these changing over time?
- How do they affect different groups of people or cause inequalities?
- What are the community's main assets and how strong are social networks?
- What do local people feel about the area and what are they concerned about?
- How do these wider factors affect the need for health and social care services?
- What does the future look like for the place as a whole?

2.1 Community wellbeing

The ONS classification of the council area and MSOAs with peer group clusters for comparative purposes

Index of Multiple Deprivation 2010*

Participation in regular volunteering

Civic participation in the local area

Percentage of people who feel that they belong to their neighbourhood

2.2 Economy and income

Employment by occupational group

Average incomes

Overall employment rate and unemployment rate

Working-age people on out-of-work benefits

Working-age people claiming out-of-work benefits in the worst performing neighbourhoods

Adults with learning disabilities in employment

Adults in contact with secondary mental health services in employment

People receiving housing benefit

People in rent arrears in social housing

Home repossessions

Estimated number of people with no recourse to public funds

Number and proportion of households in fuel poverty

Number and proportion of children living in poverty*

Free school meals eligibility

Income deprivation affecting children index*

Income deprivation affecting older people index*

People in households receiving means-tested benefits (a)

2.3 Environment

Access to services (b)

Access to natural spaces (c)

Carbon emissions (tonnes per capita)

Per capita reduction in CO₂ emissions in the LA area

Energy efficiency (private sector)

Percentage of people receiving income-based benefits living in homes with a low energy rating

Residual household waste per household

Level of air quality, for example near busy roads and industrial sites

Land contamination

Street and environmental cleanliness

Noise and vibration levels monitored by environmental health (for example, near busy roads and airports)

Information on food poisoning outbreaks – type, location and number of people affected

Level of flooding risk

Proposed developments in the area that might affect population health and wellbeing (d)

Transport – for example, journeys to school and work, traffic levels, transport surveys

2.4 Education

Children found to be working securely (achieving 6 points or more) in foundation stage school assessments

Number of children with special educational needs (SEN)

Numbers of children with statements of SEN by type of need

Percentage with five GCSEs at A* to C grade (in total and including English and maths), by gender, by ethnic group and for children in care

Achievement gap between pupils eligible for free school meals and their peers at Key Stages 2 and 4

Achievement of a level three qualification by the age of 19

Number and proportion of the population by educational level (NVQ equivalent)

Number of 16 to 18 year olds who are not in education, employment or training

Primary and secondary school exclusions

Pupil absence (authorised or unauthorised)

See also note (e)

2.5 Housing

Houses in multiple occupation

Housing condition (private sector)

Housing tenure*

Overcrowding*

Older people living alone* (f)

Older people with central heating*

People living in residential and nursing care homes (g)

Housing affordability and average house price in the area

Number of unfit dwellings

Specialist housing provision for people with particular needs (for example, learning disabilities, mental health) (h)

Adults with learning disabilities in settled accommodation

Adults in contact with secondary mental health services in settled accommodation

Number of households living in temporary accommodation

Statutory homeless households

Homeless households with dependent children or pregnant women

Rough sleepers (i)

Number of Gypsy and Traveller sites and estimated populations

Hostels, social housing schemes and the populations within them (j)

Performance and other indicators on local social housing providers (k)

Information on activity from the council's housing and supporting people departments (for example, numbers of applications for housing)

See also note (l)

2.6 Crime and disorder

Recorded crime numbers and rates including:

- burglary
- criminal damage
- drug offences
- fraud and forgery
- sexual offences
- violence
- domestic violence
- robbery
- vehicle crime
- others.

Incidents of domestic abuse

Perceptions of antisocial behaviour

First time entrants to the youth justice system aged 10-17 years

Proven re-offending rate by young offenders

Court diversions for people with mental health problems

British crime survey statistics

See also note (m).

Local views

Statistical data on perceptions of place wellbeing can include:

- perceptions that people in the area treat each other with respect and consideration
- percentage of people who believe people from different backgrounds get on well together
- percentage of people who feel they belong to their neighbourhood
- overall satisfaction with the local area
- percentage of people who feel they can influence decisions in their locality.

Surveys of the users of housing, community safety and other local services can shed light on needs that are being met or not met (including their views on preventative services or access for people in particular circumstances).

Councils often hold ward- or locality-based public meetings that provide an opportunity to hear local people's views on a wide range of issues affecting their local area.

Voluntary sector umbrella groups and specific organisations such as Citizens Advice Bureaux (and many others) can provide valuable local information on the needs of the community. Although not always comparable with national data, this information can help build a deeper understanding of issues and trends in the community.

Inequalities

The index of multiple deprivation, index of poverty affecting children and index of poverty affecting older people are all available at small area level. These can paint a detailed picture of inequalities within the local authority population. They can also be used to explore relationships with other indicators such as life expectancy or hospital admission rates (for example by grouping super output areas into deprivation quintiles to include a large enough population to analyse).

The slope index of inequality of people receiving means-tested benefits (a Marmot indicator) provides a measure of the inequality in this indicator across super-output areas within a local authority area.

Various other indicators are available at small area level and can also be broken down by gender or other factors. For example, data on employment and average earnings can highlight the level of inequality between men and women in the locality

Other inequalities can be detected by analysing data such as educational achievement by ethnic group or other factors such as poverty (free school meals) or for children being looked after.

Domain two – notes

- (a) This includes people receiving income support, job seekers allowance, pension credit, working tax credit, child tax credit and asylum seekers receiving support. The new proposed benefit called 'universal credit' will replace some individual benefits. Note that benefits and entitlements are subject to change from year to year and therefore comparisons over time may not always be appropriate.

A tool for extracting a wide range of data on work and benefits (many broken down by age group, gender and other factors) is available at: <http://research.dwp.gov.uk/asd/index.php?page=tabtool>

NOMIS is provided by the Office of National Statistics and also supplies local data on employment and related issues. These include employment and unemployment, occupation, employment sectors, qualifications, earnings and benefit claimants. See www.nomisweb.co.uk

- (b) LSOA level data on geographical barriers to services are available as part of the Indices of Multiple Deprivation 2010.
- (c) District and county reports on access to natural green spaces are available from Natural England (www.naturalengland.org.uk/regions/). These include statistics on the percentage of households with easy access to green spaces, and local maps.

- (d) A series of reports on health and the urban environment are available from the NHS London Healthy Urban Development Unit (HUDU). The site also includes a specific tool for calculating the healthcare services required in relation to new housing developments.
- (e) The Department for Education website provides data for LEAs, lower tier councils and parliamentary constituencies at www.education.gov.uk/inyourarea Topics include literacy and numeracy, exam results, special educational needs, school initiatives and workforce, funding, social care, early years, class sizes, post-16, higher education and adult education.
- (f) Projecting Older People Population Information (POPPI) provides projections of older people living alone, by council. This can lead to raised requirements for support services and can be an indicator of social isolation.
- (g) POPPI provides projections of people living in a care home, by council.
- (h) Available from social housing providers such as housing associations.
- (i) A homeless health needs audit tool has been developed by Homeless Link and is available at www.homeless.org.uk/toolkits-and-handbooks/health-needs-audit The tool guides local organisations through the process of gathering information, interpreting the results, and action planning. It also has an online tool to help with data analysis and has links to useful background information.

Information on rough sleepers is published annually by DCLG and can be supplemented by data from local outreach and other agencies.

- (j) Hostel and other housing providers often gather information on new tenants including basic physical and mental health information, GP registration, substance use, age and mobility.
- (k) Social housing data is available from the Tenants Services Authority (the social housing regulator) at: www.tenantservicesauthority.org
- (l) Council-level housing data is available at www.communities.gov.uk
These include housing stock, house building, household estimates, housing market and house prices, rents lettings and tenancies, homelessness and social housing sales.
- (m) Data on Assessments of Policing and Community Safety (APACS) are available for police force areas at www.homeoffice.gov.uk.
This includes user satisfaction, public perceptions about crime and the police, equalities, crime rates, performance data, road traffic accidents and re-offending.

Violence indicator profiles cover recorded violent crime, hospital admissions, mortality and deprivation data, available at www.nwph.net/nwpho/



Domain three: Lifestyles and health improvement

Many lifestyles and behaviours have an impact on health and wellbeing. They are often affected by the socio-economic factors outlined in the previous domain and can therefore exhibit sharp inequalities. Improving lifestyles can have very substantial long-term benefits but a multi-faceted approach that also tackles the 'causes of the causes' is likely to be most effective. This section also includes some of the specific preventative measures that can improve population health. Some key questions for the JSNA include:

- How do lifestyles and behaviours affect physical and psychological health and wellbeing in this population?
- What is the relative importance of each of them?
- Are there common causal factors that need to be tackled?
- What are the main inequalities within the area?
- What are local people's attitudes towards lifestyles and how do they think they can be supported in making the changes they want to make?
- Are preventive measures being delivered on a sufficiently large scale to make a difference to population outcomes?
- Are preventive measures being taken up by those who need them most?

3.1 Physical activity

Children travelling to school – mode of transport usually used

Participation in sport and active recreation (including recreational walking and cycling)

Modelled estimates of physically active adults (a)

Cycling participation

LA level results from the Active People Survey (b)

3.2 Healthy eating

Proportion of school pupils having school meals

Breast feeding initiation rate and prevalence of breast feeding at six to eight weeks after birth (c)

Synthetic estimates of five-a-day consumption of fruit and vegetables* (d)

Prevalence of healthy weight in four to five and 10 to 11 year olds

3.3 Alcohol

Self-reported alcohol use by children and young people

Modelled estimates of the prevalence of binge drinking

Perceptions of drunk or rowdy behaviour as a problem

Recorded crime related to alcohol

Synthetic estimates of drinking behaviour* (e)

See also note (f)

3.4 Drug misuse

Drug-related offending rate

Number of drug users recorded as being in effective treatment

Perceptions of drug use or drug dealing as a problem

Self-reported drug use by children and young people

Number of people leaving drug treatment free of dependency

See also note (g).

3.5 Smoking

Self-reported smoking among children and young people

Modelled estimate of smoking prevalence in adults over 18*

Maternal smoking prevalence (h)

Percentage of expectant mothers who are registered as a smoker when booking a first midwife appointment who by the time of delivery have stopped smoking

3.6 Health improvement interventions

Population vaccination coverage at PCT and GP practice level (i)

Uptake of flu vaccinations by GP practice

Uptake of the NHS health check programme for eligible people

Uptake of newborn hearing screening

Uptake of Chlamydia screening in under-25s

Proportion of women aged 53 to 70 and 50 to 73 screening for breast cancer (j)

Cervical screening rate by GP practice

Bowel cancer screening rate

Diabetic retinopathy screening rate

Percentage of patients on community caseloads who have been screened for alcohol intake by community service staff as part of their assessment or community care planning

Identification and brief interventions for alcohol in primary care

Four-week smoking quitter rates (k)

Modelled impact of stop smoking services on life expectancy (l)

Treatment completion rates for tuberculosis

Numbers of people provided with long-acting reversible contraception

Early access to maternity services (under 13 weeks from conception)

Percentage of looked-after children who have had a health assessment within specified time periods (once every six months up to the age of five years, then annually).

Percentage of looked-after children who have had a dental assessment within the last year

Percentage of looked-after children whose immunisations are up to date

Percentage of patients in community health services who have had a nutritional assessment using an established screening tool

Detection and prevention activities in primary care (m)

Local views

Local surveys commissioned by councils, health or other organisations can provide additional information on lifestyles and on attitudes towards health and wellbeing. These can help commissioners target resources at populations with the greatest needs and can help ensure that information and service delivery is tailored in the most effective way.

Surveys include school student surveys such as those provided by the Schools and Students Health Education Unit.

Lifestyles can be considered in a more integrated way as well as separately. For example it may be useful to establish what proportion of the population combine four key healthy behaviours together (exercising, not smoking, keeping alcohol consumption down to moderate levels and eating fruit and vegetables).

Inequalities

Equalities impact assessments are tools to assess the likely implications of decisions on the whole community. They are carried out in service planning and policy development and may generate useful data that can then be reviewed to assess actual impacts.

Routine information collection and specific exercises such as equity audits can be used to detect the degree to which lifestyles and preventative measures have a positive or negative effect on health inequalities. For example, smoking prevalence may vary by ethnic group or by locality and may merit specific targeted action.

The take up of preventative services such as screening may vary by locality, ethnic group or by specific groups such as people with learning disabilities or mental health problems.

Primary and secondary prevention interventions can be unequal as a result of different levels of coverage or participation by GP practices. Practice level Quality and Outcomes Framework (QoF) data on coverage and exclusion rates can be used to highlight inequalities.

Information on services such as immunisation coverage among children in care may reveal higher or lower rates than the wider population.

Domain three – notes

- (a) Model-based estimates and market segmentation maps are available at www.sportengland.org
- (b) Active people survey results are also available from Sport England.
- (c) A range of breastfeeding-related data is available in the Child and Maternal Health Observatory (CHIMAT) breastfeeding profiles.
- (d) Five-a-day information is available from ONS. Local survey data may also be available (including in schools).
- (e) Information on drinking behaviours is available from ONS. Local survey data may also be available (including in schools).
- (f) Local alcohol profiles for each council area are at www.nwph.net/alcohol/lape
These cover alcohol-related admissions, deaths and years of life lost, accidents, crime, people on benefits and prevalence estimates.
- (g) The local police authority, service providers and others will have detailed information on the local situation regarding drugs. A key source would be needs assessments carried out by the drugs and alcohol action team (DAAT).
- (h) Information on smoking in pregnancy (at the time of delivery) is available at LA level at www.apho.org.uk
- (i) Immunisation figures at PCT level are available from www.ic.nhs.uk annually. For children these include a breakdown of different immunisations by recommended age.
- (j) Breast screening coverage is available annually at PCT level at www.nchod.nhs.uk
- (k) Local stop smoking services can provide more detailed data on their users and outcomes.
- (l) The Health Inequalities Intervention Tool allows users to estimate the likely effects of stop smoking services on average life expectancy.
- (m) QoF indicators provide information on the scale of key preventative activities being carried out by each GP practice compared to PCT and national averages. Examples include blood pressure and cholesterol monitoring and control. Profiles are available at www.apho.org.uk/PracProf/

Domain four: Health and wellbeing status

This domain is about the health and wellbeing status of the population, which will be strongly influenced by the picture revealed in the previous three domains. It is an opportunity to delve into more specific aspects of health and wellbeing and to analyse the level of inequality within the population. The health status of different groups will vary markedly and the detail of this needs to be understood in order to take effective action. Quantifying the number of people affected in absolute terms will help to plan future services.

- How healthy are local people?
- What is their level of overall wellbeing?
- How does the current position compare with expected levels and local aspirations?
- What is the level of psychological health of local people and what inequalities exist?
- How many people have problems that limit activities of daily living?
- What are the main causes of reduced life expectancy locally?
- What are the main causes of years with disability locally?
- What are the main causes of health inequalities between different localities and different population groups?
- What are local people's attitudes to health and wellbeing?

4.1 Overall wellbeing

There is a growing body of work on the subject of overall wellbeing and how to measure it. A number of alternative approaches exist, for example asking people the following question: "All things considered, how satisfied are you with your life as a whole nowadays?" (a)

Projections of general level of health (b)

Local Index of Child Wellbeing (c)

4.2 Life expectancy and mortality

Average life expectancy at birth for males and females*

Life expectancy by deprivation quintile within each LA (d)

Life expectancy at age 75

Healthy life expectancy at age 65

Years of life lost by cause

All cause standardised mortality ratio – all ages*

All cause standardised mortality ratio – aged under 75*

Smoking attributable mortality*

Mortality rate from causes considered amenable to healthcare* (e)

Excess winter deaths

4.3 Children and young people

Proportion of babies born with low birth weight*

Perinatal mortality rate including stillbirths

Infant mortality rate

Causes of infant mortality

Child mortality rate (age one to 17 years)

Children achieving a good level of development at age five years (f)

Percentage of children that have had a two-year review by 32 months

Summary of outcomes of the Healthy Child Programme two year review

Prevalence of healthy weight in four to five and 10 to 11 year olds* (g)

Rate of dental caries in children aged five years (decayed, missing and filled teeth) (h)

Children killed or seriously injured on roads

See also note (i)

4.4 Disability

Prevalence of disabilities among children

Prevalence of visual impairment among children

Prevalence of continence problems among children

Prevalence of speech and language impairment among children (j)

Overall level of disability by severity

People with limiting long-term illness* (k)

Disability and employment (l)

People registered blind or partially sighted (m)

Prevalence of age-related macular degeneration, cataract, glaucoma and low vision (n)

Prevalence of loss of vision, projections and economic costs (o)

Number of people who are deaf or who are hard of hearing

Estimated number who have a hearing aid and of those who do not have a hearing aid but who could benefit from one (p)

Children and adults with learning disabilities

Projected numbers of people with Down's syndrome

Projected numbers of people with learning disabilities

Projected numbers of people with moderate or severe learning disabilities living with a parent (18-64)

Projected numbers of people with learning disabilities with challenging behaviour (aged 18 to 64)

Projected numbers of people with autistic spectrum disorders (aged 18 to 64)

Projected numbers of older people with mobility problems

Projected numbers of older people with moderate or severe visual impairment

Projected numbers of older people with moderate severe or profound hearing impairment (q)

People aged 65 and over providing unpaid care to a partner, family member or other person
People aged 65 and over unable to manage at least one domestic task on their own
People aged 65 and over unable to manage at least one self-care activity on their own (r)
See also note (s)

4.5 Mental health

Estimated prevalence of postnatal depression
Percentage of new mothers that have had an assessment for postnatal depression
Estimated prevalence of conduct disorders among children
Estimated numbers of children needing tier one, two, three and four child and adolescent mental health services (CAMHS)
Estimated prevalence of learning disability among children
Estimated prevalence of children with autistic spectrum disorders
Estimated numbers of young offenders with a mental health disorder
Estimated number of looked-after children with a mental health disorder (t)
Number of children who say they have someone to talk to
Number of pupils who say they have been bullied (u)
Recorded prevalence of dementia, depression, psychoses and learning disabilities by GP practice (v)
Estimated number of people with dementia by level of severity and by intervals of care requirements

Estimated prevalence of dementia and projections
Estimated prevalence of depression in older people and projections
Estimated prevalence of severe depression in older people and projections (w)
Percentage of patients on community caseloads who have been screened for anxiety and depression (including results)
Proportion of years of life lost and of disability-adjusted life years relating to mental health problems
Suicide and injury of undetermined intent mortality rate
Mental illness needs indices
Mental illness prevalence rates (x)
People on incapacity benefits due to mental health problems per 1,000 working age population.
Rates of people detained under the Mental Health Act (and on guardianship) by age, gender and ethnicity.
See also note (y)

4.6 Cardiovascular health, cancers and respiratory health

Recorded prevalence of coronary heart disease (CHD), stroke, hypertension, chronic obstructive pulmonary disease (COPD), asthma, cancer, epilepsy, chronic kidney disease, and hypothyroidism by GP practice
Modelled prevalence of hypertension
Modelled prevalence of coronary heart disease
Modelled prevalence of COPD

Under-75 mortality rate from cardiovascular disease*

Mortality rate from all circulatory diseases all ages*

Mortality rate for CHD (all ages and under-75) and standardised mortality ratio (SMR)*

Mortality rate for stroke (all ages and under-75) and SMR*

Cancer registrations (incidence rates)
Incidence of common cancers (for example, skin, breast, colorectal, lung and prostate) (z)

Standardised mortality ratio for cancers (all ages)*

Under-75 mortality rate from cancer*

Cancer survival rates

Under-75 mortality rate from respiratory disease

Mortality rate from chronic obstructive pulmonary disease

Respiratory disease mortality SMR all ages*

Tuberculosis notifications

Projections for older people with heart attack, stroke and bronchitis/emphysema (aa)

4.7 Sexual health

Under-18 conceptions

Under-16 conceptions

Proportion of under-18 conceptions that end in abortion

Numbers and rates for sexually transmitted infections (bb)

Chlamydia diagnosis rates per 100,000 young adults aged 15-24

Prevalence of HIV (cc)

Proportion of people presenting with HIV at a late stage of infection (dd)

4.8 Other key health issues

Under-75 mortality rate from liver disease

Alcohol attributable mortality

Prevalence of diabetes by GP practice and commissioning groups (ee)

Number of people with uncontrolled diabetes by GP practice

Modelled prevalence of obesity (adult)* (ff)

Recorded prevalence of adult obesity by GP practice

Obesity attributable mortality

Smoking attributable mortality (directly age standardised rate aged 35 and over) (gg)

People killed and people seriously injured in road traffic accidents

Mortality rate for communicable diseases

Numbers of people known to have serious or multiple long-term conditions and who are identified as having a particularly high level of risk of ill-health and hospital admission and who may merit a more pro-active approach in the community (hh)

Projections of numbers of older people having a fall and those admitted to hospital due to a fall
Projections of numbers of older people with continence problems
Projections of numbers of older people with obesity
Projections of numbers of older people with diabetes (ii)

Estimated numbers of children and adults requiring palliative/end of life care

Proportion of people dying at home

Local views

More specific needs assessments on particular health and wellbeing topics will be an opportunity to involve local people and organisations in offering their own perspective and experience. Local voluntary sector organisations will often have a wealth of qualitative and other information to offer new insights on the health and wellbeing of specific groups. These might be specific to particular age groups. For example, 'You're Welcome' assessors and youth parliaments are just two ways of encouraging young people to contribute their views.

An increasingly useful source of information on health status is the Patient Reported Outcome Measures (PROMs). This asks patients about their health status before and after treatment and can be used to gain a deeper understanding of the level of problems being experienced by people with a specific health condition and the degree of benefit derived.

HealthWatch will be the local consumer voice for people who use and need health and social care services. It will carry forward functions of existing Local Involvement Networks (LINks) as well as delivering on new responsibilities to provide advice and information as well as signposting to enable people to navigate their way through the health and social care system.

Inequalities

Many of the detailed indicators above can be broken down by age, gender, ethnic group, small area, and some by GP practice. This will help identify groups that may suffer inequalities and merit specific attention.

The slope index of inequality of life expectancy for males and females is based on the gap in life expectancy within the council area after grouping small areas into deciles according to their level of social deprivation. There is a similar indicator based on disability-free life expectancy.

More detailed information on the health and wellbeing of specific higher risk and more vulnerable groups is available from a wide range of sources. These are too numerous to list but one example directly relevant to the JSNA is the report 'Including migrant populations in joint strategic needs assessment – a guide' available at www.nepho.org.uk

It is also important to understand if health and wellbeing inequalities are becoming wider over time or if the gap is narrowing. Some specific small areas may be seeing improvements whereas others may show signs of a continuing cycle of deprivation.

Domain four – notes

- (a) This question was included in the DCLG question bank. It is a 'level 1' (universal) indicator that can be supplemented with information on specific domains of wellbeing. These are outlined in the 2008 IDeA report 'Local wellbeing – can we measure it?'. Self-reported wellbeing data may be gathered through the Health Survey for England and/or the national GP survey.
- (b) Available from POPPI.
- (c) This is made up of a number of elements and can be found at www.communities.gov.uk
- (d) Available at www.communityhealthprofiles.info
- (e) Available from www.nchod.nhs.uk
- (f) This is available at council level and is derived from data from the Early Years Foundation Stage Profile. It is based on teachers' assessments of children in the year they turn five using 13 assessment scales based on early learning goals. However this does not normally cover private schools.
- (g) Primary school data available from www.ic.nhs.uk/ncmp
- (h) DMFT data collected through biennial survey and at www.bascd.org
- (i) A wide range of information on children and young people's health and maternal health is available at the national Child and Maternal Health Observatory (www.chimat.org.uk). This includes a data atlas, child health profiles and a wide range of needs assessment tools providing data on various aspects of child and maternal health.
- (j) Children's disability prevalence data available from CHIMAT
- (k) Local area data available from census tables. Projections for councils are available from POPPI and include information by housing tenure, ethnic group and people living alone.
- (l) Annual population survey/labour force survey data on disability available at www.nomisweb.co.uk
- (m) Data on blind/partially sighted from the NHS Information Centre.
- (n) Epidemiological information for local areas is available at www.eyehealthmodel.org.uk
- (o) Research reports at www.rnib.org.uk can be applied to the local population
- (p) Both of these are available from the Royal National Institute for Deaf People.
- (q) These various projections are available at a council level from PANSI/POPPI as appropriate.
- (r) These are available at a council level from POPPI.
- (s) A range of other quantitative and qualitative information is available from specific organisations working with disability issues and from umbrella organisations such as the Voluntary Organisations Disability Group.
- (t) Children's prevalence data available from the CHIMAT CAMHS needs assessment tool (local areas may have additional information through use of the CAMHS self assessment matrix).
- (u) These have been available through the Tellus4 survey. Localities may have access to alternative local information.

- (v) This is QoF recorded prevalence and should be compared with expected prevalence to identify the extent of the detection gap in each GP practice and consortium. Models of expected prevalence for a number of chronic diseases are available at www.apho.org.uk/ (resource 48308).
- (w) These are available at a council level from POPPI.
- (x) Both the mental illness needs index (MINI) and an index based on the National Psychiatric Morbidity survey (ward level) are available at www.nepho.org.uk/mho/ The site also contains prevalence estimates for common mental health problems by LA and age group.
- (y) The national mental health outcomes strategy ('No health without mental health') sets out six shared objectives and a range of indicators to measure progress.
- (z) Cancer registrations data available from www.nchod.nhs.uk The specific cancers where figures are sufficiently large to be disclosed on the non-NHS version of the National Centre for Health Outcomes Development (NCHOD) are: all cancers, all skin cancers, and breast, colorectal, lung and prostate cancers. More information on cancer is available at the National Cancer Intelligence Network.
- (aa) Available from POPPI.
- (bb) Health Protection Agency (HPA) data collected from genito urinary medicine (GUM) clinics.
- (cc) Sexually transmitted infection (STI) and HIV data available from the HPA (diagnosed cases only).
- (dd) Late diagnosis is defined as a CD4 count of less than 350mm³ within three months of diagnosis.
- (ee) Recorded prevalence available through QoF. Modelled diabetes data is at www.yhpho.org.uk
- (ff) Modelled adult obesity data is at www.ic.nhs.uk
- (gg) Age standardised deaths attributable to smoking are available at LA level at www.communityhealthprofiles.info.uk
- (hh) A number of risk identification and stratification tools are available. One example is the combined risk predictive model developed by the King's Fund.
- (ii) Projections available from POPPI.

Domain five: Service utilisation

Use of services is affected by not only the health and wellbeing status of the population but also by other factors such as community expectations, referral pathways and the pattern of supply of services. The JSNA should support a good understanding of local demand and utilisation and how this is changing over time. This could include services other than the health and social care issues listed here. Good analysis of need should help commissioners to predict future service requirements and to anticipate future changes in activity. There will also be normal variation in activity which should be understood and allowed for. Some key questions include:

- What are the levels and trends in the use of different services locally?
- What does the profile of service users look like?
- Are there some very specific groups that have a high usage of services?
- What are the main drivers of service utilisation?
- What would be the effect on service use if inequalities were reduced?
- What would be the projected level of service use if current utilisation rates continued?
- What would be the projected level of service use under alternative future scenarios?
- What are local people's views about current service gaps and likely future need?

5.1 Social care

Looked-after children by type and location of placement

Outcome indicators for looked-after children

Children in need including information on children subject to a child protection plan

Numbers of new clients for whom an assessment was completed, by age group, gender, ethnic group and sequel (assessment result)

Number of clients with physical disability, frailty and sensory impairment, learning disability, mental health problems (including dementia), substance misuse, vulnerable people

Number of these receiving services in the community

Breakdown of above clients by age, ethnic group and gender (a)

People supported to live independently through social services

Proportion of people with long term conditions supported to be independent and in control of their condition

Carers receiving needs assessment or review

Carers receiving specific carer's services (including respite), advice and information

Projected numbers of carers aged 65 and over providing unpaid care (b)

Proportion of people using social care who receive self-directed support (including personal budget)

Admissions to residential care homes per 1,000 population

Percentage of all referrals to adult safeguarding services which are repeat referrals (c)

Projected numbers of older people helped to live independently

Projected numbers of older people receiving services in the community

Projected numbers of older people in residential and nursing home care

Projected numbers of older people admitted to permanent residential or nursing home care during the year

Projected numbers of carers aged 65 and over receiving social care services

Projected numbers of older people receiving social care services through direct payment or personal budgets (d)

Projected numbers of households receiving intensive home care (aged 18 and over)

Projected number of people with learning disabilities helped to live independently

Projected number of people with learning disabilities supported in care homes

Projected number of people with learning disabilities receiving direct payments or personal budgets (e)

Projected number of people with mental health problems helped to live independently

Projected number of people with mental health problems supported in care homes

Projected number of people with mental health problems receiving direct payments or personal budgets (f)

5.2 Health care

Access to general practitioner services

Access to dental services

Number of people accessing NHS dentistry services (g)

Accident and emergency attendance rate

First outpatient attendances*

Subsequent outpatient attendances*

Outpatient re-attendance rate*

Emergency hospital admissions and rate per 1,000 population for all causes*

Other non-elective hospital admissions and rate per 1,000 population for all causes*

Elective hospital admissions and rate per 1,000 population for all causes*

Total hospital admissions and rate per 1,000 population for all causes*

Emergency re-admissions within 28 days of discharge from hospital

Early access for women to maternity services

Access to NHS-funded abortion services before 10 weeks gestation

Unplanned hospitalisation for chronic ambulatory care sensitive conditions (adults)

Emergency admissions for acute conditions that should not usually require hospital admission*

Unplanned hospitalisation for asthma, diabetes and epilepsy in under-19s.

Hospital admissions caused by unintentional and deliberate injuries to children aged one to five, and five to 18

Emergency hospital admissions for asthma, epilepsy and diabetes among children

Hospital admissions for children with lower respiratory tract infections

Acute admissions as a result of falls or fall injuries for people aged 65 and over*

Emergency hospital admissions for hip fracture in the over-65s*

Emergency bed-days associated with multiple (two or more) acute hospital admissions for people aged 75 and over.

Mental health outpatient attendances and rate per 1,000 population

Mental health hospital admissions and rate per 1,000 population

Rate of hospital admissions per 100,000 for alcohol-related harm*

Hospital admissions due to alcohol-specific conditions in under-18s

Accident and emergency attendances related to alcohol

Hospital admissions due to substance misuse in people aged 15 to 24

Hospital admissions relating to self-harm

People referred for and receiving psychological therapies as a percentage of those estimated to have depression and/or anxiety disorders

Admissions and occupied bed-days for people with a primary diagnosis of dementia and for people with any diagnosis of dementia, for acute and mental health trusts

Admissions and occupied bed-days for people with a primary diagnosis of psychosis and for people with any diagnosis of psychosis, for acute and mental health trusts

Admissions and occupied bed-days for people with a primary diagnosis of substance misuse and for people with any diagnosis of substance misuse, for acute and mental health trusts

CHD emergency hospital admissions*
CHD elective hospital admissions*
Myocardial infarction emergency hospital admissions*

Stroke emergency hospital admissions*

Respiratory disease elective hospital admissions*

Respiratory disease emergency hospital admissions*

COPD emergency hospital admissions*

Modelled future activity taking into account utilisation rates and local population projections (h)

See also note (i)

Local views

There is an increasing number of statistical measures of local views on services including:

- Social care-related quality of life (this is a composite measure reflecting social care users' reported experience of seven outcome domains: control, dignity, personal care, food and nutrition, safety, social participation and accommodation).
- The proportion of people using adult social care services who have control over their daily life (this is a self-reported measure, reflecting the individual's perception of their control over their daily life).
- Overall satisfaction with local adult social care services – adults social care survey.
- Percentage of adult social care service users who feel safe and secure.
- User-reported measure of respect and dignity in their treatment.
- Self-reported experience of social care users.
- Parental experience of services for disabled children.
- Patient-reported outcomes measures for elective procedures.
- Patient experience of hospital care.
- Women's experience of maternity services.
- Patient's experience of community mental health services.
- Proportion of people feeling supported to manage their condition.
- Patient experience of primary care.

The national adult inpatient survey results by hospital trust feed in to the Patient Experience CQUIN tool and allow trusts to benchmark their scores against other organisations.

Local HealthWatch and other mechanisms described in section 4 above can offer views on local services. Reports from previous arrangements such as LINks and overview and scrutiny committees may also be a useful source of material.

Local foundation trust members and governors can also provide views from their perspective.

Inequalities

Service utilisation rates by small area and deprivation quintile can help to highlight inequalities, particularly if the data are standardised.

The proportion of service utilisation and spend that is taken up by a relatively small number of frequent or intensive service users (for example people with multiple conditions) can highlight those with high levels of need.

Some groups are 'hidden' or do not readily access health and social care services. These are hard to quantify but may be prone to health inequalities or late presentation of problems. Some utilisation data can help to identify such groups but other mechanisms such as audits or qualitative research may also be needed.

The balance between emergency and elective hospital admissions by deprivation level can indicate higher morbidity/ later presentation/ poorer access to primary care and preventative interventions.

Ethnic monitoring of social care and health care services can highlight groups with lower or higher than expected utilisation and which may reveal issues for further investigation. This can be part of an equity audit process that can also examine factors such as gender, disability and other issues.

Are utilisation inequalities becoming wider over time or is the gap narrowing? What would the gap look like under various alternative futures?

Domain five: notes

- (a) Numbers of clients derived from referrals, assessments and packages of care (RAP) returns and available through NASCIS, NHS Information Centre.
 - (b) Projections available from POPPI.
 - (c) Abuse of Vulnerable Adults return.
 - (d) Available through POPPI.
 - (e) Available through Projecting Adult Needs and Service Information (PANSI).
 - (f) Available through POPPI.
 - (g) NHS dentistry figures at PCT level are available quarterly from www.ic.nhs.uk (primary care data) and include the percentage of the population seen.
 - (h) Simple projections can be made using age/sex utilisation and population data. A number of tools can be used to support and add depth to this process depending on local requirements.
- (i) A wide range of PCT and practice level data on healthcare utilisation is available at www.nhscomparators.nhs.uk
NHS quality observatories aim to promote the quality of health care by enabling local benchmarking, developing metrics and helping staff to innovate and improve services. Often linked to public health observatories at a local level, they largely provide data relating to provider trusts rather than commissioning organisations. See www.qualityobservatory.nhs.uk for details.

Domain six: Priorities for action

JSNAs can include a wealth of data that deepens understanding of local needs and helps to predict future service requirements. However their role is also more proactive and should guide commissioning priorities. JSNAs should therefore include data that is directly relevant to priority-setting. This involves making comparisons between different alternatives and including evidence on effectiveness and cost effectiveness. Such information is always important but has added significance when resources are very limited and funding may need to be moved from one service or intervention to another.

Some data relating to priority-setting is outlined below. It is divided into two sections: data to support the development of overall strategic priorities of the health and wellbeing board, and data to help commissioners make specific investment plans. Although this is set out as a two-stage process, in practice there will be some overlap between these two elements of priority-setting.

6.1 Priorities for the joint health and wellbeing strategy

JSNAs can aid transparency by setting out the local health and wellbeing board's agreed criteria for establishing strategic priorities. It is then possible to present data to help in the assessment process and in forming a shortlist of priority topics for the local health and wellbeing strategy.

The assessment and shortlisting process can use data such as:

- **Numbers of people affected by the issue**
This data should be covered in earlier chapters of the JSNA. It can also include information on which segments of the population are affected or at higher risk.
- **Effect on people's health and wellbeing**
Data on the severity or harm caused by the topic is important. This can be about medical implications (for example, CVD risk of death or disability) or about wider and multiple consequences (for example, problems in early years increasing the risk of later unemployment or offending). The relationship between the topic and the overall health and wellbeing strategic objectives set by the board should be clarified. Measures such as the number of years of life lost or quality adjusted life years (QALYs) lost can help with priority-setting by combining numbers of people affected with the health impact of the problem. QALYs should be used with caution though as they can include 'hidden' value judgements such as the relative importance of health now compared to health in the future.

- **Projected future position if no action taken**

Population projections and trend data can be used to assess the extent to which the position may get better or worse in future years. This might have important consequences for overall health and wellbeing and for resource use. For example, if the age/sex-adjusted prevalence of a condition is increasing and the specific population at high risk is increasing, there will be a major impact in years to come. Sensitivity analysis can help to test the effect of different futures and allow for variations from current expectations.

- **Scope for improvement**

Comparative data can help to assess the extent to which improvements could be made taking into account the current level of provision or state of need on the ground. This can include comparisons with 'high-performing' councils across the country or with councils in a specific peer group. It can also involve examining differences within the council area. For example, what would happen if outcomes in the bottom performing quintile reached those in the top quintile? Sources of comparative data include www.nhscomparators.nhs.uk and the NHS Atlas of Variation in Healthcare (at www.sepho.org.uk). Modelling tools such as the health inequalities intervention tool can help to measure the degree to which improvements can be made under different assumptions.

- **Resource impact**

Financial information sources can help to identify how money is being spent locally in comparison with other parts of the country. This can help raise questions for further investigation and can assist in comparing actual spend on services with the desired pattern based on local population need. NHS programme budgeting data is available at www.dh.gov.uk and related spend and activity information can be found at www.networks.nhs.uk/nhs-networks/health-investment-network. Tools that can be accessed through this site include a programme budgeting benchmarking tool, the spend and outcome tool (SPOT), and the inpatient variation expenditure tool (IVET). PCT-specific 'health investment packs' that draw key information from these sources can be found at www.ic.nhs.uk

Social care expenditure information can be found on the NASCIS website. This includes total spend and average costs for a wide range of social care services and is provided at council level with national summary data for England.

Local service mapping can help to identify the volume of resources dedicated to a particular issue. This can include services provided by statutory and other local organisations and can build up a more comprehensive picture than otherwise available from statistical sources. The mapping process can help to identify duplication or gaps that could be addressed in the commissioning cycle and improve value for money.

- **Contribution to inequalities** (see section below)

- **Local views** (see section below)

- **Other considerations**

There may be other locally-set criteria against which topics can be assessed when setting priorities. National requirements or ‘must dos’ can also come into play.

There are different ways of using the above (or other) criteria to develop a list of priority topics for strategic action. Many organisations use a simple scoring system and often include weightings of each criterion according to their importance to establish a ‘score’ for each topic. Another alternative is to use high/medium/low ratings or to agree a small number of ‘must-meet’ criteria that will narrow down the field. The chosen method is best carried out as a transparent process and care taken to avoid unintended bias or discrimination. The resultant shortlist of key strategic priorities can provide a direct way in to the local health and wellbeing strategy and help to guide commissioning plans.

6.2 Turning strategic priorities into commissioning plans

JSNA data should also provide valuable evidence to guide health and social care commissioning plans. The top strategic priorities identified above will need to be turned into specific actions and investments if they are to have any impact on local people. This may mean switching resources from one use to another and understanding the implications of doing so. The evidence will need to be applied to local authority populations, other geographical area populations and/or clinical commissioning groups’ populations as appropriate.

Commissioners will need to be clear how they would want the JSNA to support the commissioning process bearing in mind the degree of flexibility available in the real world. This is best articulated very early in the needs assessment process and will help JSNAs to be of practical use in guiding investment decisions.

Types of data that can help to translate a shortlist of priority topics into more specific investment plans might include:

- **More detailed information on current and projected service need, including a year by year breakdown for the period of the commissioning plan**

This would be a translation of the JSNA data into a form that is directly applicable to commissioners and the local commissioning process (for a small number of prioritised topics only). The data would be applied to the specific populations covered by each commissioner. It would help commissioners to understand the drivers of demand for key services and the factors and levers that might influence future resource requirements.

- **Main sources of evidence of effectiveness and cost-effectiveness, and evidence-based pathways for key topics taking into account local circumstances**

Depending on the topic this may involve guidance from National Institute for Health and Clinical Excellence (NICE) or other guidance and quality standards for the topic translated into a local action pathway. A range of social care evidence and good practice guidelines is available from SCIE (Social Care Institute for Excellence). Interpretation of this evidence will help

establish how practical the proposals are in the local situation. It can also help ensure that interventions are designed and implemented to take account of local need, existing services and community assets.

- **Modelled results showing inputs, processes, outputs and outcomes**

This can include quantifying pathways and impacts (for example the extent to which CVD prevention leads to fewer strokes, which leads to lower disability and death rates, reduced hospital admissions and reduced social care requirements). Looking at the impact and resource implications across a range of agencies (and users and carers) can build up the whole picture and encourage a joint approach, avoiding cost-shifting or unintended consequences. Sources such as NICE economic models and others can help to quantify these costs, impacts and savings. Modelled results should where possible show the time lag between inputs and outcomes, the relative impact on different local agencies and the level of uncertainty associated with the intervention (for example, using sensitivity analysis). They should also pay attention to inequalities – will the intervention be taken up equally (and be equally effective) among different groups? Should there be some special arrangements or targeting to make sure that the intervention narrows the health and wellbeing gap rather than widens it?

JSNA evidence of this kind can help to build up a recommended list of investments, disinvestments and other specific changes. This process will help to ‘join up’ the JSNA with commissioning plans by helping to prioritise specific actions in a more explicit way. It would, where possible, suggest the most cost-effective use of resources consistent with meeting overall health and wellbeing outcomes for the local population.

JSNAs could also support the monitoring and evaluation process by suggesting indicators or other methods for measuring the impact of changes. This can help ensure that they do actually meet local objectives or that action is taken to adapt or withdraw interventions over time if appropriate.

Local views

The relatively technical evidence above should be complemented by local people’s perceptions, which can tell a different story and reveal new insights. HealthWatch will have access to a wide range of sources of local views. The board and its constituent agencies may also be involved in specific exercises to find out what people think about local services and priorities for improvement in the future. This can help to address the views of groups that do not normally engage with ‘official’ channels.

Local voices can also help to ensure fairness and to add another dimension to priority-setting. This may be about ensuring that criteria and scoring systems are set fairly (before any actual topics are considered) and potentially taking part in the assessment of particular topics.

As well as being involved in overall priority-setting, local voices can reveal much about the way that people engage in specific services or take up opportunities aimed at improving health and wellbeing. There can be wide variations in people's attitudes and beliefs which need to be taken into account. These can help in the design of services so that they are commissioned and delivered in a way that can bring maximum benefit from the resources used.

Inequalities

Modelling tools can be used to estimate the effects of interventions on different populations and can sometimes quantify the impact on overall inequalities. For example it is possible to quantify the impact of increasing the uptake of NHS health checks in a specific locality or GP practice list and to estimate the consequent improvement in health outcomes and reduction in hospital admissions.

All models should have explicit assumptions and it is often possible to adjust these to take account of differences across the population. For example, it could be assumed that uptake of an intervention will be higher or lower in a specific group or that effectiveness may be different to the population average. These adjustments can be used to model levels of inequality across populations and to assess the scale of the interventions required to overcome them.

This information can be included in equalities impact assessments to help ensure that equalities issues are fully taken into account in planning and policy development.





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