



Meeting the need

What makes a 'good' JSNA for mental health or dementia?



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Acknowledgements

Centre for Mental Health would like to thank the following organisations and individuals for their vital and generous support for this project:

- Public Health England
- The National Mental Health, Dementia and Neurology Intelligence Network
- Blackburn with Darwen Borough Council
- Bradford City Council
- London Borough of Haringey
- Surrey County Council
- Swindon Borough Council
- Dr Andrew O’Shaughnessy and Dr Bunny McCullough, Bradford City Council
- Dr Jeanelle de Gruchy and Dr Tamara Djuretic, London Borough of Haringey
- Maya Twardzicki, Surrey County Council
- Frances Mayes, Swindon Borough Council
- Dr Kenneth Barnsley, Blackburn with Darwen Borough Council
- Paul Ogden, Local Government Association
- Dr Geraldine Strathdee, Cam Lugton and Sam Lane, National Mental Health, Dementia and Neurology Intelligence Network
- All of the participants in the focus groups and the people who kindly agreed to be interviewed for this research
- The members of the JSNA steering group who provided comments and suggestions for the report

Executive Summary

Centre for Mental Health investigated what makes a 'good' joint strategic needs assessment for mental health or dementia. We visited five local areas to understand how they produced their needs assessments, how they used them and what impact they had. We found that public health teams and local partners had found a range of innovative and creative ways to produce needs assessments that raised the profile of mental health or dementia, that were user-friendly and communicated effectively and, crucially, that brought about change in people's lives.

We found that a mental health needs assessment can have a significant impact in a local area. It can raise the profile of issues that might otherwise be ignored and direct investment into improved support. It can stimulate investment in new services or protect those that provide good value from being lost. And it can help local agencies to come together to solve shared problems collaboratively. But it is not a straightforward process. Reliable, up-to-date information is hard to come by and the capacity in local areas to find, use and interpret data is limited. There is a lot of competition for people's time, resources and attention in every local area. And despite growing evidence of the benefits of prevention and early intervention in mental health, cuts to public health budgets are likely to make this more difficult in the near future.

We have identified eight key success factors behind the creation of an effective and impactful needs assessment for mental health:

1. Leadership

Mental health and dementia were often selected as topics for a standalone JSNA as a result of the enthusiasm and commitment of elected members or senior officers in local councils. This 'championing' form of leadership is vital to ensure that adequate resources (and expertise and time) are put into assessing mental health needs. Leadership also has a key ongoing role in ensuring JSNA findings lead to action once the assessment is completed.

2. Purpose

An effective needs assessment process comes from there being an actual or perceived need for it to address a priority. It does not come from the routine industry of doing JSNAs and some of the most effective needs assessments have been carried out separately, for example in developing a new health and wellbeing strategy.

3. Engagement

The process for developing a needs assessment is as important as the document itself. The JSNAs we saw that made an impact were produced collaboratively with partners inside and outside the local authority. Some were 'owned' by multi-agency steering groups that continued to meet and work together following the assessment in order to implement the recommendations.

4. National policy

Policy directives from national bodies can have a significant impact on local decisions, either to focus on a specific issue or to help to fund implementation of a strategy. The *Dementia Challenge* and *Future in Mind* (for children's mental health) both had a major impact in areas we visited in raising the profile of needs assessments relating to dementia and children's mental health.

5. Research evidence and data

Many public health teams found it difficult to obtain reliable and relevant local data on key issues (e.g. prevalence of mental health conditions). They found a variety of ways of getting around this problem, however, including the extensive use of research evidence and NICE guidelines to demonstrate the gaps between levels of need and current provision. Some also sought evidence from a wider range of local sources, including voluntary sector organisations, schools, police forces and community groups.

6. Voices of experience

All of the needs assessments we looked at had some element of the voices of people with lived experience. A range of ways of seeking people's views and experiences was attempted. Several of the people we interviewed said this was vital and some wished that they could do this in greater detail in future.

7. Presentation

The way a JSNA is presented is crucial to making an impact. JSNAs need to speak to their target audiences – they are telling a story about their local area and as such they need to engage and speak in a language that is understood. This may mean more than one version of the document is required.

All of the people we spoke to who used JSNAs valued them being easily accessible (written in plain English and easy to find on publicly available websites). Creative ways of presenting data, such as PowerPoint presentations, infographics and one-page topic summaries were helpful for council members, directors, voluntary sector organisations and CCG partners to make best use of the JSNAs.

8. Follow up

An effective JSNA can become an important part of a cycle in local areas where needs and gaps are identified, where interventions are put in place, and where their impact is measured over time in order to keep making improvements. Many local areas described frequent changes in patterns of need and demand meaning that JSNAs need to be flexible enough to allow for updating as new data emerges and regular review of the priorities they identify.

Key messages for local and national bodies

National bodies could support local areas to assess their mental health needs in the following ways:

1. Communicating clearly what data is available and wherever possible providing it centrally to free up local resources to do what can only be done locally, such as seeking the views of people with lived experience and engaging with multi-sector partners.

2. Encouraging data sharing so that JSNAs can understand current provision and the journeys people take through services. This would include information on use of primary care services, referrals to secondary care and mental health support to people with long-term physical conditions.

3. Producing JSNA guidance that recognises reduced local resources and puts the onus on national bodies to take a 'do once and share' approach with data wherever practical and possible. Guidance should include clear messages about the importance of working with local communities to identify needs and assets.

4. Exploring ways in which local JSNAs can inform national policymaking on mental health and dementia.

For local authorities:

One size of JSNA does not fit all and there need to be local decisions on how to maximise the benefits of the process, but we would advocate the following to local authorities to get the most out of their mental health and dementia needs assessments:

1. JSNAs generally make most difference when there is a specific needs assessment for a particular issue (e.g. for children's mental health or dementia) with a specific purpose, for example to develop a new strategy or commissioning plan, and with ongoing oversight of implementation from health and wellbeing boards.

2. Local areas should know about and make use of nationally available data (e.g. from the resources available from the National Mental Health, Dementia and Neurology Intelligence Network) and produce a JSNA in a format that allows routine updates wherever possible to be incorporated.

3. There is clear benefit in including the perspective of people with lived experience of mental health and dementia in needs assessments. Schools, community and voluntary organisations and user-led groups can provide useful routes for people's voices to be heard, especially those who have the most

complex or least understood needs. This takes time and resources but gaining an accurate picture of local needs and assets should provide long-lasting economic and social benefits to the local authority, and its partner agencies.

4. The support of a senior local authority official, elected member or senior member of the CCG can make a difference, and effort should be made to identify a ‘champion’ for the development and implementation of mental health needs assessments.

5. Needs assessments (and strategies where relevant) should be produced in collaboration with a range of local statutory and voluntary sector partners, and where possible these partnerships should be retained to support implementation and review processes.

6. Implementation of interventions or strategies on the basis of a JSNA should be reviewed routinely to measure success on the basis of realistic milestones set for delivering complex and long-term changes.

1. Introduction

Centre for Mental Health was funded by Public Health England to investigate what makes a 'good' joint strategic needs assessment (JSNA) for mental health or dementia. The aim of our work was to share learning in order to help local areas understand their mental health needs and assets, and what can help the process of developing joint health and wellbeing strategies (JHWS). Through the work, we hope to inform commissioning priorities and plans in both the NHS and local government.

We visited five local areas where needs assessments have been used to change policy and practice in relation to children's mental health, adult mental health or dementia. We sought to understand the process by which the needs assessment was produced, how it was used and what impact it had. Crucially, we looked at how and why these five needs assessments had more impact than some in other areas, and what the success factors might be for high-impact JSNAs.

In each local area we conducted a focus group with people who have been involved in one way or another with a mental health or dementia JSNA – either in producing it or using it. We also interviewed people individually who were unavailable for the focus groups or who had additional evidence to offer. We wanted as many perspectives as possible and to explore the challenges local areas have experienced as well as the success factors. Focus groups and interviews were semi-structured, with questions (see appendix) designed to elicit conversation and discussion.

The local areas we visited for this project were:

- Blackburn with Darwen
- Bradford
- Haringey
- Surrey
- Swindon

In Blackburn with Darwen, our research focused on their Integrated Strategic Needs Assessment (ISNA) for children and young people's emotional health and wellbeing. In Bradford we explored their Health Needs Assessment for dementia. In Haringey and Swindon we looked at their JSNAs for both adult and child mental health while in Surrey our focus was on their adult mental health needs assessment.

The areas chosen for this study were identified through discussions with Public Health England, the Local Government Association and through the Mental Health Challenge network of local authorities with mental health champions. The five we selected are not the only, nor necessarily the most exemplary, mental health JSNAs to achieve a significant local impact, but they provide insight and intelligence into the potential for needs assessments to make a difference to people's lives.

All the quotes in this report are taken from interviews and focus groups conducted for this research project.

2. How did mental health or dementia get chosen?

“A joint strategic needs assessment is neither joint, nor strategic, nor does it really assess needs.”

The processes by which mental health or dementia were selected for a needs assessment were many and varied. Decision-making processes in local authorities vary widely, but a common feature in this study was the importance of leadership (from a range of different people) in making the case for a focus on these issues.

In Bradford, the health needs assessment (HNA) for dementia was carried out separately from the JSNA process. Interviewees there described a separation between the ‘routine’ production of JSNAs as a rolling process and the focused work required for a one-off, thematic HNA. It was the latter, not the former, that had the biggest impact on the level of priority given to different issues and the way resources were allocated.

In Surrey, the adult mental health JSNA was produced at a time that enabled it to inform a joint commissioning strategy. This meant the public health team producing it knew it would have a purpose and “not just go on a shelf”.

In Haringey, mental health emerged as a priority from councillors’ surgeries and was supported by a new chief executive. Both children’s and adult mental health were identified as priorities for creating joint frameworks between the CCG and the council, reporting to the health and wellbeing board (HWB).

In Swindon, prioritisation of needs assessment topics is undertaken by a multi-agency steering group which is a sub-group of the Health and Wellbeing Board. Mental health was recognised as a significant issue within Swindon as its impact affects all statutory agencies and partnership working was well established in the context of a unitary local authority with a single, coterminous CCG. The children and adolescent needs assessment was undertaken as part of the commissioning cycle:

“If a service is due to be recommissioned then this is fed into the JSNA planning process. We then take a holistic view to ensure prevention

and promotion of mental wellbeing was included.”

Blackburn with Darwen chose to produce Integrated Strategic Needs Assessments rather than JSNAs in order to look across policy areas, e.g. including housing and community safety, rather than conducting separate assessments for each. The council set up a leadership group to manage its ISNA process which reported initially to the Local Strategic Partnership and then the Health and Wellbeing Board. The leadership group determined priorities for ISNAs and then each one was led by someone from public health and a commissioner who ‘owned’ it.

Children’s mental health was chosen as a priority topic for an ISNA because public health was taking on extra responsibilities for children’s health at the time and because “every single person I spoke to all talked about emotional wellbeing for children and young people, including children [themselves].” This decision coincided with the 2013 Chief Medical Officer’s report on children’s mental health, which “made us take a wider scope” than originally intended, looking beyond child and adolescent mental health services to the wider influences on emotional wellbeing.

The objectivity of the process for determining priorities for JSNAs or their alternatives was the subject of differing views. Some interviewees said priorities were selected on the basis of “who shouts loudest” while others described processes by which the relative merits of different issues were compared before priorities were chosen.

“There is no prioritisation process...no one has a remit, guidance or support to decide what goes up and down the priority list.”

“National policy and passionate voices can take the crowd along with them.”

In all cases, however, the role of the health and wellbeing board ‘owning’ the JSNA and its selection was regarded as important to the process of prioritising mental health or dementia.

3. How the JSNAs were produced

“Data is people telling us that something makes a difference.”

Getting data together for needs assessments was a challenge in all the areas we visited. Public health workers described a range of difficulties in relation to mental health JSNAs that they felt were greater than for most physical health JSNAs. These included:

- A lack of up-to-date, reliable local prevalence data;
- Poor quality service data, e.g. the use of GP Quality and Outcomes Framework (QOF) data to estimate levels of depression or psychosis in local populations;
- Difficulties getting access to NHS data since public health teams were moved to local authorities (for example to be able to follow patient records from primary care into specialist services and understand the pathways people take through the health and social care system);
- Poor quality information on ethnicity and the experiences of some communities of mental health and mental health services.

The teams we interviewed found a number of different, often creative, ways of coping with the paucity of local data for their needs assessments, and of determining the specific approaches they took to data collection.

Blackburn with Darwen’s JSNA was “initially seen as a CAMHS review” but gradually moved away from a focus on services to focus on emotional wellbeing. Interviewees told us they “didn’t want the tip of the iceberg” but to understand what protects children’s wellbeing and what compromises it.

“We didn’t only want to target those in services already, and evidence shows we need to focus on prevention.”

At the outset of the process, the team recognised that little was known already and that the most ‘recent’ prevalence data was from 2004, and then only available at a national level.

“We were starting from scratch... We knew we’d have a lot to do from the ground upwards.”

The team took a decision, however, to use national data rather than spending time trying to establish local prevalence estimates: instead, they prioritised the collection of qualitative data from children and young people living in the borough. To achieve this, rather than sending out public health officers to interview young people, they worked through trusted intermediaries: for example an educational psychologist who already had access to schools, and a local charity working with families. The team also ensured they engaged with under-represented groups of young people, including from BME communities, homeless young people, looked-after children and those misusing substances. They worked with a community group in the South Asian community: “an easy way to contact people we’d have difficulty getting the confidence of”.

The team trained young people to carry out interviews with peers and used a range of activities to draw out intelligence, including work with a local school that produced a film and carried on working with the team afterwards.

“This is the voice of young people in our borough.”

Bradford’s HNA included a qualitative study of stakeholder interviews with more than 50 people including councillors, patients and carers. This provided the team with rich information, for example about how much they valued dementia cafes. Interviewees for this report in Bradford noted that it was the priorities of stakeholders that drove the work, not data. “Too often data drives decisions”. Where data was unavailable, the team used research evidence as a proxy.

“There is a risk of not doing important things because of a lack of data about them.”

This process was also found to have longer term benefits: “Involving lots of people in the process in itself generates partnership” which helped to

bring people together for implementation of the strategy the HNA created.

Surrey's adult mental health JSNA had a particularly strong focus on the social determinants of mental ill health and the groups of people facing the highest risks.

“Inequalities are why we [public health] exist.”

To do this, where there were gaps in the availability of data for high-risk groups, the team approached local organisations to seek any information they had, for example in relation to the survivors of domestic abuse and to family carers.

In Swindon, there was a bigger focus on reviewing what services were currently in place and identifying gaps in provision: “we needed to see what was out there”. It was also noted that:

“Some services closed during the children’s JSNA [data collection] so we wanted to show the impact of that... Where are those children going to be picked up? This is what we’ve got and these are the gaps for re-commissioning services.”

Swindon did benefit, however, from the data provided by its primary care psychological therapy service, LIFT Psychology, which was said to be proactive in its use of data and evaluation. They also used national data on prevalence and extrapolated this for Swindon to identify likely levels of need.

The team also engaged with schools in the borough through its Healthy Schools lead and they undertook some consultation with schools that fed into the needs assessment for children and young people.

4. Leadership and management

Several of the needs assessments we explored were overseen by a steering group, often bringing in a range of local organisations with an interest in the topic and a role to play in using the data.

In Bradford, the HNA was overseen by a pre-existing Dementia Strategy Group that included members from voluntary sector organisations as well as CCGs, service providers and a range of departments of the City Council. All of the members of this group had a part to play in developing and creating the HNA and this helped to bind them together in a partnership that remained strong after the work was completed (in 2014). The group began as a voluntary sector partnership but grew after the HNA to include a range of statutory bodies.

The group was said to work well because it gave everyone an equal voice, it built trust between commissioners and providers and it was founded on a long history of working together. It was also mentioned that efforts were made to include agencies from outlying areas of the city which had previously been isolated and not involved in the group.

In Swindon, the adult JSNA has a steering group whose members included current mental health service users. This helped to dispel myths and get an objective view of services: it “gives insight rather than a bureaucratic view” and challenges the assumptions of providers. The children’s JSNA steering group included the borough’s Youth Forum and a local UK Youth

Parliament member, who engaged other young people locally. Service providers were also involved and consulted young people – and while this brought a risk of conflicts of interest, it provided valuable information on waiting times and the visibility of CAMHS for young people that would have been missed without their involvement.

Haringey started their process with a workshop chaired by the Chief Executive and attended by a wide range of senior leaders across the partnership to understand the borough’s ‘state of play’. They also had a steering group and an expert reference group to bring in a wider range of views and experiences. Providers including non-statutory organisations contributed data and this helped them identify gaps in their services. People we interviewed in Haringey noted that it was important to involve both commissioners and providers so that population data can be merged with that from services: without both being involved the picture would have been far less clear.

Blackburn’s ISNA for children’s emotional wellbeing had a steering group including commissioners from a range of agencies and was championed by the Director of Children’s Services. The group also included the local CVS, colleges and the police. It held a workshop on what the priorities should be from which schools emerged as key. As a result of this, local schools were involved in a workshop for head teachers and staff with PSHE funding.

5. Presentation

A consistent theme from every focus group and interview was the importance of high quality presentation of data from JSNAs or their alternatives. It was felt to be vital that needs assessments were made widely available, proactively publicised, and well-presented in ways people can easily use.

Bradford's dementia HNA is hosted on an external website, which was felt to be important to make it more accessible to more people. It was published during Dementia Action Week with an awareness event that was widely promoted beforehand to get public support. The format chosen for the HNA was to provide a summary of each chapter on a single page, providing a summary of the issue, facts and figures, and recommendations for each topic. Interviewees told us it was easy to read, including for elected members, and clearly linked recommendations with the evidence for them. Arranging the HNA thematically meant that the reader 'doesn't have to do the work all over again' by piecing together material on a single topic from different sections. This format also enables new sections to be added and material to be updated without rewriting the whole thing. Members of the Dementia Strategy Group said that this meant they could take relevant sections to meetings or insert them into other documents.

Haringey's JSNA was published in the form of 30 PowerPoint slides taking a 'life course approach' with information on a range of issues, for each age group. It focused on daily life for people rather than taking the more 'traditional' format of being divided into prevalence, risk factors and services. It also used individual stories to provide a narrative alongside the data being presented. The aim was to look at what need exists at different points in the system and to relate that back to the lives of the people concerned:

"What does it mean for a young person waiting for an assessment?"

The key message throughout was that 'mental health is everyone's business', for example by linking it with housing, employment and criminal justice. Interviewees said that this was the first time many people had seen the evidence all in one place. It also provided comparisons with other areas and within the borough, where there are stark differences between localities (demonstrated through maps showing data by ward).

"The more you make data accessible the more people want to know and continue having conversations about it... What's the story and what more do we need to know?"

The JSNA included a 'tree diagram' comparing expected levels of need in the population with current provision of care. This was described as being very influential in raising awareness of the size of the gap. Interviewees said it was important in a JSNA to "take agencies through the steps, not just present them with facts or recommendations". The role of the JSNA in this was to act as a 'conversation starter' and its presentation in simple, concise format was essential to that purpose. The people involved in the process from different agencies were then able to "tell the story" in different places and sustain organisational memory.

"It's a story, not a dump of data."

Swindon's JSNA adult mental health was described by interviewees as a good opportunity to get the prevention message across where it is not normally heard. It put all the information in one place for the first time:

"There were lots of conversations but they were crystallised through the JSNA".

In Swindon each full JSNA is summarised into an 8 page bulletin which highlights the key issues in an accessible format.

In Surrey, the JSNA is available on a Data Hub with more detailed information behind it where

possible. New data can be incorporated when it becomes available and the interpretative text then changes with it, and JSNA chapters are refreshed every couple of years.

During our discussions in a number of local areas, there was some disagreement between and within them about how long a JSNA should be. In some cases this led to tensions between those seeking short, concise documents and those wanting to show the breadth and complexity of the issues involved.

“The design brief gets lost by trying to be everything to everyone. No one’s sure what it’s meant to be and who it’s for.”

“It’s long, but it needs to be.”

But there was universal agreement that JSNAs have to be presented in a way that makes it easy for busy people to use the material to achieve impact according to their particular requirements:

“I want all the relevant data in one place and data analysis there to extract what I need as a commissioner.”

6. Moving from intelligence to action

“[A needs assessment] produces an energy in itself if you don’t do it in a darkened room by yourself.”

“Needs assessments kick-start conversations, if nothing else.”

The process of converting data and intelligence into action provides useful insights into the importance of sustaining momentum once the JSNA has been produced.

In Bradford, the City Council decided against producing a separate needs assessment and strategy, incorporating both in one document. It was agreed that the HNA couldn’t be implemented all at once and they decided to start with ‘easy wins’ while other items would take longer to get implemented. They asked for five years (or as long as it took) to implement the recommendations, knowing that many would have to alter with time because of changes in the wider world.

The Dementia Strategy Group provided a forum to bring in a wide range of organisations to implement the recommendations and that fact that it meets monthly was felt to add a sense of momentum; it went from being a ‘talking group’ to a ‘doing group’. By comparison, it was felt that traditional JSNAs lack a process for bringing about action: “we don’t go beyond talking about it”.

The HNA also identified the need for a greater understanding of the needs of people with dementia in care homes. This led to the production of a more focused needs assessment which was subsequently incorporated into the HNA.

In Surrey, the JSNA was developed with the purpose of creating a joint commissioning strategy for adult mental health. One CCG led the development of the strategy after the JSNA was published but all of the county’s CCGs were asked to sign it off. District and borough (second tier) councils were also engaged because of their important role in matters such as housing. To enable this, the County Council is providing each district with its own local JSNA

highlighting the facts and figures and key issues for their area to make it relevant locally.

The steering group for Swindon children’s JSNA was developed into a transformation steering group in order to manage the Transformation Plan (required of each local area following the *Future in Mind* children’s mental health strategy in 2015). This was felt to have created continuity between the needs assessment and the transformation plan – linking up local initiative with national policy imperatives.

In Haringey, a joint CCG and local authority Mental Health Framework was produced as a result of the JSNA process. The framework identified four priority areas, including improved mental health support for children and young adults and the development of an ‘enablement’ model for people living with mental health conditions. This has led to a number of changes in commissioning, including the creation of a new supported employment service and discussions (at the time of writing) about pooled budgets. A voluntary sector-led suicide prevention group used the JSNA as a framework to engage a wider range of community organisations in its work.

And in Blackburn, the workshop for school headteachers following the production of the JSNA enabled the key messages to be shared and helped to build connections with schools nurses. Since that time, some schools have continued to engage actively. Interviewees noted that there are ‘significant challenges’ to sustain this when schools are now so autonomous and have many competing priorities, but they felt that they were ‘starting slowly to create whole system change’ and that schools that recognised the benefits have stayed in touch.

Areas producing children’s mental health needs assessments pointed to particular difficulties in engaging with schools. This is partly a result of the financial pressures they face and partly because of the independence of academies, limiting the ability of public health teams to work with more than a handful at any one time.

7. The impact of the JSNAs

The most difficult question for many focus groups was to identify where needs assessments had made a clear impact in communities and on services. In some areas, the needs assessments we explored had been completed too recently for a sustained impact to be discernible. In others, the JSNA was one of a number of influences on local policies and commissioning decisions. And all were published during periods of austerity for local councils and their partners.

In more than one local area, interviewees expressed the view that the needs assessments had helped to prevent cuts to services that had been identified in the process as having great value to people. While they may not have prompted new investment, it had at least 'saved' existing investments that provided good value for money.

The merging of the dementia health needs assessment and strategy in Bradford was felt by the focus group there to have given it an immediate impact. It cut out an extra step in the process and avoided a lot of bureaucracy. It was used in the procurement of nursing and residential homes and data was shared with individual care homes to help them see how well they are doing and explore areas for improvement. It was also used in the council's market brief for domiciliary care. And data about unplanned hospital admissions for people with dementia highlighted the need for enhanced care models (including telemedicine) in care homes.

"[The HNA] gave us the focus and organisation to take things forward in concert."

Interviewees in Bradford said that the HNA recognised existing good practice as well as providing local agencies with data about their performance and use of evidence-based practice to help them find ways of improving.

In Surrey, the JSNA informed development of an Emotional Wellbeing and Mental Health Integrated Commissioning Strategy with a three year Action Plan. Implementation against identified indicators of progress is overseen by the Health and Wellbeing Board. And the County Council told us that their contract for a county wide mental health promotion service requires the provider to target areas of higher mental health need and groups with higher risk – as identified in the JSNA.

Swindon's JSNA for children's mental health was described as "focusing the direction of travel" for CAMHS transformation. It was noted that the timing of the children's JSNA made it more useful than most, coming at the time of new investment being made available for CAMHS following *Future in Mind*. Interviewees noted that the council runs a broad range of services relating to children's mental health (including housing and domestic violence) and the JSNA provided:

"a good opportunity to join up services... and demonstrate how the council's work has implications for mental health."

The children's JSNA was cited in a successful bid for funding for parenting support and the council set up a pilot programme with a school academy chain to use data to give them a profile by year group in the hope this will be taken up more widely.

The adult JSNA, meanwhile, had 21 recommendations, seven of which were given priority by the council following discussions. Unlike the children's JSNA that followed (and learned from experience) there was no specific strategy group to oversee and scrutinise the implementation of the adult JSNA: as a group "we didn't monitor what happened" although it did contribute to the Mental Health Programme Board's work programme. This makes it challenging to capture the progress made on each recommendation. Some individual recommendations were picked up, however: for example the JSNA highlighted the importance of debt and a benefits group was set up to address the issues raised.

In Haringey, the JSNA was described as providing a 'baseline for the future':

"To come back and see what's changed and has it made any difference?"

Like many other JSNAs, it can be modified as new data becomes available. For example, the team was currently looking at employment data because of the opportunity created by devolution arrangements in this area. Interviewees said they hoped to refine specific areas of the JSNA over time rather than revisit the whole thing occasionally. And while originally the JSNA identified broad areas, they are now digging deeper in areas of focus and embedding mental health in other strategies, e.g. in relation to tackling Violence Against Women and Girls and reducing homelessness.

8. Monitoring and accountability

In Bradford, an annual report is produced to keep track of progress. This was described as essential to ensure that the necessary connections are being made, work is being driven forward and changes are fed back into the HNA over time.

In Surrey, the integrated commissioning strategy for which the JSNA was produced is monitored through six-monthly reports to the health and wellbeing board (HWB) against each item in the Action Plan. RAG (red-amber-green) indicators are used to track progress and an outcomes dashboard is also used to monitor changes in life satisfaction scores and the reach of the Time to Change anti-stigma campaign. The HWB also hears case studies at each meeting and this was described as important because council members did not to come into contact with service users as often as staff.

Haringey is currently developing a dashboard linking to the commissioning of services and an evaluation of their impact.

“The next stage is about monitoring and performance monitoring.”

The fact that a number of agencies have consistently worked together through the development and monitoring of the JSNA was described as important. They felt they were trying to do a job together, not seeking separate roles, with responsibilities shared between agencies all of which make their own contributions. And crucially, public health was seen as a partner in the process rather than just a provider of information, offering:

“Leadership, not handing it over.”

9. Reflections for the future

We asked participants in each local area to tell us their reflections on the process so far, what they would do differently in future and what advice they had for other local areas. Many of their comments reflected the limited time and resources public health teams have to carry out JSNAs and the difficulties they face in being able to make an impact.

Moving public health to local authorities without agreements about NHS data access has limited the scope of some JSNAs. This has left some public health teams with very little detailed information to work from:

“We’ve got births and deaths.”

This leaves a big gap in understanding people’s experiences of health services:

“Where do people turn up? How many times did they turn up before they were taken seriously? Who’s getting no further than diagnosis?”

But it was also noted that public health being within councils gave the JSNA a higher profile and more ownership than it had in the past because it was now signed off and ‘owned’ by the HWB.

A concern was raised about the difficulty of producing JSNAs quickly enough to respond to local or national policy directives.

“By the time it’s finished it’s out of date.”

Another participant noted that the time it takes to produce a JSNA can stop people taking action to address issues while the assessment is being prepared:

“Don’t improve before we’ve understood the baseline.”

The timing and process for producing JSNAs raised an important issue for one interviewee, who pointed out that a lack of connection between local and national decision-making

and policy development leaves it to chance whether a JSNA will have an impact locally (such as if it coincides with when a national strategy is being developed) and indeed whether JSNAs from local areas can ever be aggregated to inform policy at the national level. It felt to some participants that JSNAs were being produced on a conveyor belt with no strategic direction:

“Is it a cycle or is it for targeting strategy?”

“How do JSNAs inform national strategies?”

With limited resources for public health, it was suggested that better coordination between local and national government could ensure that JSNAs were targeted on priority areas of work where they could be most useful at a given time, both in implementing national policy and in providing intelligence back to central government.

In all local areas, resource constraints in public health teams were a major worry. Several people told us that they would be unable to produce JSNAs of the same quality in future. There is ‘less time to crunch data’ so the key function for local public health staff will increasingly be to collect insights and analyse and interpret data from the Mental Health Intelligence Network rather than producing data themselves. But for that to happen, the Mental Health Intelligence Network would need to be user-friendly (for example to enable data to be pasted into local documents) and reliable, stating clearly where data is ‘real’ and where it is estimated based on national surveys or research.

In one focus group, it was stated that too often public health staff spend a lot of time working on strategies or producing a rolling programme of JSNAs that reduce their capacity to take action. In another, it was stated that a JSNA needs one person to carry the process and have protected time to do it thoroughly from start to finish and then to sustain the organisational memory afterwards and ensure that it makes an impact.

10. Conclusions

Our research has shown that a mental health needs assessment can have a significant impact in a local area. It can raise the profile of issues that might otherwise be ignored and direct investment into improved support. It can stimulate investment in new services or protect those that provide good value from being lost. And it can help local agencies to come together to solve shared problems collaboratively. But it is not a straightforward process. Reliable, up-to-date information is hard to come by and the capacity in local areas to find, use and interpret data is limited. There is a lot of competition for people's time, resources and attention in every local area. And cuts to public health budgets are likely to make this more difficult in the near future.

We have found eight key elements that characterise successful needs assessments for mental health and dementia:

1. Leadership

Mental health and dementia were often selected as topics for a standalone JSNA as a result of the enthusiasm and commitment of elected members or senior officers in local councils. This 'championing' form of leadership is vital to ensure that adequate resources (and expertise and time) are put into assessing mental health needs. Leadership also has a key ongoing role in ensuring JSNA findings lead to action once the assessment is completed.

2. Purpose

An effective needs assessment process comes from there being an actual or perceived need for it to address a priority. It does not come from the routine industry of doing JSNAs and some of the most effective needs assessments have been carried out separately, for example in developing a new health and wellbeing strategy.

3. Engagement

The process for developing a needs assessment is as important as the document itself. The JSNAs we saw that made an impact were produced collaboratively with partners inside and outside the local authority. Some were 'owned' by multi-agency steering groups that continued to meet and work together following the assessment in order to implement the recommendations.

4. National policy

Policy directives from national bodies can have a significant impact on local decisions, either to focus on a specific issue or to help to fund implementation of a strategy. The *Dementia Challenge* and *Future in Mind* (for children's mental health) both had a major impact in areas we visited in raising the profile of needs assessments relating to dementia and children's mental health.

5. Research evidence and data

Many public health teams found it difficult to obtain reliable and relevant local data on key issues (e.g. prevalence of mental health conditions). They found a variety of ways of getting around this problem, however, including the extensive use of research evidence and NICE guidelines to demonstrate the gaps between levels of need and current provision. Some also sought evidence from a wider range of local sources, including voluntary sector organisations, schools, police forces and community groups.

6. Voices of experience

All of the needs assessments we looked at had some element of the voices of people with lived experience. A range of ways of seeking people's views and experiences was attempted. Several of the people we interviewed said this was vital and some wished that they could do this in greater detail in future.

7. Presentation

The way a JSNA is presented is crucial to making an impact. JSNAs need to speak to their target audiences – they are telling a story about their local area and as such they need to engage and speak in a language that is understood. This may mean more than one version of the document is required.

All of the people we spoke to who used JSNAs valued them being easily accessible (written in plain English and easy to find on publicly available websites). Creative ways of presenting data, such as PowerPoint presentations, infographics and one-page topic summaries were helpful for council members, directors, voluntary sector organisations and CCG partners to make best use of the JSNAs.

8. Follow up

An effective JSNA can become an important part of a cycle in local areas where needs and gaps are identified, where interventions are put in place, and where their impact is measured over time in order to keep making improvements. Many local areas described frequent changes in patterns of need and demand meaning that JSNAs need to be flexible enough to allow for updating as new data emerges and regular review of the priorities they identify.

11. Key messages for local and national bodies

National bodies could support local areas to assess their mental health needs in the following ways:

- 1. Communicating clearly what data is available** and wherever possible providing it centrally to free up local resources to do what can only be done locally, such as seeking the views of people with lived experience and engaging with multi-sector partners.
- 2. Encouraging data sharing** so that JSNAs can understand current provision and the journeys people take through services. This would include information on use of primary care services, referrals to secondary care and mental health support to people with long-term physical conditions.
- 3. Producing JSNA guidance that recognises reduced local resources** and puts the onus on national bodies to take a 'do once and share' approach with data wherever practical and possible. Guidance should include clear messages about the importance of working with local communities to identify needs and assets.
- 4. Exploring ways in which local JSNAs can inform national policymaking** on mental health and dementia.

For local authorities:

One size of JSNA does not fit all and there need to be local decisions on how to maximise the benefits of the process, but we would advocate the following to local authorities to get the most out of their mental health and dementia needs assessments:

- 1. JSNAs generally make most difference when there is a specific needs assessment for a particular issue** (e.g. for children's mental health or dementia) with a specific purpose, for example to develop a new strategy or commissioning plan, and with ongoing

oversight of implementation from health and wellbeing boards.

- 2. Local areas should know about and make use of nationally available data** (e.g. from the resources available from the National Mental Health, Dementia and Neurology Intelligence Network) and produce a JSNA in a format that allows routine updates wherever possible to be incorporated.
- 3. There is clear benefit in including the perspective of people with lived experience of mental health and dementia** in needs assessments. Schools, community and voluntary organisations and user-led groups can provide useful routes for people's voices to be heard, especially those who have the most complex or least understood needs. This takes time and resources but gaining an accurate picture of local needs and assets should provide long-lasting economic and social benefits to the local authority, and its partner agencies.
- 4. The support of a senior local authority official**, elected member or senior member of the CCG can make a difference, and effort should be made to identify a 'champion' for the development and implementation of mental health needs assessments.
- 5. Needs assessments (and strategies where relevant) should be produced in collaboration with a range of local statutory and voluntary sector partners**, and where possible these partnerships should be retained to support implementation and review processes.
- 6. Implementation of interventions or strategies on the basis of a JSNA should be reviewed routinely to measure success** on the basis of realistic milestones set for delivering complex and long-term changes.

Appendix 1: Focus group questions

1. How was the JSNA produced?
 - a. How was the topic chosen for this JSNA?
 - b. How did you choose what data to collect?
 - c. Where did the data come from? How easy was it to find?
 - d. Who contributed to the assessment and in what ways?
2. How was the JSNA used?
 - a. How was it made available, to whom and in what format?
 - b. Was the presentation of the data important and if so in what ways?
 - c. What discussions took place after it was published?
 - d. How was the evidence used by the different agencies involved?
3. What happened next?
 - a. What evidence is there of impact in commissioning, priority-setting and service planning?
 - b. How did you ensure that the JSNA met the needs of all the relevant local organisations?
 - c. What plans are there to develop the JSNA in future?
 - d. How is implementation scrutinised and monitored?
4. Reflections on the process
 - a. What helped and hindered at each stage of the process?
 - b. What advice would you have for other local areas?
 - c. What (if any) help or support would you like from national organisations?
 - d. Would you do anything differently next time?

In addition to these questions, we sought to understand the specific approaches taken in each local area, the particular challenges they faced and the ways they aimed to overcome them.

Appendix 2: JSNAs from our chosen local authorities

The local areas we visited for this project were:

- Blackburn with Darwen
- Bradford
- Haringey
- Surrey
- Swindon

In Blackburn with Darwen, our research focused on their Integrated Strategic Needs Assessment (ISNA) for children and young people's emotional health and wellbeing. In Bradford we explored their Health Needs Assessment for dementia. In Haringey and Swindon we looked at their JSNAs for both adult and child mental health while in Surrey our focus was on their adult mental health needs assessment.

Haringey: <http://www.haringey.gov.uk/social-care-and-health/health/joint-strategic-needs-assessment/jsna-summary-2013-14>

http://www.haringey.gov.uk/sites/haringeygovuk/files/130606_mental_health_haringestat.pdf

Swindon (children and young people's mental health): <http://www.swindonjsna.co.uk/dna/CYP-JSNA>

and (adult mental health): <http://www.swindonjsna.co.uk/dna/adult-mental-health-and-wellbeing-needs-assessment>

Surrey (adult mental health): <http://www.surreyi.gov.uk/ViewPage1.aspx?C=Resource&ResourceID=667&cookieCheck=true&JScript=1>

Bradford (dementia health needs assessment): <https://jsna.bradford.gov.uk/Health%20Needs%20Assessments.asp>

Blackburn (children's emotional health ISNA): <https://www.blackburn.gov.uk/Lists/DownloadableDocuments/CYP-Lite-ISNA-FINAL.pdf>

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Published November 2016

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