Implementing Joint Strategic Needs Assessment: pitfalls, possibilities and progress
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**Contact Details** | Dr Jo Ellins
Health Services Management Centre, University of Birmingham
Park House, 40 Edgbaston Park Road
Birmingham
B15 2RT
0121 414 7450

**For Recipient's Use** |
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Please note: this report is accompanied by three additional standalone appendices focusing on:

- Needs assessment in regeneration and economic development
- Health care needs assessment
- Needs assessment in local government
Acknowledgements

This paper has been authored by Professor Jon Glasby and Dr Jo Ellins at the Health Service Management Centre University of Birmingham.

The authors are grateful to participants in this research, to the Integrated Care Network and the Department of Health for commissioning this report and to the authors of the three standalone appendices that accompany the main report. They are also grateful to Jackie Francis for her help in distributing and collating surveys.
Implementing Joint Strategic Needs Assessment: pitfalls, possibilities and progress

Introduction

In 2007, section 116 of the Local Government and Involvement in Health Act introduced a duty for local authorities and PCTs to undertake a Joint Strategic Needs Assessment (JSNA) of the health and social care needs of the area. Subsequent statutory guidance (currently in draft form) described JSNA as “the means by which they [local partners] will describe the future health and social care needs of the population” (HM Government, 2007, para.3.28). This is expected to be carried out jointly by the Director of Public Health, the Director of Adult Social Services and the Director of Children’s Services, with the new duty set to commence on 1st April 2008. This was later reinforced in best practice guidance published in December 2007, which sets out expectations with regards to (Department of Health, 2007):

- The various stages of JSNA
- Stakeholder and community involvement and engagement
- Timing and duration
- Links to other strategic plans

In particular, JSNA is defined as “a systematic method for reviewing the health and wellbeing needs of a population, leading to agreed commissioning priorities that will improve the health and wellbeing outcomes and reduce inequalities” (Department of Health, 2007, p.7). Conceived as a continuous process, JSNA should be underpinned by effective partnership working, community engagement and evidence of effectiveness, with each JSNA reflecting unique local circumstances. Focusing on current and future needs (over at least 3 to 5 years, but also including a longer term assessment), JSNA should align with three-yearly Local Area Agreements (LAAs) and should link to a range of additional local authority and PCT strategies and plans (with 12 examples listed on p.12 of the guidance). Given that The Children Act 2004 requires local authorities to produce a separate Children and Young People’s Plan (based on a comprehensive needs assessment), further work is being undertaken to develop a specific needs assessment tool for children (and this explains the subsequent focus of this report on adult health and social care – see below for further discussion).

In addition, the best practice guidance contained an appendix signposting users to a range of existing data sources to assist the JSNA process. While work is ongoing on this core dataset, the guidance was also clear that such sources should be supplemented by “information gained through active dialogue with local people, service users and their carers” (p.13), with communities involved at all stages of the JSNA process. As part of this, “ensuring the engagement of particularly vulnerable and hard to reach groups, those with complex medical and social care needs and those experiencing exclusion” was recognised as “one of the significant challenges of JSNA” (p.14).
Once needs have been identified via JSNA, the guidance emphasises the role of the Local Strategic Partnership (LSP) in identifying shared targets to meet these needs through the Sustainable Community Strategy and the LAA. In order to identify priorities for commissioning, an outcomes-based approach will be required.

Against this background, the Integrated Care Network and the Department of Health have commissioned the Health Services Management Centre at the University of Birmingham to conduct a national survey to explore preparations underway locally for implementing JSNA, key barriers and enablers, and the potential implications for the delivery of the NHS and Local Government White Papers (Department of Health, 2006; Department for Communities and Local Government, 2006). In addition to the main report, three standalone appendices seek to summarise learning from related and other fields (regeneration and economic development, health care needs assessment and broader local government) in order to identify any transferable lessons and to avoid ‘reinventing the wheel’.

In particular, HSMC’s focus has been on JSNA as a potential mechanism for developing and strengthening existing inter-agency relationships. In principle, JSNA could be ‘the glue’ that holds current and future health and social care partnerships together, enabling both organisations to fully understand the needs of the local area and begin to design future services together. Equally, without an underlying commitment to joint working, to involving local people in planning services and to understanding the future together, JSNA runs the potential risk of becoming yet another ‘tick box exercise’ and not a genuine lever for change at all. Commissioned at exactly the time when the new duty of JSNA comes into force, we hope that this report is a timely contribution to this process.
Methods

Using Department of Health email circulation lists, HSMC conducted a national survey of all PCT Chief Executives, Directors of Adult Social Services and Directors of Public Health in England (a total of 459 people). The survey is reproduced in Appendix A, and was emailed out in February 2008 (at the time when health and social care communities had received the best practice guidance and were preparing to implement the new duty). The initial email was followed up by one email reminder, with all completed surveys analysed by both authors using a grounded approach. This involved reading all survey returns and identifying key themes and topics from open text answers, constantly checking back over previous surveys to ensure that the emerging categories remained a helpful way of categorising and summarising the data.

As Appendix A demonstrates, the questions asked in the survey were very broad and hence were open to a number of different interpretations. Where completing the survey had been delegated to a more junior member of staff, moreover, respondents at different levels within their respective organisations suggested that the survey had sometimes taken some time to reach them, and some responses had therefore been completed at quite short notice. As a result, the findings in this report represent only a snapshot of the first stages of the implementation of the JSNA duty, and should be seen very much as giving a flavour to and an overview of early developments, rather than as anything more systematic or in depth. At times, we have also drawn initial conclusions from the language used, the focus of specific responses and the overall ‘feel’ of the surveys – and such initial impressions may either be confirmed or denied by more detailed future research and by local and regional improvement activity.

As explained above, the decision to send the survey to PCT Chief Executives, Directors of Adult Social Services and Directors of Public Health rather than to Directors of Children’s Services was a response to the additional requirements of the latter under The Children Act and ongoing work with regards to needs assessment in children’s services. As a result, the remainder of this report focuses primarily on adult health and social care, although many of the broader issues raised apply across children and adult user groups.
Findings

Nature and rate of response

During the research, we received 92 responses to the survey (see Table 1). When duplicates and missing data were removed, this left a total of 87 responses from approximately 72 local health and social care communities (and it is this latter figure that formed the basis of subsequent analysis). Whereas a small number of areas submitted joint returns (or indeed submitted different returns from different local organisations), the vast majority sent in one return per health and social care community. While accompanying emails suggested that these single returns had been circulated to other partner agencies prior to submission on some occasions, others read very much as single agency interpretations of local developments (for example, referring to one agency as “us” and the partner agency as “them”).

Depending on the definition of a health and social care community, the 72 areas represented in this survey equate to nearly half of the local authorities in England and nearly half of Primary Care Trusts (PCTs). Responses also came from a wide variety of areas of the country, both rural and urban; from unitary and two-tier councils; and from co-terminous local authorities/PCTs as well as from organisations working with multiple partners. While only providing a brief overview of early developments, therefore, the results of this survey do draw on a significant range of experiences and areas.

Table 1  Survey responses

<table>
<thead>
<tr>
<th>Respondent (either direct or on behalf of)</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Director of Public Health</td>
<td>51</td>
</tr>
<tr>
<td>Director of Adult Social Services</td>
<td>19</td>
</tr>
<tr>
<td>PCT Chief Executive</td>
<td>3</td>
</tr>
<tr>
<td>Joint submission signed by multiple Directors/Chief Executives</td>
<td>14</td>
</tr>
<tr>
<td><strong>Total responses</strong></td>
<td><strong>87</strong></td>
</tr>
<tr>
<td><strong>Total number of health and social care communities represented</strong></td>
<td><strong>72</strong></td>
</tr>
</tbody>
</table>
Although only anecdotal, a number of additional observations arose from this initial section of the survey:

1. In the vast majority of cases, responses came from or on behalf of Directors of Public Health (DPHs), which is to be expected given that these are often joint posts, that JSNA builds on work already being undertaken by DPHs and that the work required may well sit most comfortably within the remit of the DPH. However, as discussed below, some respondents have questioned the extent to which the duty of JSNA will be understood and owned by staff beyond traditional Public Health Departments/functions, and it will be interesting to see the extent to which future JSNAs are genuinely seen as a joint, cross-cutting priority. A key test may also be the extent to which DPHs can take a lead in this area, whilst also securing support from senior leaders from within broader health, social care and local government in their local areas.

2. Also linked to this issue is the low number of responses from PCT Chief Executives, particularly in relation to the number of responses from Directors of Adult Social Services. This is despite the survey coming from a Health Services Management Centre that has a higher profile with PCTs than in social care. While this is probably due to the fact that PCT Chief Executives saw the DPH as the natural person to complete the survey, it does raise a question about the extent to which JSNA will be central to all parts of the PCT rather than to DPHs alone.

3. Overall, surveys demonstrated significant differences in terms of the ‘jointness’ displayed. Thus, responses ranged from those where participants from different partner organisations submitted joint returns, copied each other in to responses or each sent an identical response, to areas where different responses were sent in from different organisations with no apparent co-ordination. Interestingly, a small number of DPHs also described themselves as a joint appointment between the PCT and the local authority, yet cited the name of their organisation as being the PCT and used language that seemed to identify more with the PCT than with local government (for example, “us” for the PCT and “them” for social care). Some responses also referred to JSNA work being available via the website of one partner organisation (often the PCT), but not the other. While this may be reading too much into a relatively short and quick overview, the degree of partnership behaviour and language demonstrated by responses did seem to vary significantly.

Perhaps most importantly of all, however, was the sense that surveys gave of local commitment to inter-agency working and to the JSNA process. Despite tight timescales, there was a high response rate to this survey, and many individual responses were very detailed and demonstrated evidence of significant discussion at local level prior to submission. Overall, therefore, the impression from surveys received was of a health and social care system taking the new duty extremely seriously and with significant aspirations to make JSNA a future driving force for local service changes. While this was undoubtedly a positive feature of the study, the high level of people’s commitment and aspirations could also play out in other ways (for example, in frustration with aspects of national policy and/or the response of local partners). Thus, the overall ethos of survey response was one of high hopes, but also of high demands of respondents’ own organisations, local partners, regional support mechanisms and national policy makers (see below for further discussion).
Current approaches and existing data

When asked about previous and current work with regards to needs assessment, participants were able to cite a (very) long list of data already collected, approaches used and systems in place (see Box 1 for some examples). This was true of virtually all submissions, and it was clear that the new duty of JSNA builds on a large amount of work already undertaken locally and on a wide range of datasets, reports and strategies. Indeed, such was the level of detail provided that the overall impression was not of a health and social care system with insufficient information on which to base decisions, but almost of a situation in which there might be too much information from too many different sources to be able to provide a coherent overview. Thus, a key activity in many areas seemed to be ongoing work to make existing data more accessible and easier to interrogate – including, for example, attempts to create single points of access via web-based portals, resources and profiles. At the same time, individual areas also seemed to have invested heavily in various different approaches to needs assessment such as various software packages and data systems. The impression was of considerable activity (and expense) at a local level with potential scope to reduce the duplication of effort by greater regional and national support.

Despite the many examples cited in Box 1, several respondents identified areas where data was currently weak and/or where further work was required. For some areas, this included the importance of understanding the needs of very mobile and/or transient populations (such as students, economic migrants, asylum seekers etc). Interestingly, only a small number of respondents flagged up the importance of specific data/approaches in order to capture the needs of ‘seldom heard’ groups – such as people from specific minority ethnic communities – although it may be that those respondents who did not spontaneously mention this feel that it is so important that they take it for granted without needing to draw specific attention to it.

More generally, there was also a sense from some respondents that formal processes of population needs assessment were more developed in health care than in local government (see the appendices which accompany this main report) and that further work might be required to boost the quality and improve the accessibility of some social care and broader local government data. Other participants felt that the NHS had historically tended to focus more on aggregated population needs, while social care had a longer track record of responding to individual needs and aspirations. While these different histories add to the richness of local relationships, they could also make it difficult to develop a shared language and approach. In contrast, other responses appeared to suggest that the local authority as a whole has access to a much broader range of data and insights into local need, and that this could be crucial if JSNA is to be genuinely joint and to move beyond the limitations of (more single agency) traditional health needs assessment approaches.
Box 1 Examples of existing approaches to needs assessment

In one area, needs assessment and data analysis are built into all joint commissioning processes (for older people, mental health, children and young people, learning disabilities and public health). This includes a regular residents’ survey and a health and lifestyle survey, as well as use of data via the annual Public Health report, Health Atlas, formal statutory assessment processes, Ofsted and government comparative data, and consultations with residents, local communities, voluntary groups, the local Council of Schools and practitioners (via a Community Improvement Partnership).

In another area, the two main population sources are the GP Registered Population database and Census data, supplemented by a range of national survey/commissioned survey data and various standard Office for National Statistics (ONS), socio-economic and health datasets/sources (around births and deaths registrations, education, income, social security benefits, housing, employment, crime etc). This supports needs assessment at a strategic/headline level, with geographical analysis on the basis of 100 neighbourhoods (via a local Neighbourhood Information System) and a series of ‘service districts’ for children and young people (influenced by school catchment areas). This is supplemented by more detailed individual population/disease/service specific needs assessments as appropriate (recent examples include older people, sexual health, and child and adolescent mental health).

Other datasets and analytical tools used by respondents included:

- Standard population/epidemiological data
- Data on current service use (e.g. Hospital Episode Statistics)
- QOF data
- ONS
- Service user, carer and lifestyle (public health) surveys
- Mosaic
- Data from Public Health Observatories
- POPPI
- EpiData
- EpiInfo
- SPSS
- Instant Atlas
- Snap
- Performance Plus
- Planning4Care
- Indices of Multiple Deprivation
- GIS
- QMAS
- Predictive modelling
- Health Equalities Impact Assessment
- Rapid Appraisal techniques
- Appreciative Inquiry techniques
- External support (e.g. from a local University/Mori/Dr Foster etc.)
When asked about the extent to which current needs assessment was joint, many respondents were able to describe various joint strategies, governance structures and projects that they had developed over time. However, a common response was to highlight local good practice and success stories, whilst also acknowledging that previous approaches had often been relatively “ad hoc” in nature and/or focused primarily on one specific user group or service area (see Box 2). For many people, therefore, the new duty of JSNA represented an opportunity to make existing work and relationships more formal, consistent, overarching and systematic. As one respondent suggested:

“Prior to the JSNA when joint interventions were planned a joint understanding of local needs was developed for that specific area of work, but this was not taken systematically.”

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**Box 2  The degree of ‘jointness’ of existing work**

One area is working hard to establish more effective joint commissioning, but recognised that joint working to date had been “inconsistent” across service areas.

“There is an element of work done on a joint basis but not as systematic as described in the JSNA [guidance].”

“Ad hoc work in this area has happened in the past and the JSNA has energised this process and developed new relationships.”

“This formalises an approach that was already taking place to support the LAA.”

“The basis for robust joint work was already in place before JSNA was announced, but the introduction of JSNA has added impetus.”

“JSNA is not in any way replacing existing mechanisms for... needs assessment, but is providing a valuable focus for drawing them together.”

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Also significant were differences in the focus of responses. Some respondents were concentrating on needs assessment in health and social care, often with a strong emphasis on health and social care partnership structures, utilisation of health and social services and health status. Others were focusing more on strategic needs assessment across the NHS, local government and beyond. In the case of the latter, the focus was much more on the LSP, LAAs, the neighbourhood renewal agenda and the Sustainable Community Strategy as appropriate vehicles for taking forward JSNA. A small number of responses described this in the terms of the concept of ‘place-shaping’ advocated by the Lyons Review (2006), suggesting that JSNA may be crucial to this future agenda. In contrast, some responses focused more on health and social care and rarely mentioned such broader structures and issues – and this was flagged as a potential lost opportunity by one respondent:
“If JSNA becomes truly linked into the LSP’s decision-making processes, then we should see JSNA findings re the determinants of health and well-being reflected in future ‘refreshes’ of LAA targets. That should in turn feed into changes re priorities for investment in community settings across all partners, to address the wider well-being and lifestyle issues which impact on well-being. This is perhaps a more challenging linkage than that across health and social care, but is no less important.”

**Public and patient involvement**

In contrast to the wealth of data on the technical aspects of needs assessment, some participants felt less comfortable describing ways in which the public and people who use services were involved in assessing needs. Indeed, the detailed responses to prior questions about data and systems contrasted strongly in some responses with the lack of detail about involvement. As various participants suggested:

“[The Council/PCT] are aware that there is a need for more rigorous and systematic gathering of qualitative information from the public and people who use services, and that this information should be used to make more effective judgements about need in conjunction with quantitative sources of information.”

“[Local people have been involved] only to the extent that previous consultation and involvement exercises have been included. Nothing specific to the JSNA has been done yet. This is a major weakness and the subject of much debate. Apart from the difficulties inherent in involving the public and service users in this sort of work, there are several parallel activities going on or planned with the PCT, the Council and the LSP which need to be coordinated and are not. This is a big weakness and needs development.”

“To date epidemiology [rather than involvement] has been the key driver.”

“This year’s JSNA has been mainly data focussed, and has used existing information from consultations with care groups or service users. It is intended to focus on qualitative input from the public and service users in the phase 2 JSNA in 2008/9.”

Interestingly, some of these respondents were not the only people to highlight a potential difference between quantitative/epidemiological and qualitative/patient-centred data. Others described this distinction in even more pronounced terms – for example, one person described quantitative data as representing “evidence”, while information gained from involving patients and the public was seen by others as more anecdotal in nature (often implicitly rather than explicitly). While this is a broader theme than can be dealt with here, it raises a wider issue about what constitutes valid evidence and appropriate ways of knowing the world. Elsewhere we have argued for the need to move away from definitions of ‘evidence-based practice’ which focus on
quantitative data and research, to a more nuanced notion of ‘knowledge-based practice’ which includes the lived experience of people who use services and the tacit knowledge of practitioners as well as the findings of different types of research (see, for example, Glasby and Beresford, 2006). Thus, behind an apparently simple desire to carry out a joint assessment of ‘need’ and to ‘involve’ local people in the process lies a broader philosophical issue about what constitutes valid evidence and about how best to bring together knowledge from very different sources and stakeholders. As one participant suggested:

“A JSNA will enable everyone to work on many agreed sources of evidence… But… we don’t live in a technocracy and there may be other voices besides those of evidence.”

Despite these limitations, other areas had a large number and a broad range of involvement mechanisms in place more generally, and were using these to provide data for JSNA-related purposes or recognised their potential to do so. While examples are provided in Box 3, these ranged from relatively standard patient representatives on relevant committees and ad hoc focus groups, through to more sustained attempts to involve local people in the health and social care system (such as standing citizens’ panels, local priorities fora, ‘Question Time’ sessions and the appointment of ‘Community Ambassadors’).

However, as with the question about existing approaches to needs assessment, the issue of involvement identified so much diversity and complexity that the overriding impression was that some areas would benefit from developing a more coherent and systematic approach. For these areas, the problem did not seem to be insufficient dialogue with local people, but too much ad hoc and potentially unchannelled involvement which could arguably reduce the overall impact of such data and lead to consultation fatigue. Moreover, most of the involvement methods described were focused on gathering feedback from users and the public, rather than creating opportunities for them to directly shape the JSNA process or influence decisions about future service provision. This was recognised by one respondent, who commented that:

“The next steps would be for specific planning to involve users in agreement what key changes might be needed [and] how the services need to do things differently.”

Overall, therefore, the impression of current levels of involvement was two-fold:

1. In many areas, more attention appears to have been paid to the technical aspects of JSNA and to the collection of quantitative data, rather than to the involvement of local people in the JSNA process. For many respondents, public and patient involvement was recognised to be an important area of future development, and several people called for greater guidance and good practice examples to assist with this.

2. At the same time, some areas seemed to have so many more generic involvement processes in place that it must be difficult for them ever to bring this material
together and gain an overview. For these areas, one aim might be to develop more systematic and joint approaches to existing work, rather than to develop new involvement mechanisms (a recognition that sometimes ‘less is more’). As an example, one area spoke about co-locating current Council and PCT complaints/customer service and patient liaison staff, and this seemed a helpful example of a possible way forward.

### Box 3 Examples of public and patient involvement

- A range of standard approaches via interviews/focus groups for specific projects, listening exercises and more general representation on various local committees/working groups
- Standing committees, assemblies or panels of local people to comment on key service issues
- A Priorities Forum to engage local people in deciding commissioning priorities
- A ‘Health Matters’ magazine for the general public with health-related information
- Community ‘case conferences’ to seek the views of local people and service providers in specific deprived areas (to inform micro-JSNAs for these areas)
- The appointment of local people as Community Ambassadors to engage local community groups
- Regular MORI surveys and/or health and lifestyle surveys
- Use of community development approaches to engage local communities
- Training/recruitment of older people to research older people’s services
- ‘Question Time’ approach to discussing key issues with local people
- Longer-term survey and consultation work with over 50s to explore future issues for older people’s services
- (Jointly) commissioning social marketing to feed into and inform future involvement work
- Specific work with seldom heard groups such as black and minority ethnic communities (although this was rarely mentioned – see above) and children and young people

### The potential implications of JSNA

Although respondents felt that it was very early days, they had a number of aspirations for JSNA and identified a number of potential impacts/implications. First and foremost, participants felt that JSNA had scope to raise the profile of the importance of jointly agreed approaches to needs assessment and to joint working more generally. While such joint work was already well established in many areas, respondents nevertheless highlighted the potential of JSNA to deliver:

- A joint approach to data collection and analysis across agency boundaries.
- A joint understanding of current and future needs.
• The identification of gaps in current knowledge.

• A more systematic approach to identifying and agreeing local needs, with scope to achieve senior commitment to shared priorities.

• Scope to use this understanding to inform joint commissioning and shape future service responses.

However, for many people, JSNA is not only at an early stage in its development, but is only part of the overall process. Thus, many respondents emphasised that JSNA is merely a process (albeit a potentially helpful one) that could contribute to producing wider changes in the system and better outcomes for local people. However, these participants stressed that JSNA is simply a means to an end, and not an end in itself. While a statutory duty and accompanying guidance could therefore provide helpful clarity and focus, the danger was that this could lead to a failure to ‘see the wood for the trees’ and to an emphasis on ‘having’ a JSNA for the sake of fulfilling policy requirements. Instead, participants emphasised that “JSNA is a process rather than a product.” As other responses suggested:

“The aim would be for the JSNA to provide the core information for the delivery of both health and local government plans. The overarching ‘big picture’ will then provide the priorities for commissioning strategies/priorities in the LAA... The aim is for it to be a continuous process (rather than a ‘one-off’).”

“A key approach... is not to view the JSNA as some large unwieldy document that sits on a shelf and is revisited every few years but as a training programme for commissioners and supporting commissioners to make well evidenced decisions, informing short, medium and long term decisions.”

“We are very keen to ensure that the JSNA is not seen as an end in itself but as a spring board to some more in depth analysis for specific areas of work.”

In addition to this, many participants stressed that the success of JSNA would depend not just on the rigour with which it collated robust data, but also on the extent to which it was genuinely able to act as a platform for driving wider changes in the health and social care system:

“Implementation of the JSNA will require considerable work in understanding and redesigning and expanding services to meet the needs identified by the JSNA. The JSNA is an essential first step in this process but will not of itself deliver the changes that will lead to the better outcomes required.”

“The conclusions arising from the JSNA will inform the commissioning strategy... from 2009 onwards... Much of this is about ‘hearts and minds’ and moving away from investments in buildings towards services
that improve health and also prevent ill health...Much depends on the ability of commissioners (both health and social care) to have a greater shared agenda of delivery. The jointly agreed process of world class commissioning... will assist in commissioning having the tools available to commission effectively and really deliver a transformational change which the outcomes of the JSNA is likely to require if it is truly to affect the health of the local population.”

“If we are to move beyond a simplistic view of JSNA as an analysis and presentation of... data and service gaps..., then JSNA must become a process that culminates in prioritised options and recommendations for alternative uses of the finite resources of both organisations to increase net social benefit. That would require a level of systematic commissioning, alignment of planning cycles, and co-ordinated user/public involvement that simply does not exist in [name of area].”

In order for this to happen, respondents were clear that a number of additional principles and prerequisites needed embedding in the system (and areas seemed to vary on the extent to which these were already in place locally):

- A commitment to seeing JSNA as a live document and a continuous process, rather than a one-off exercise and a document on a shelf.
- The importance of time to build relationships and influence long-term change.
- Local organisational commitment to JSNA and to acting on the results, including senior commitment and support from local politicians.
- Joint commissioning functions and strategies, to underpin JSNA and support collective action across health and social care communities to meet identified needs.
- The ability to link specific work around JSNA into broader strategic planning process (including the work of the LSP, the LAA, the Sustainable Community Strategy etc.) and other policy areas (such as Practice-based Commissioning).

For this to happen, participants felt, required not only local commitment and vision, but also regional and national support (see below for further discussion).

Practical support and longer-term changes

When asked about factors that could help or hinder the implementation of JSNA and about what support would be useful, participants tended to identify one or both of the following key issues:

- Practical/technical issues concerning the collection, sharing and use of data.
• Broader issues concerning mechanisms for embedding JSNA in current partnership working and commissioning structures.

While each of these is explored in more detail below, a key message from this initial overview seems to be the need to balance the development of rigorous approaches to data analysis (getting the technical basics right) with the need to embed the results of this process within the system as a whole. In one sense this could be characterised as seeing both the ‘big picture’ and ‘the detail’ at the same time, and may well require a mix of skills not always combined in one person or profession.

1. Getting the data right

Here, participants called for:

• Greater financial support for the extra requirements of JSNA, which runs the risk of being very “data hungry” and of making high demands on already limited data analysis, modelling and health economic capacity/expertise. Of all potential barriers, this was the most commonly cited, with many participants feeling that such analytical skills were already in scarce supply.

• Easy access to a regional/national common dataset, to make relevant indicators available without local areas having to duplicate effort. For several participants, the role of current Public Health Observatories needed reviewing, restating and refreshing in order to ensure a greater availability of appropriate data.

• Support to benchmark local data and trends against regional and national comparators (also linked to the above comments about the role of Observatories).

• Support to assure the quality of external organisations seeking to provide support to the JSNA process.

• More detailed work to improve access to high quality social care data – which was felt by some to be underdeveloped compared to some forms of health care data.

• Broader awareness raising of the implications of JSNA, especially for non-public health staff.

2. Embedding the findings of JSNA

Here, participants called for:

• The continued promotion of an outcomes-based approach and greater cost-effectiveness evidence with regards to complex issues such as developing a preventative approach.

• More detailed guidance/support on patient and public involvement and on influencing the commissioning agenda.
• Greater support with regards to organisational development in order to help turn assessed needs into practical service changes.

• Greater recognition of the upheaval and tensions created by ongoing organisational restructurings – both internal reorganisation and nationally imposed mergers – and of the additional complexities involved in working with multiple partners in systems of two-tier local government.

• Greater recognition of the need to ensure a joined-up approach between children’s and adult services. Several people were critical of current guidance – and indeed of this survey/report – for seeming to marginalise the needs of children and young people.

• More general policy support to promote more effective inter-agency relationships, including more joined-up targets/performance management, guidance on inter-agency information sharing, more compatible IT systems etc.

Above all, however, many respondents suggested that what mattered most was local flexibility to act upon the needs and priorities identified via JSNA. This was phrased in a number of ways, but the same underlying message was clear: without a reduction in the number of centrally prescribed targets, indicators and reporting requirements, JSNA was felt to run the risk of becoming a token exercise with much of its potential power reduced. In other words, the biggest threat to the new duty was felt to be a perceived lack of local power to do things differently if this was what the JSNA called for. For several people, this would require a sustained commitment to realigning the current balance between local, regional and national priorities, otherwise JSNA could quickly become little more than “a paper exercise.” Closely linked to this, participants called for a greater alignment of nationally imposed planning processes and timescales in order to ensure that local areas had maximum opportunity to integrate JSNA into other complementary work and structures. As a result of this, the timing of the recent guidance received particular criticism as it was felt to be poorly aligned with LAA timescales, and hence not as effective as it could have been.

3. More general support

To fulfil both narrow technical requirements and broader partnership ambitions, participants also called for much greater regional and national support to share good practice, promote success stories, learn from mistakes and avoid ‘reinventing the wheel’. This was virtually unanimous (either implicitly or explicitly) in all survey responses, and key ideas/requests included:

• A national contact list of local JSNA leads.

• Development of a regional/national Learning and Improvement Network(s).

• Online examples of completed JSNAs, useful toolkits and worked examples of key processes. In particular, the desire was for positive success stories – for example, to convince senior colleagues and politicians who may be sceptical – and for practical ‘how to’ approaches.
• Specific examples of successful approaches to public and patient involvement, to shaping the commissioning agenda, to conducting JSNA in two-tier local authorities and to developing a preventative approach.

• Scope for peer review of local JSNA documents and processes to add value and act as a critical friend.

In addition, many respondents were critical of recent guidance, claiming that this had been unhelpfully delayed, lacked clarity and sometimes failed to provide sufficient detail. In defence of policy colleagues, however, some respondents wanted much more prescriptive guidance to help them do what was required to meet their new statutory duty, whilst others sought much more flexible and permissive guidance to set a national framework and enable maximum local discretion. Viewed from this angle, local dissatisfaction with the guidance to date may therefore be a result of the age-old policy dilemma of how best to balance national prescription with local flexibility, whilst also enabling those areas who are already doing it to carry on, yet ensuring that those areas who aren’t are given a clear way forward.
Summary

Overall, this survey of Directors of Adult Social Services, PCT Chief Executives and Directors of Public Health has provided an early national snapshot of local efforts to implement the new duty of JSNA and of emerging themes, barriers and success factors. As the duty comes into force in April 2008, many local health and social care communities see JSNA as a positive opportunity to build on existing work and relationships in order to continue developing a joint understanding of their communities and of future shared priorities. However, if JSNA is to become ‘the glue’ that holds the system together and to drive genuine change in local services, then a range of local, regional and national support is required in order to ensure:

- Easy access to meaningful and high quality data, and to the skills needed to analyse and act upon such data.

- Coherent and systematic local planning and strategy processes, with senior commitment, shared vision, aligned timescales and co-ordinated public and patient involvement.

- Regional and national sharing of good practice.

- Greater availability of local, regional and national data to aid benchmarking and prevent duplication of effort.

- A more supportive national policy context, with more joined-up central policy/systems and greater local flexibility to be able to act on the findings of JSNA.

It is often said that ‘strategy is what you do, not what you write’, and the same seems so far to be true of JSNA. Ultimately the test of the impact of the new system will be the extent to which it can become fully embedded in local structures and partnerships, local commissioning strategies and local mindsets – genuinely impacting on future services and hence on outcomes for local people.
References


Appendix A: National survey to support the Development of Joint Strategic Needs Assessment (on behalf of the Integrated Care Network)

Sent to all Directors of Adult Services, PCT Chief Executives and Directors of Public Health, February 2008

[Please note: the layout of the original survey contained significant space for free text and detailed answers (with approximately half a page of A4 per question) – in the interests of space, the questions have been reproduced here in list form]

Are you:

Dir. of Adult Social Services  [ ]  PCT CE  [ ]  Dir. of Public Health  [ ]

Do you work for:

Local authority  [ ]  PCT  [ ]  Joint PCT/LA  [ ]  Other  [ ]

If ‘other’, please specify: ______________________________________

What is the name of your organisation?  ______________________________________

(Please note: this question is entirely voluntary, and is designed to help us compare and contrast different views from local LA, NHS and DPH perspectives. Any information collected here (as elsewhere) will be used in a non-attributable fashion.)

How does your organisation currently assess the needs of the local population?  (please describe current approaches in detail)

To what extent is this currently done jointly across the local health and social care community?  (please describe current approaches in detail)

How and to what extent are the public and people who use services involved in assessing the needs of the local population?  (please describe current approaches in detail)

Does your organisation use particular tools, data sources or techniques to assess population needs?  If so, please give details and (if possible) attach a copy.

What implications does a duty to conduct a Joint Strategic Needs Assessment have for local health and social care organisations, and how will you develop current approaches to meet this new duty?

What factors will help successful implementation of Joint Strategic Needs Assessment in your area?  What factors will hinder this process?

What additional support would be helpful to implement Joint Strategic Needs Assessment?
What implications will Joint Strategic Needs Assessment have for the delivery of the NHS and Local Government White Papers? In particular, how might it inform future investment in care closer to home, the development of LAAs, the redesign of provider services and the implementation of the White Paper vision? *(Please explain in full and give examples where appropriate)*

Do you have examples of local good practice that would be of interest to other health and social care communities?

Are there any other comments or observations you would like to make? *(please continue on a separate sheet if necessary)*