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## **North West Joint Improvement Partnership**

### **Commissioning and Joint Strategic Needs Assessments**

#### **Report**

**June 2010**

A new UK Government took office in May and the White Paper *Equity and Excellence: Liberating the NHS* was published in July 2010 both of which occurred after the fieldwork leading to this report had been finalised. As a result some of the content in this report may not completely reflect the most current Government policy.

This work was funded by the North West Joint Improvement Partnership ([www.northwestjip.co.uk](http://www.northwestjip.co.uk)) and the Department of Health.

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# North West Joint Improvement Partnership

## Commissioning and Joint Strategic Needs Assessments

### 1 Introduction and aims

The preparation and production of a Joint Strategic Needs Assessment (JSNA) became a statutory responsibility of the Directors of Public Health, Children's Services and Adult Social Services through *The Local Government and Public Involvement in Health Act 2007*<sup>1</sup>. However, whilst the JSNA was seen as a distinctive exercise its product was not seen in isolation. The guidance already referred to its role in helping to support world class commissioning and subsequently as the box below shows Putting People First identified the JSNA as a key enabler of effective Commissioning and linked into the range of strategies and approaches currently being undertaken.

#### **Putting People First Enablers**

*A joint strategic needs assessment undertaken by local authorities, relevant PCT and NHS providers.*

*These should be undertaken in conjunction with local assessments and plans (for example, local housing strategies). The joint strategic needs assessment and other plans will inform the Sustainable Community Strategy and will also be accompanied by an integrated approach with local NHS commissioners and providers to achieve specific outcomes on many issues.*

*Commissioning which incentivises and stimulates quality provision offering high standards of care, dignity and maximum choice and control for service users.*

*Supports third/private sector innovation, including social enterprise and where appropriate is undertaken jointly with the NHS and other statutory agencies, e.g., Skills Council. This must be shaped by the Joint Strategic Needs Assessment.*

Putting People First - Working to Make it Happen Adult Social Care Workforce Strategy – Interim Statement, 23 Jun 2008, DH

This key relationship between the JSNA and local commissioning strategies was underlined in the initial JSNA guidance. It was seen as "a systematic method for reviewing the health and well being needs of a population, leading to agreed commissioning priorities that will improve health and well-being outcomes and reduce inequalities".<sup>2</sup>

This study was designed to explore and test whether the desired relationship between strategic commissioning<sup>3</sup> and the JSNA had actually occurred and if not what could be done to improve that relationship. The project was structured around five key questions:

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<sup>1</sup> The Local Government and Public Involvement in Health Act, TSO, 2007

<sup>2</sup> Guidance on Joint Strategic Needs Assessment, DH, 2007

<sup>3</sup> The phrase strategic commissioning is used to distinguish it from contracting or procurement which in effect is concerned more with the process of purchasing services.

1. Can a clear specification be developed of commissioners' requirements of the JSNA process? Can this be easily reconciled with the practice and requirements of people working in public health – and vice versa?
2. How can the JSNA processes best be constructed to help commissioners to engage in outcomes-based commissioning?
3. Are the requirements of local government and NHS commissioners entirely compatible – or are there areas in common and areas of distinction? Does this change if the commissioning "audience" is widened to include, for example, "Total Place"?
4. The original JSNA guidance focused on the JSNA informing commissioning at first, second, and third, rather than individual levels. How does this reconcile with the increasing focus on personalized services and approaches such as *"Working together for change: using person-centred information for commissioning?"*<sup>4</sup>
5. Are the skills of commissioners, people working in public health, and other players in the JSNA processes adequate to address the requirement to reduce inequalities? What enhancements might be required?

This report has been designed to address the above questions describing the IPCs field activities. It provides an explanation of the methodology and evidence upon which the briefing paper is based, which is a companion publication to this report.

## **2 How we addressed the project questions?**

The work for this project was jointly funded by the Department of Health and the North West Region Joint Improvement Partnership (JIP). It involved the review of, and discussions with, eight local authorities; four that were part of the North West JIP and four from the rest of England. Across the eight sites there were two county councils, two metropolitan boroughs and four unitary authorities. All authorities were self-nominated through the national JSNA steering group on a basis where they had something "good or bad" to say about their JSNA and its process. Therefore, overall, within the limits of such a small sample, a reasonable attempt was made to achieve a distribution by type of authority, geography and self-assessment of JSNA.

Each of the JSNAs were reviewed against the five project questions together with a sample of commissioning strategies. Interviews were conducted with Directors of Public Health, Directors of Adult Social Services and Directors of Children's Services at each of the eight localities using a semi-structured interview (see Appendix 1). Interviews were also conducted with people who were responsible for the coordination and preparation of the JSNA.

One site withdrew at in the middle stage of this project due to other pressures and so another authority was substituted. Another site was going through a major restructuring and hence at this site it was not possible to interview people

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<sup>4</sup> Working together for change: using person-centred information for commissioning?, DH, 2009

who had been involved at a senior management level because they had left and posts had not been filled. In this instance only the coordinator of the JSNA process was interviewed.

Interviews were conducted mostly over the telephone and some face-to-face using the semi-structured interview schedule that interviewees had been sent beforehand. Each interview was written up and sent to the interviewee for them to review. All the responses were collected together and analysed against the five project questions, presented in section 4.

### **3 Findings and discussion: A content analysis of the eight JSNAs**

Eight JSNAs were systemically analysed along with a sample of commissioning strategies. The table below offers a summary of their content and their links to strategic commissioning in the JSNAs. .

**Table. Descriptive content analysis of eight JSNAs.**

Site	No' of pages	Main Areas Covered	Limited or missed areas	Link to strategic commissioning
1	55	Well Being, Children & Young People, People in disadvantaged communities, Older People, Carers, Mental Health, Learning Disability, Alcohol, Drugs, Long Term Conditions, Black & Minority Ethnic Groups, Homelessness. A comprehensive needs analysis present, with considerable NHS activity data.	Social care activity data less developed. Limited linkage to the Children's Plan	Each section with a Key Issues box, which makes clear what the priority concerns or issues are; The JSNA looks at root causes and the basis for a review of all plans and commissioning strategies.  One section of the JSNA designed for commissioners and other decision makers to inform on policy, strategy and service design.
2	44	Staying Healthy, Birth & Maternity, Children & Young People, Mental health & Well Being, Long Term Conditions, Learning Disability, Older People, Carers, End of Life Care, Initiatives that deliver, Commissioning for impact, Developing and Improving, Involving you.	No sections on: Substance misuse issues, BME needs and HIV. Limited linkage to the Children's Plan.	Outcomes based strategic commissioning linkage, giving targets for defined population, with a focus on better partnerships, effective joint working and delivering services as locally as possible.
3	112	Sections on Demographic & Economic profile,	No sections on: HIV, and LGBT issues.	No analysis to indicate the priorities or issues that commissioners could focus on.

Site	No' of pages	Main Areas Covered	Limited or missed areas	Link to strategic commissioning
		Health and Lifestyle & Risk Factors, Burden of Ill Health & Disability, Children and Young People, Vulnerable Adults & Older People, Adult Social Care. Detailed data presentation.		
4	118	Staying Healthy, Children & Young People , Adults with Learning Disability, Mental Health & Well Being, Drugs & Alcohol, Hard to Reach Groups, Long Term Conditions, End of Life Care and Carers.	Limited linkage to the Children's Plan.	Each topic covered has a section on plans for the future.
5	114	Public Health plans with comprehensive coverage of conditions and disorders, Children's services that follows the 5 key areas for children's services, Adults with sections on Learning Disability, Physical Disability, Mental Health, Drugs & Alcohol, hard to reach groups (including domestic violence,		Descriptive, overall statements of objectives and intentions. Explicit links to the Children's Plan. Overall statements of intent, direction of travel and where possible specific developments.

Site	No' of pages	Main Areas Covered	Limited or missed areas	Link to strategic commissioning
		offenders, homeless, HIV, gypsies and travellers, asylum seekers), Long Term Conditions (including sight & hearing impairment, autism), cancers. Older people, End of Life Care, Carers.		
6	94	Background, describing how the JSNA was prepared, its aims and consultation processes; Demography, Community Perspectives, Health and Well Being needs (Children & Families, Adults and Older People, vulnerable groups, personal challenges to well being i.e., smoking, alcohol, obesity); Locality Focus; Access to Primary Care; Future challenges; Resources – financial forecasts for the Council and the PCT.	No section on Learning Disability, but coverage of Autism present.	Sets out recommendations for commissioners in each section that highlight the services and development priorities for that area based on the analysis in the JSNA. Comprehensive linkage to strategic commissioning.
7	JSNA Hub with several hundred pages	Overview, Children and Young People, Young Adulthood, Healthy Adulthood, Older People.	No section on Learning Disability. Limited social care needs	Commissioning linkage through a highlighted box in each section.

Site	No' of pages	Main Areas Covered	Limited or missed areas	Link to strategic commissioning
			<p>analyses.            Limited linkage to the Children's Plan.</p>	
8	<p>JSNA intelligence resource unit with 45 chapters consisting of several hundred pages</p>	<p>Health and well being issues facing the population.</p>		<p>Each report has a section on recommendations for commissioners in LA and PCT setting out the areas that commissioners should consider.</p>

Five overarching themes emerged from the content analysis which were:

### **Purpose**

All the JSNAs documents described a clear purpose. They identified trends and changes over time for the whole population of the authority and appeared to support and inform discussion and consultation on needs and priorities. However, it was not apparent how some of the JSNA information would meet the likely requirements of commissioners.

### **Preparation**

In all the JSNAs (as was the case nationally) Public Health took the major role in its preparation. Consequently, most of the JSNAs were centred on the key health determinants of the population and referred to core data sets required nationally. There was limited data and analysis on the distinctive health and social care issues being faced in each locality. Several of the localities had outsourced the preparation of the JSNA to private management consultancies. How this method of production promoted or limited joint working was difficult to decipher from the documents but in general these JSNAs were not that different from the others.

### **Partnerships and joint working**

The significance of partnership working was stressed in all JSNAs and there were references made to a JSNA board or steering group comprising the three directors with the statutory responsibility for the JSNA. However, the distinctive needs of various partners, particularly social care commissioners were not clearly visible in JSNAs.

### **Participation and engagement with citizens**

Some of the JSNAs in the review contained clear reference to consultation with service users and patients. However, two potential areas were not so well addressed. Firstly, understanding future needs of older people from the perspective of pre-retirement populations. Secondly, from both a health and a social care perspective it is important in older people to understand the pathways to high intensity provision and where might people have been able to make different choices that could have produced different outcomes. Understanding such routes could be highly important in constructing preventative interventions.

### **Presentation**

All the JSNAs reviewed were written documents. Some were freely accessible to all, while others were only accessible through registration and passwords. There were considerable variations in styles and readability. Most of the JSNA documents were highly technical, laden with quantitative prevalence data with detailed population analyses. Recommendations for commissioners were not always clear.

## **4 Findings and discussion: an analysis of the interviews**

This section is divided into five areas, each relating to the project questions. There are some direct quotations from interviewees below, referenced with a number and letter (e.g. 1A), to help illustrate the point being made.

**Question 1. Can a clear specification be developed of commissioners' requirements of a JSNA process? Can this be reasonably reconciled with the practice and requirements of public health professionals – and vice versa?**

There was unanimous agreement that the completed JSNA was for use by commissioners. In some cases the purpose of the JSNA was seen in much broader terms with reference to authority-wide health and well being and other partnership strategies. However, this intention was not supported by clear specifications from commissioners and there is little evidence that commissioners were involved in the design of JSNAs. This lack of involvement may have led to confusion for some stakeholders in understanding the nature of the JSNA, as shown by one Director:

*"There are tensions here on the actual purpose of the JSNA and whether it realistically informs the commissioning plans of the local authority? It seems that it has not done so and it is seen as a chore (4C)".*

Future guidance may need to consider how key stakeholders are involved and offer direction on developing more robust mechanisms that can facilitate the links between commissioning and JSNA authorship. These arrangements need to be deliverable locally and be sustainable.

For two of the JSNAs there was an agreed approach to commissioning between the PCT and the local authority. Respondents from both sites spoke of the commissioning cycle and the place of the JSNA being at the front end, supporting or providing the needs analysis that was seen as being the essential first stage to having effective commissioning strategies.

When assessing the range of commissioning strategies at each project site it was clear that whilst some had strong information about demand and need this had clearly not been derived from the JSNA. The opposite was also true. At least six JSNAs had some recommendations for particular issues that commissioners could follow up and in at least two commissioning strategies from separate sites this did not occur.

For some sites there were frequent references to the idea of the JSNA being an agreed repository of data which could support partnership working and joint strategies. For others this connection was not so clearly stated but there was reference to the JSNA underpinning a needs analysis.

Some of the sites saw the JSNA as supporting the development of local, ward or town based commissioning strategies or at least plans for local development and service change. This was linked to those authorities' local arrangements for engagement and participation with local communities and interest groups.

The area of most significant disagreement or tension was in children's services, where the requirements of the Children's Plan gave rise to a conflict with those of the JSNA.

*"Children's services are less experienced in commissioning than adult social care or the PCT". (1A)*

One authority saw direct conflict between adult and children's service requirements while another saw the Children's Plan and the JSNA and being disconnected but not necessarily in conflict with each other. This issue gave further evidence of the significance of joint arrangements and a broad vision for the purpose of the JSNA: where this was the case the requirements of the Children's Plan and the JSNA were not seen as being in conflict and in one area the JSNA had the same role in supporting the children's plan as it did for other strategies and plans.

Two sites identified the importance of broadening out from a traditional public health approach. As two PCT Directors said:

*"It is important to not to get tied down by the public health purists" (8A)*

*or*

*"Public Health can be too zealous on methodology while local government can be too zealous over users' perceptions". (3A)*

Most sites commented on the need to broaden the information base for the JSNA to include social care data, case clinical data, the perceptions and views of local people and a greater sense of the health and social care market including the views of service providers, including those from the Third sector. For example:

*"If more (JSNA) partners were able to contribute and provide qualitative data, the stronger the JSNA would be". (6E)*

However, the need for change was strongly identified by a number of Directors, for example:

*"The big priority for commissioners now is the big money savings for up to 2012. It is difficult to see how the JSNA can inform this with data and evidence. The massive financial reductions required of the PCT need considerable performance information data and the JSNA does not really cover this". (4C)*

## **Summary**

In answer to the baseline question, then a clear specification can be developed, at least in part, but there are issues:

- A balance has to be struck in the JSNA process between breadth and depth. In this round of JSNAs some areas were clearly covered that social and health care commissioners may have little chance to influence although it may encompass broader health care concerns. On the other hand some areas, such as learning disability (the second highest area of social care expenditure) were poorly addressed. In terms of depth then the test will be within a given resource framework, how far can JSNA authors be expected to drill down into data to uncover what it is commissioners need.
- There is little point in commissioners complaining that the JSNA does not meet their needs if they fail to specify what data they would want captured and analysed. The capabilities of commissioners to define what they need to make informed decisions varied. Commissioners need to be proactively involved in the design of JSNAs and JSNA authors need to actively invite this to happen.

- The relationship between commissioners and the authors of the JSNA clearly reflects the degree of joint ownership and what sort of picture of the community gets presented. A robust model of joint working that is both local and sustainable needs to be encouraged.
- There are differences between public health analysts and social care commissioners in terms of background and training and understanding of the role and function of the JSNA that are not easy to reconcile. This means if JSNAs are to effectively contribute to future strategic commissioning then a shift in thinking will be required by both people working in Public Health and commissioners of health and social care. For example, stakeholders need to agree their approach to strategic commissioning and the model to be used for the preparation of strategies and plans. The challenge may lie in answering who is best to help negotiate these processes, along with who locally specifies the JSNA outcomes? Is this ultimately the LSP or the three key directors?
- Obviously, this review of JSNAs looks backwards at what has happened. Evidently since the JSNA process was initiated the climate has changed, both in terms of recognising the future impact that a much larger older people's population will have as well as the much more stringent economic climate, to name two key factors. This is likely to create increased pressure for the JSNA to be able to help commissioners reconcile these two issues.
- If the JSNA only starts from peoples existing perception of what is required then it is unlikely to change and will probably continue to represent a fairly high level, mainly health orientated, view of particular communities. If a shift is to be made towards a document and a process that provides more analytical input into strategic decision making about what provision should be commissioned, then the starting point for the process needs to change. There may be considerable benefit within local communities of JSNA authors and strategic commissioners getting together and reviewing:
  - What the existing process offered strategic commissioning and what it did not?
  - What JSNA authors felt was missing from the current document and why?
  - What are the decisions strategic commissioners feel they will have to make over the next three to four years and what data is needed to help make those decisions?
  - How do those decisions fit with the analytical skills and capacities of JSNA authors?

## **Question 2. How can the JSNA process best be constructed to help commissioners to engage in outcomes-based commissioning?**

Historically, commissioners and service designers have measured performance by outputs, e.g., the number of beds occupied, the number of procedures conducted rather than by the outcomes achieved. An outcomes-based approach to commissioning encourages a shift in focus from activities to results. This approach is interested in measuring whether the service that is procured achieves the desired impact on the service user or in the case of the JSNA, the specific population. Across all the eight JSNA sites there was a commitment to the development of outcome based commissioning. However, the depth and

scope of outcome based commissioning varied significantly with most of the commissioning strategies still focussed on delivering outputs although there was some commitment to contracts specifying outcomes. In general, the JSNA was seen as:

*"The first step towards outcome based commissioning" (2B).*

The degree to which the JSNA could support outcome based commissioning also varied. In general, it was felt that it could and should be at the population and group levels but not at the individual level. One Director said:

*"We are going through the transition to outcome based commissioning. This is about joined up working which is not a mature process yet. The JSNA currently is at a high level and needs to be broken down to a level that can be influenced measurably by commissioning". (4C)*

Support for population and group level outcomes could be achieved by the broadening of the JSNA data to include wider views, for example, the views and perceptions of the services, users' aspirations and social care data. While some of this was recognised in the original JSNA guidance, it may now require further encouragement and sign-posting. For example:

*"The goal was to have commissioners focussing on a smaller number of outcomes for services to achieve. Use the partnership boards' and users' contributions to say what the outcomes to be achieved are. Partnership boards are joint with the PCT and include DWP, Provider Trusts, Boroughs, Police and a broad range of representatives of user organisations. The JSNA can be seen as a reference book supporting priorities". (3B)*

Perhaps overall the debate is based around 'are we trying to assess demand in terms of social conditions or are we trying to assess demand against a framework of outcomes for the population'? For example Putting People First defines a series of outcomes to be achieved by health and social care:

*"Agreed and shared outcomes which should ensure people irrespective of illness or disability are supported to:*

- *Live independently.*
- *Stay healthy and recover quickly from illness.*
- *Exercise maximum control over their own life and where appropriate the lives of their family members.*
- *Sustain a family unit which avoids children being required to take on inappropriate caring roles.*
- *Participate as active and equal citizens, both economically and socially.*
- *Have the best possible quality of life, irrespective of illness or disability.*
- *Retain maximum dignity and respect.*<sup>5</sup>

If the JSNA was being constructed on an outcomes basis it may wish to review only the data that informs whether those outcomes are being achieved or not. It

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<sup>5</sup> Putting People First: A shared vision and commitment to the transformation of Adult Social Care, HM Government, December 2007

does this in some respects already in its broad descriptions of well being or ill health within given populations. However, the capacity to live independently or exercise maximum control over their lives is not measured by most JSNAs or at least the results are not couched in those terms.

## Summary

- In general, when investigating commissioning strategies, the tendency towards outputs remained as compared to enough focus on outcomes.
- The degree to which it would be possible to identify whether outcomes were being achieved also varied, with the JSNA being seen as a broad population level document not intended for individual based outcomes
- There is a need for local dialogue between commissioners and JSNA authors as to what outcomes are commissioners trying to achieve, how this fits with nationally defined outcomes and what evidence might be collected locally to say whether outcomes are being achieved.
- There is also a need to develop local skills to identify the relationship between outcomes to be achieved, the methods and approaches by which they might be delivered and the costs of doing so.

### **Question 3. Are the requirements of local government and NHS commissioners entirely compatible – or are there areas in common and areas of distinction? Does this change if the commissioning “audience” is widened for or by, for example, “total place”?**

It is clear that the NHS and the Local Authority have different organisational requirements, performance measures and governance arrangements. As one Director commented:

*“There are tensions that arise from different accountability and governance arrangements. The NHS is centrally driven and has a strong influence from clinicians. Local Government has local democratic accountabilities and local interests”. (7C)*

Where there was evidence of strong joint working and partnership arrangements there was also evidence that structural incompatibility was seen as less of a problem, or was experienced but was manageable through the joint working arrangements, for example:

*“[Tensions] can be resolved through partnership working, which is very strong in [this locality] with joint appointments. Tensions are resolved by generating high levels of understanding of the demands and pressures on different organisations”. (1A)*

*“Clear leadership reduces and manages the tensions”. (2B)*

The tensions that were noted by most JSNA sites were the different reporting requirements for the NHS and local authorities. Most areas described the top down and central approach to managing the NHS as contrasted with the local approach and priorities for social care that applied to local authorities. It is this fundamental difference that led to the view that there was incompatibility.

The strength of partnership working and joint arrangements was related to the significance to that area having a strong and overarching strategy, expressed through the Local Strategic Partnership and supported by the JSNA. In this context any incompatibility between the two sets of commissioners was simply seen as a reality that had to be dealt with: all the priorities were important and it was primarily a matter of the order and manner in which they were to be dealt with.

Within the JSNAs there was no discussion of the Total Place agenda although an authority wide and agreed picture of demand and future pressures could considerably contribute towards the Total Place agenda. JSNAs may also take on some new responsibilities suggested by Total Place for example:

*"...viewing the services provided through the eyes of customers, and using tools such as 'customer journey mapping' to develop a collective understanding of how individuals interact with different services and how this could be improved<sup>6</sup>".*

## Summary

- The requirements for PCTs and local government are not the same but ought to be compatible.
- The tension that exists may be managed by a strong collaborative Local Strategic Partnership, where there is a greater recognition, respect and understanding of mutual objectives.
- In the current economic climate, both the PCT and local authorities need to know how they can lessen demand through positive interventions. Therefore, joint working in developing the JSNA may lend itself to map supply with demand in order to identify gaps in provision or potential overlaps in services. Both compatibilities and efficiencies may be found in this way.
- The Total Place agenda much more strongly links the provision of services with customer experiences and cost saving. This needs considerable expertise if appropriate and sustainable judgements are to be made.

### **Question 4. The original JSNA guidance focused on the JSNA process informing commissioning at first, second, and third, rather than individual levels. How does this reconcile with the increasing focus on personalised services and approaches such as "*Working together for change: using person-centred information for commissioning?*"<sup>7</sup>**

*Putting People First* makes it clear that personalisation will only flourish where investment is made in all aspects of support for people. These are: universal services, early intervention and prevention, choice and control, and social capital. On a broad level the overall objectives of transformation will be supported by a well evidenced holistic, whole system approach, which is a core rationale for the JSNA.

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<sup>6</sup> Total place: a whole area approach to public services, HM Treasury, March 2010

<sup>7</sup> Working together for change: using person-centred information for commissioning?, DH, 2009

The JSNAs investigated were not focussed on personalisation and the transformation agenda although there was a clear commitment to these principles from respondents across all eight JSNA sites. One key issue that was expressed was the degree to which personalisation was relevant to, or supported by, the JSNA. For two respondents:

*"Personalisation was very focussed on the individual but not incompatible with the JSNA [respondent could not describe how] but could not be dealt with in detail". (5A)*

*"The JSNA is population based and not relevant to personal budgets or personalisation". (6A)*

For most respondents the personalisation of services policy was seen to be too fine grained in terms of JSNA requirements. One respondent saw transformation as a very broad strategy, beyond the PCT and social care, and in this context personalisation was a clear direction of travel and not incompatible with the JSNA.

There was evidence that the broader objectives of the transformation agenda (the development of preventative and community based services) was impeded by the priority that the NHS was directed to give to shorter term, acute service issues such as the 18 week waits. This was seen as a frustration to achieving strategic goals.

*"The PCT does not have the same capacity for [strategic] commissioning. PCT commissioners get drawn into individual cases. PCTs are now commissioning organisations and therefore may focus on acute rather than joint commissioning, which would be more concerned with upstream activities. Investment in prevention from the PCT is low compared with the investment from local government. If the PCT is pre-occupied with e.g. 18 weeks it is less likely to focus on, for example, falls". (3B)*

JSNAs should be able to support and drive the development of early intervention and preventative services, and contribute to the development of social capital. The inclusion of information on the social care market will be important in driving an analysis to support market development, to ensure that there are real choices available to people and help local authorities in their responsibilities to commission for the whole population and not just those supported by the state. One Director of Adult Social Care said:

*"The JSNA is too broad brush to support personalisation. It could support more on market development but this will mean different information." (5B)*

## **Summary**

- JSNAs are not currently focussed on personalisation but key stakeholders were clearly committed to it and the transformation agenda.
- Personalisation seen as too 'fine grained' for the JSNA however, personal contracting could be aggregated to get a strategic view of demand.

- There is a need to support the NHS and local authorities to understand the commissioning of personalised services including at strategic level and how JSNA can identify the right outcomes and specifications.
- Transformation and personalisation strategic direction could be supported by the JSNA through developing a market analysis, along with presenting an evidence base of what services people are choosing and what interventions work best for whom and when.

**Question 5. A primary objective for JSNAs is the reduction in health inequalities. Are the skills of commissioners, public health professionals, and other players in the JSNA process adequate to address the requirement to reduce inequalities? What enhancements might be required?**

Respondents from all eight sites reported a clear and strong relationship between JSNAs and the addressing of health inequalities. For example, one Director of Children's Services said:

*"Of course it's very important; it's absolutely central". (1A)*

When asked whether the JSNA material informed their local policies and plans for tackling inequalities there was a more mixed response. Several respondents gave a broad acknowledgement, while two were able to say that it informed:

*"The narrowing the gaps policy" (3C) and  
"Some priorities". (6A)*

The capabilities of both commissioners and people working in Public Health need to be enhanced to address inequalities through the JSNA and the consequent strategic commissioning process.

One Director of Adult Social Care described the gap and said:

*"Local government commissioners should develop more in children and young people areas". (3C)*

In Public Health there is a greater need to consider professional work boundaries and include children's and social care services in particular given their contributions towards addressing inequalities.

Such a consideration may also offer an opportunity to include and apply a wider range of qualitative and quantitative data in the assessment of community needs. Two Directors, one from Public Health and the other from Adult Social Care acknowledged the need for *"commissioners to develop stronger data gathering" (4A) and analysis skills" (5B).*

There is also a greater understanding required of the commissioning process itself. Public Health leaders need to improve on strategic joint working across the disciplines through developing and supporting strong and sustainable local mechanisms.

Commissioners also need to consider their work boundaries in order to influence across disciplines particularly to inform others of the specifications of strategic commissioning. Commissioners, particularly in social care, also need to improve on their analyses of local intelligence, along with developing the market to help procure the best deal for service users.

All the key JSNA stakeholders need to develop an economic and outcomes oriented awareness so that they are able to prioritise with evidence what outcomes work best and at what price. Working strategically with these intentions are likely to enable the JSNA to be used to harness efficiencies and operate as a vehicle of strategic change in the health and social care system.

## **Summary**

- The capabilities of both commissioners and people working in public health need to be enhanced.
  - For people working in Public Health there needs to be more: working jointly and across boundaries including children's and social care services; appreciation of quantitative and qualitative data from multi-disciplinary stakeholders and strategic commissioning awareness.
  - Commissioners need to: work jointly and across boundaries; understanding whole and target populations approaches and harness the right intelligence to make evidenced based decisions and develop the market to procure the best service for users.
  - All key JSNA stakeholders need to enhance their awareness of the relationship between future demand and the resources to meet that demand and in particular where investment may best be made.

## Appendix 1 – Interview Schedule

Thank you for agreeing to take part in this national study on the development of the Joint Strategic Needs Assessment and its relationship with commissioning. Your contribution will help to improve the use of the JSNA and the commissioning of health and social care in England.

The interview questions below will be used to explore the project’s objectives. We hope these will help you prepare for the interview. You may wish to put your answers in brief note form or key words next to the questions below to help focus our conversation. If you do this, please send these notes you make to X or to the interview if possible.

All the material and information gathered through the interviews will be completely confidential and will meet data protection legislation requirements. We will ensure that quotes or examples that we use in the final report are anonymous so that you or your locality is not identifiable.

### Respondent

Name	
Employing Authority	
Job Title	
Overall Role and responsibilities	
Role and responsibilities in relation to the JSNA	

### JSNA preparation

In the preparation of your area’s JSNA, did you use external consultants for (if yes, please can you say which organisation?):		
For data collection?	Yes (Who?)	No
For data analysis?	Yes (Who?)	No
For writing up and preparation?	Yes (Who?)	No

#### Area 1

**Can a clear specification be developed of commissioners’ requirements of a JSNA process? Can this be reasonably reconciled with the practice and requirements of public health professionals – and vice versa?**

1. What do you see to be the main purpose of the JSNA?	
2. Did you set any particular requirements for the JSNA that the final product had to meet?	
3. Who did you see as being	

the key users or customers for the JSNA? How did this shape the way in which it was prepared or published?	
4. Did this give rise to any particular tensions or issues in the preparation of the JSNA? Please describe.	
5. How would you like to see the JSNA developing in the future for your area?	

## Area 2

### **How can the JSNA process best be constructed to help commissioners to engage in outcomes-based commissioning?**

An outcome based approach should be seen as shifting the focus from activities to results, from how a programme operates to the good it accomplishes, and can be applied to an individual, a service or a population.

1. In preparing the JSNA, did you see it as supporting the preparation or review of commissioning strategies?	
2. How far do your commissioning strategies have an outcome-based approach?	
3. How far have you gone in developing an outcome-based approach to commissioning? How far do you think your JSNA supports commissioners in an outcome-based approach?	

## Area 3

### **Are the requirements of local government and NHS commissioners entirely compatible – or are there areas in common and areas of distinction? Does this change if the commissioning “audience” is widened for or by, for example, “total place”?**

1. Commissioning is very significant for both the NHS and Local Government. Do you think that the requirements for either set of commissioners are:	
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2. Incompatible or in tension with each other? Please explain your answer.	
3. Compatible and are able to be met without tension? Please explain your answer.	

#### Area 4

**The original JSNA guidance focused on the JSNA process informing commissioning at first, second, and third, rather than individual levels. How does this reconcile with the increasing focus on personalised services and approaches such as “Working together for change: using person-centred information for commissioning?” (DH, 2009).**

Personalised services should be taken to include the development of services that will give the service user a range of choices in how they meet their needs. It should be seen as covering prevention, day services, self directed support, and early intervention

For local government:

1. What has been your Council’s approach to Transforming Adult Social Care (TASC) and personalisation?	
2. What is the approach to TASC and personalisation taken by your colleagues in the PCT?	
3. How has this informed or shaped what is required from the JSNA?	
4. Are the requirements of TASC or personalisation in social care, and the introduction of personal health budgets in the NHS, compatible with the original guidance for the JSNA to focus on the higher levels of commissioning?	

For PCT Commissioners and Public Health:

1. What is your PCT’s approach to the proposed personal health budgets?	
2. What is the approach to TASC and personalisation	

<p>taken by your colleagues in local government?</p>	
<p>3. How has this informed or shaped what is required from the JSNA?</p>	
<p>4. Are the requirements of TASC or personalisation in social care, and the introduction of personal health budgets in the NHS, compatible with the original guidance for the JSNA to focus on the higher levels of commissioning?</p>	

<p><b>Area 5</b></p> <p><b>A primary objective for JSNAs is the reduction in health inequalities. Are the skills of commissioners, public health professionals, and other players in the JSNA process adequate to address the requirement to reduce inequalities? What enhancements might be required?</b></p>	
<p>1. How important has the requirement to reduce health inequalities been in the preparation of your JSNA? Please explain your answer.</p>	
<p>2. Has the date in your JSNA informed the policies and plans for tackling health inequalities?</p>	
<p>3. Are there particular approaches and skills you think are necessary or desirable in commissioners to support the reduction of health inequalities? Are there particular issues in services for older people, Physical Disability, Learning Disability, Mental Health or any other groups?</p>	

### **The Future**

Please summarise how you would like to see the JSNA developing and in particular how it can better support and inform commissioning.	
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### **Anything else?**

Please add any further thoughts or comments you may have on the JSNA arrangements and the relationship between JSNAs and commissioning nationally or locally.	
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Thank you for your help and time in this national study. Please return the completed questionnaire to: