

**Proposal to the Health & Wellbeing Group
(a sub-group of the Havering Strategic Partnership)
for Joint Strategic Needs Assessment (JSNA)**

October 2007

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Background

- The JSNA is the means by which PCTs and Local Authorities will describe the future health, care and well-being needs of local populations and the strategic direction of service delivery to meet those needs. The JSNA should inform the next round of Local Area Agreements (LAA2)
- There is a statutory obligation on PCTs and local authorities to work together on the needs assessment. The JSNA will cover all age groups in the population and look ahead for the next 3-5 years.
- Following a meeting of the Health and Well-Being Group, a sub-group of the Local Strategic Partnership, and discussion at the PCT's Strategic Planning Group, this document has been put together to gain agreement from partners on the key principles, methods and responsibilities.
- The JSNA will form the basis of the Annual Report of the Director of Public Health for 2006-7.

Defining the JSNA

- 'Health, care and well-being' encompasses the prevention of ill health and promotion of good health and wellbeing as well as the provision of health and care services. Some of the latter may target 'early intervention' as a means of preventing health or social issues in later life.
- The concept of 'need' as defined here implies a *capacity to benefit* from an intervention. This can include treatment and cure, empowerment, symptom control and the promotion of independence. Effective and evidence based interventions are required to deal with need in this context.

Overall approach

- The approach will be to adopt a social model, using a mix of quantitative and qualitative data to provide a 'collage' of local information. The approach will signal a shift from being concerned solely with 'disease' or 'services', to a broader, more inclusive needs assessment looking at the major issues that impact on health and well-being.
- The 'hard' data will be as in Appendix A (but subject to revision following the anticipated additional guidance due in October 2007). Some of this data is readily available from the partners and will need pulling together in a coherent and informative way. The Research Network will be re-established to oversee this area of work.
- It was agreed that the area that is most important and also most challenging is to ensure input from communities, particularly those in 'hard to reach' groups. A variety of methods will be developed to enable communities to identify, priorities and decide actions to take to meet health needs.

The process of working with communities to identify their needs must be an empowering one, so that it becomes an exercise that 'engages' rather than creates a barrier. There are opportunities to increase the skills and knowledge in communities through adopting an empowering approach.

- The approach should build on, and incorporate, the needs identified in other areas of work being undertaken already in the Borough, e.g. Harold Hill Ambitions Project, forthcoming analysis of height/weight data collected in primary schools. Some of these areas can be 'fast tracked' to give early wins.

The approach outlined will need the co-operation and input of all the key local partners.

Outputs

1. Picture of current health needs
2. Picture of future health needs (3-5 years)
3. Understanding of current service provision
4. Anticipated need for services in the future
5. Gaps in services
6. Information to support Practice based commissioning
7. JSNA will inform revision of strategies, as follows:
 - a. HSP Community Strategy
 - b. HPCT Clinical Services Strategy and related Primary Care Strategy
 - c. Specific health improvement strategies:
 - i. Obesity (2008)
 - ii. Teenage Pregnancy (2008)
 - iii. Physical activity (2009)
 - iv. Alcohol harm reduction (2009)
 - v. Hypertension

Principles

The JSNA should reflect the principles of the Community Strategy, namely:

- Engage local communities and reflect local needs and aspirations in policies and plans
- Coordinate actions of HSP members to meet the needs of the community in an efficient and effective way
- Achieve sustainable development and local improvements
- Promote the development of a cohesive and safe community
- Encourage the development of co-ordinated and joint service plans

Proposed consultation and involvement process

Engagement with the following groups will be undertaken by the team appointed to work on the JSNA, led by the Associate Director Health Improvement.

- Health and well-being group (steering group for JSNA)
- Community Participation Group
- Older People's Board
- Environment Group
- Safer Communities Group
- Practice based commissioning leads
- HAVCO
- Homes in Havering
- Children and Young People's Strategic Partnership
- Teenage Pregnancy board
- Priorities Forum
- Patient and Public Involvement Forums (PPI)
- Front-line staff (through Prime Times, Intranet and staff forums)

- Research Network (LBH/PCT)
- Community groups
- Voluntary groups, including First Steps
- CAMHS
- *Others to be identified and added*

Governance

The JSNA will be overseen by a strategic planning group, the Health and Well-being group (a sub-group of the Havering Strategic Partnership). An operational group will report to the strategic planning group (see Appendix B).

Timescale

The following is proposed:

October 2007

- Sign up to the JSNA process by PCT, LBH and partners
- Advertise posts as identified in appendix E
- Scope data required and develop methods of community engagement
- Early analysis of Health and Well-being Survey (attached – Appendix D)

November-December 2007

- Appoint to advertise posts
- Establish JSNA Project Group
- Health and Well-being survey results available

December 2007

- Collect and collate data
- Commence community needs assessment
- Communicate findings of health and well-being survey

January-February 2008

- Begin data and information analysis to build a 'collage'
- Draft annual report produced

March 2008

- First cut of JSNA available
- Publish annual report

Issues to resolve

- How to engage practice based commissioning in the process
- Ways to ensure all relevant groups are involved in the JSNA
- Finding the right tools to engage with communities, e.g. rapid appraisal, focus groups.
- Find the right ways to address cultural barriers and skills competencies to ensure engagement

Appendices

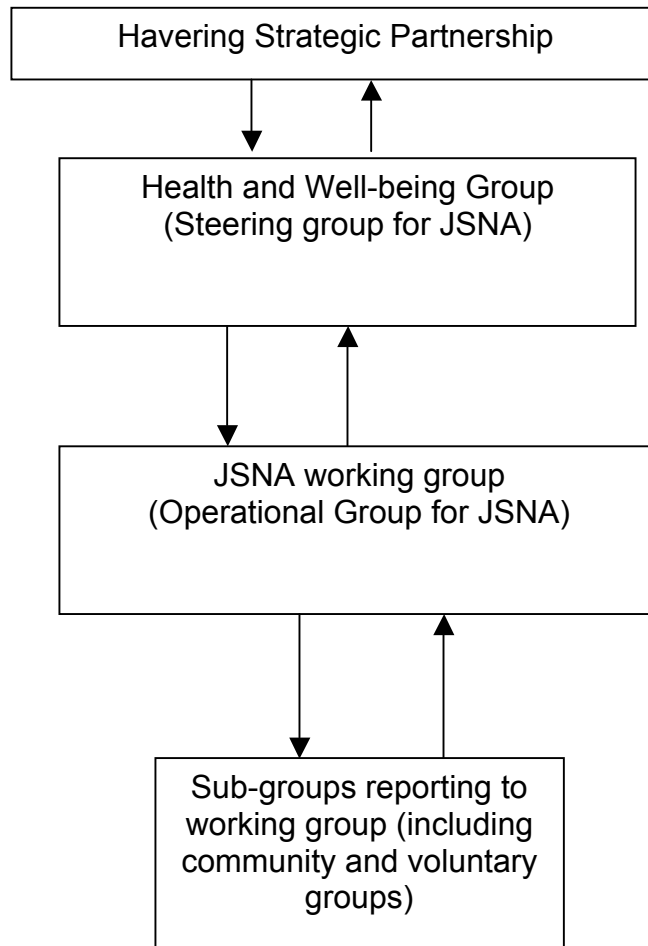
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|------------|---|
| Appendix A | Primary data for JSNA |
| Appendix B | Reporting mechanism and structures for JSNA |
| Appendix C | Identification of resources and funding streams |
| Appendix D | Early analysis of Health and Well-being Survey |

Public Health Directorate
October 2007

Appendix A: primary data needed for a Joint Strategic Needs Assessment

| | | | |
|--|--|----------------------------------|--|
| 1 | Demography | Population numbers | Current population estimates x5-year age bands and gender Population projections 3-5 years' time % Change |
| | | Births | Current births and projected rates |
| | | Older people | Current total aged 65+, male and female and five year projection |
| | | Ethnicity | Current numbers, percentages and projections |
| 2 | Social and environmental context | Benefits data | Children under 16 in households dependent upon Income Support |
| | | Deprivation | IMD 2004 |
| | | Characteristics | Housing tenure |
| | | | Living arrangements/over-crowding |
| | | | No access to car or van |
| | | | Employment data |
| | | | Average incomes |
| Rural or urban location | | | |
| 3 | Current known health status of population | Illness and lifestyle | British health survey 2004 Quality and Outcomes Framework GP QMAS data Risk factor data (smoking prevalence) |
| | | Teenage conceptions | Age <16 rate plus 95% CI Age <18 rate plus 95% CI |
| | | Census 2001 | Standardised limiting long-standing illness ratio (persons in household) |
| 4 | Current met needs of the population | Social care | RAP 3: Source of referrals |
| | | | P1: Clients receiving community-based services |
| | | | RAP P2f: Clients receiving community-based services |
| | | | RAP C1: Carers |
| | | Primary Care | SWIFT |
| | | | Predicted prevalence versus known prevalence of x diseases |
| | | | Dental: % DMFT 5 year-olds - trend |
| | | Hospital care (HES data) | Immunisation: Resident-based uptake rates |
| | | | Top 10 causes of admission |
| Top 10 diagnoses consuming most bed days | | | |
| 5 | Patient/service | Social care | Average, medium and range of length of stay |
| | | | User surveys |
| | | Primary and community-based care | GPAQ |
| | | | PALSLINKs data (qualitative and quantitative) |
| | | | Complaints data |
| Hospital care | Self-reported health outcomes | | |
| | Patient satisfaction surveys | | |
| 6 | Public demands | Local authority | Annual residents survey |
| | | NHS | Health scrutiny reports |
| | | | Petitions received |

Appendix B – Reporting mechanisms and structures for JSNA



Appendix C – Identification of resources and funding streams

| Resource requirement for JSNA | Purpose of funding | Funding source | Amount |
|--|---|-------------------------|----------|
| Project Manager to oversee and co-ordinate the JSNA | Ensure JSNA is completed and delivered on time. This will be undertaken by the Associate Director, Health Improvement, Havering PCT | PCT – in kind | N/a |
| Senior Public Health Commissioner (Strategic Planning) Band 7 (mid point) | To assist with the above | LPSA1 reward | £43,858 |
| Public Health data analyst 0.5 band 6 (mid point) | To provide additional support for data analysis for the JSNA | LPSA1 reward | £18,692 |
| 2 x Public Health Project Officers (community engagement) band 5 (mid point) | To engage with hard to reach communities and ensure qualitative data is fed into the JSNA | LPSA1 reward | £61,132 |
| Health and Well-being Survey | To provide up to date information on lifestyles of local people | LPSA1 reward | £40,000 |
| | | TOTAL REQUIRED | £163,682 |
| | | Total LPSA1 | £115,000 |
| LBH contribution to above costs | Ensure JSNA is adequately resourced | LBH – Mark Gaynor | £28,000 |
| Printing/stationery | Produce materials suitable for lay and professional use | PCT Public Health funds | £20,000 |
| | | Shortfall | £682 |

Appendix D

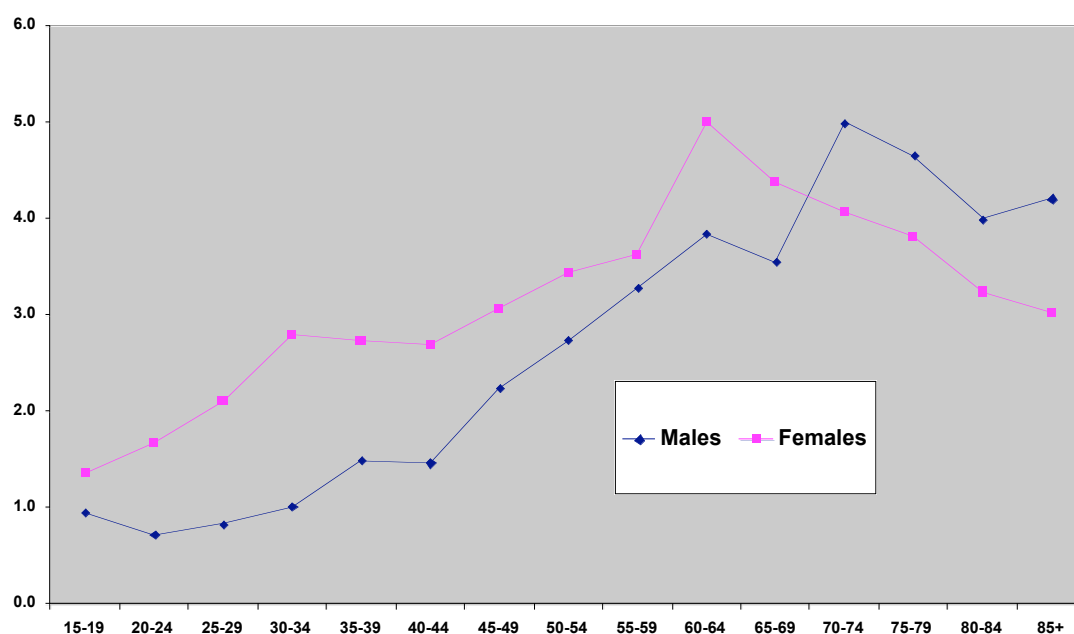
Report on Main Findings of Havering Health & Lifestyle Survey (Interim Data)

1. Introduction

1.1 This note summarises interim results from the 2007 Havering Health and Lifestyle Survey (abbreviated as HHALS). The returns so far are based on a 26.3% response rate (5143 over 19487), after taking account of people who have moved, died or were otherwise ineligible. In the summary of selected responses below, two ways of looking at socioeconomic effects were used: by the IMD2004 decile of the superoutput area of residence and by ward group. The latter compares the five most affluent wards (Cranham, Emerson Park, Pettits, Squirrels Heath, Upminster) with the three most deprived (Gooshays, Heaton, S Hornchurch).

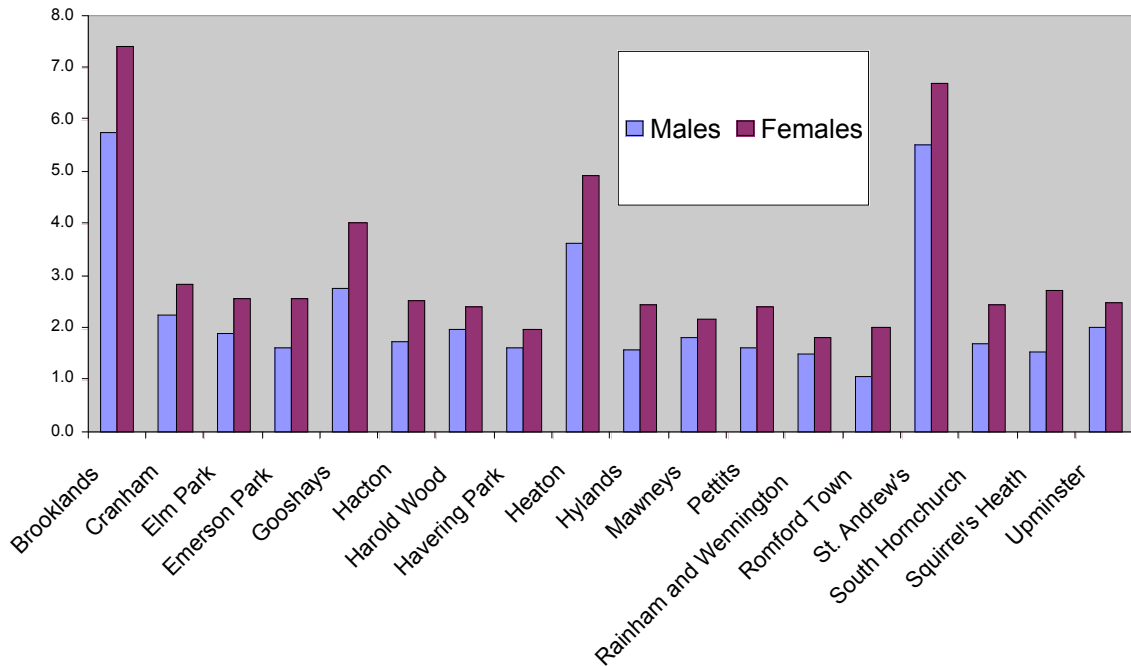
1.2 Of 5143 responses, 3042 are by women (3.1% of the adult female population of 98 thousand, as from the 2006 mid year estimate), and 2047 are by men (2.3% of the adult male population of 89 thousand). Representation of the population in the sample is higher at older ages; Figure 1 shows the numbers in the survey (by age/sex) as a percent of the total resident population.

Figure 1 Survey Coverage by Age-Sex Group (%)



1.3 Response rates by ward also vary widely (Figure 2), though response in the two most deprived wards is relatively good; for example, the male response rates in Gooshays and Heaton of 2.8% and 3.6% compare to a Havering wide male response rate of 2.3%.

Figure 2 Response rates by ward



2. Smoking

2.1 Assessing smoking prevalence from the survey has been impeded either by question design or non-response. The percent responding yes to the ever smoked question (question 28) is 63% for males and 47% for females, but the current smoking rates assessed from question 29 are implausibly low (14% for males, 12% for females).

2.2 The latter current smoking figures compare to a synthetic estimate of 24% smoking prevalence in Havering for the period 2000-2002 (males & females combined). These synthetic estimates were produced as part of a research project to test and produce area-level estimates of healthy lifestyle behaviours, which was carried out at the National Centre for Social Research. The General Household Survey (GHS) for 2005 covering all British households reports a 25% current smoking rate for males and 23% for females¹.

2.3 The replies obtained to the ever smoked question in the 2007 HHALS mean that 38% of males had *never* smoked, and 53% of females. This compares to results from the GHS 2005 (Table 1.3 in the ONS Report "Smoking and Drinking among Adults 2005") showing never smoking rates of 47% and 57% among males and females respectively. The never smoked rate in Havering among males is around 40% except in the top two deciles of the IMD2004 score, where only 32% of males report never smoking. Similarly only 32% of males in the three most deprived wards of Heaton, Gooshays and South Hornchurch report never smoking.

2.3 For women, the gradient in never smoking over area types is steeper. The never smoking proportion falls from 62% in the most affluent IMD decile to

40% in the most deprived decile. Similarly comparing the five most affluent and three most deprived wards, the respective never smoking rates are 58% and 45%.

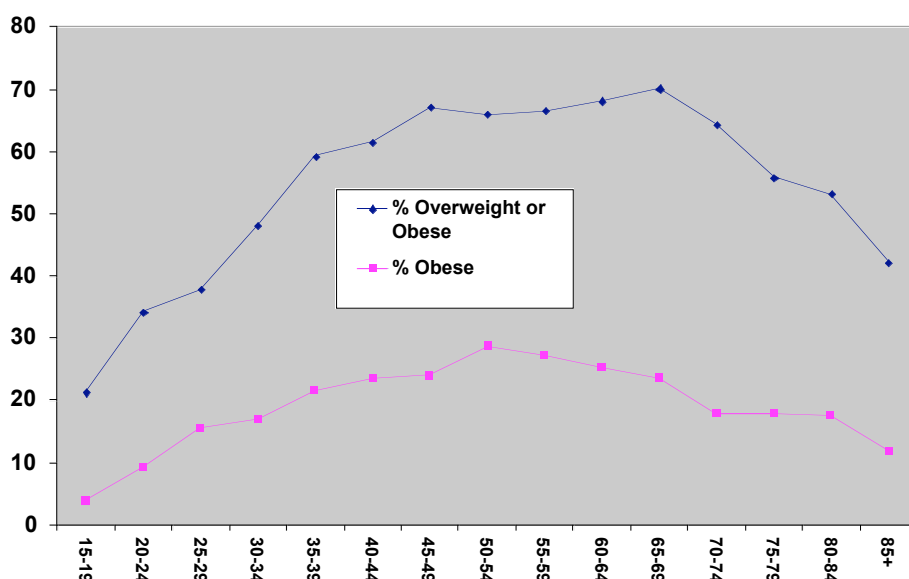
2.4 So despite the sampling and response issues, there are quite marked differences apparent from the survey in smoking behaviour according to area type, and by extension socioeconomic group. Looked at by household tenure (Q45), as opposed to area type, only 36% of women and 27% of men in households renting from Havering council had never smoked. In terms of annual household income (Q46), for incomes under £10,000 per annum the never smoking rates among men and women are 26% and 43% but for incomes over £50,000 per annum, the respective rates are 55% and 60%.

3. Obesity

3.1 The 2001 report 'Tackling Obesity in England' by the National Audit Office found (using 1998 data) that 19% of adults in England were obese, with a BMI over 30.1. More women than men were obese: 21% of women compared to 17% of men. But more men than women were in the overweight category (BMI between 25 and 30), namely 46% compared to 32%. Combining the overweight and obese groups, in 1998 nearly two thirds of men and just over half of women were either overweight or obese. They argue that the main reason for the rising prevalence is a combination of less active lifestyles and changes in eating patterns.

3.2 In Havering, the HHALS finds 23% of males to be obese in 2007 and 20% of females. For overweight and obese categories combined, the respective percents are 66% (males) and 55% (females); that is, 43% of males and 35% of females are in the overweight but not obese category (BMI 25-30). Obesity and overweight peaks in late middle age and early old age (Figure 3).

Figure 3 Percent of Persons Overweight or Obese



3.3 There appears to be some association with socioeconomic group too. The percent of males overweight or obese in the lowest three deprivation deciles is 62% compared to 66% in the three most deprived deciles; for females the respective figures are 51% and 58%. A comparison of ward groups shows the same: the male overweight/obesity rate in the three most deprived wards is 70%, compared to 63% in the four most affluent wards; for females the respective percents are 58% and 51%.

4 Health Status and EuroQol

4.1 The EuroQol-5D (EQ-5D) questionnaire is a brief, generic, health status measure. It defines health in terms of five dimensions, (mobility, self-care, usual activity, pain or discomfort, anxiety or depression) with each rated at one of three levels, (no problem, some problem, extreme problem). EQ-5D also includes a single value for health status obtained via a visual analogue scale, namely a thermometer-like scale in which the respondents self-rated their health status from 0 to 100 (100 = best status).

4.2 For Havering residents one finds the overall health score to decline by age, as expected (Figure 4). There are also area differences: for males the average health score in the four most affluent wards is 78.3 compared to 74.5 in the three most deprived wards; for females, the respective averages are 80.6 and 76.1. There is also a socioeconomic gradient in EQ5D scores (Figure 5), with poorer scores in low income households.

Figure 4 EQ5D sores by age and sex

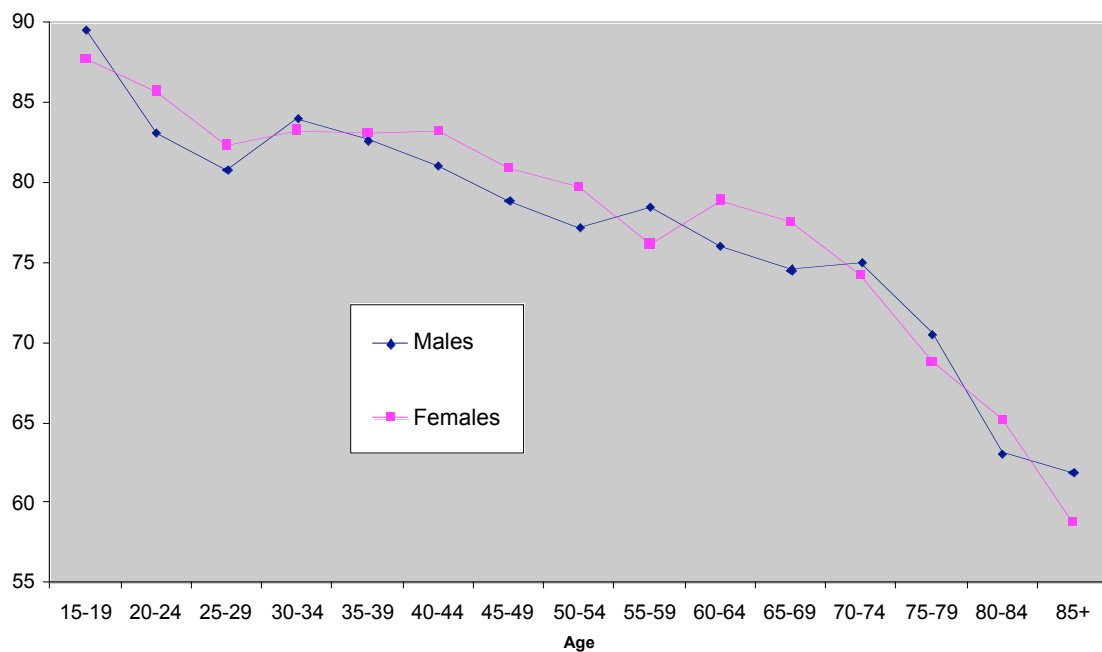
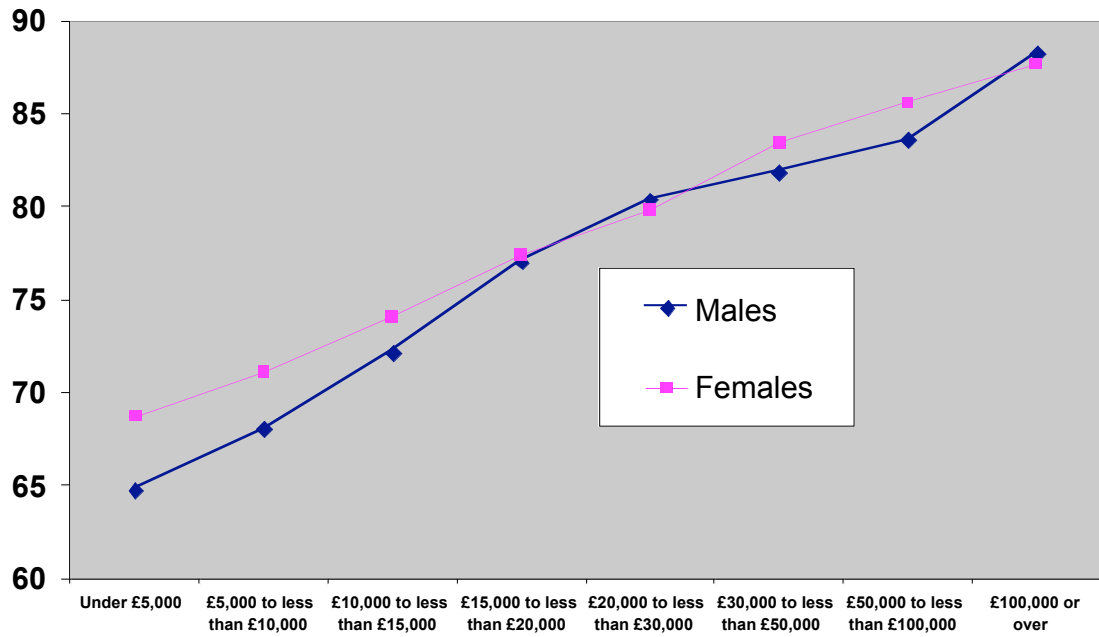


Figure 5 EQ5D Score by annual household income



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References

1. Office of National Statistics (2005) General Household Survey, 2005; Smoking and drinking among adults 2005