

Warrington Joint Strategic Needs Assessment

2009 JSNA Work Programme Executive Summary

Creating...

**A HEALTHIER
WARRINGTON**

for all

1. INTRODUCTION

1.1 What is the JSNA?

The requirement for a Joint Strategic Needs Assessment was stipulated in the Local Government and Public Involvement in Health Act in 2007. The JSNA is an assessment of the current health and wellbeing of the people of Warrington. The main purposes of the JSNA is to provide a top level, holistic view of the health of local populations, in order to inform and guide decision makers in the setting of medium to long term strategy, and the commissioning of services which address the needs of local populations.

1.2 Links to Strategic Planning and Priority Setting

The JSNA has formed the basis for the development of the strategic plans and has informed organisational priorities and goals. Findings from the JSNA have been used as a basis for strategic planning, priority setting and action plans. The outcome metrics chosen as part of the WCC assurance process clearly link with the priority needs identified in the JSNA.

The JSNA has informed the development of the borough wide Health Inequalities Strategy. Findings from the JSNA documenting the extent of inequalities within the borough have lead to a review of the Health Inequalities Strategy; forming the basis of comprehensive action plans aimed at addressing health inequalities.

The JSNA data and analysis formed the basis for the Neighbourhood Co-Ordination Area (NCA) profiles that were produced collaboratively with Warrington Borough Council (WBC) in 2009. Findings from JSNA analyses were presented to residents at neighbourhood area planning meetings and consultation events. The feedback obtained, along with the detailed NCA profiles, formed the basis for the development of comprehensive area action plans. In turn, issues or gaps identified by residents or stakeholders are fed into the on-going JSNA programme.

The JSNA has informed the development of the Local Area Agreement, and has lead to the development of additional monitoring of LAA targets at a sub-Warrington level, in order to track progress on reducing inequalities within the town, as well as monitoring overall improvements in borough-wide statistics.

2. PROGRESS TO DATE

2.1 The 'Core' JSNA in 2008

A project team, consisting of representatives from the Public Health Directorate of the PCT, and WBC Social Services and Children's Services departments was formed in October 2007. The team produced a 'core' JSNA document which was completed in 2008. The document provided detailed

analyses on various indicators relating to health determinants and health outcomes; key findings are summarised in section 3.

2.2 Development of the JSNA Programme during 2009

2.2.1 Greater Clinician and Stakeholder Involvement

The JSNA development programme for 2009 and beyond has been overseen by the Warrington Clinical Leadership Team (CLT). The development of the programme of supplements has been prioritised with the support of CLT and clinicians at the Acute Trust. Local GPs and Primary care professionals have been engaged in the JSNA process through the Warrington Practice Based Commissioning consortia. Requests for in-depth analysis on mental health need within the borough from both commissioners, and clinicians at the 5 Boroughs Partnership lead to the production of a comprehensive mental health needs assessment as part of the JSNA programme. The Local Strategic Partnership (LSP) receives regular updates on findings from the JSNA and contributes to its development.

2.2.2 Enhanced Collaboration and Sharing with Partners

The vision for the JSNA locally is to further develop on-going collaborative processes aimed at ensuring timely data and intelligence is available on which to make commissioning decisions. During 2009 collaboration between PCT and WBC was strengthened. Research and Intelligence Networks have been re-formed to help facilitate better data sharing and avoid duplication of effort, and an intelligence sharing partnership established. Resources have been invested in the development of technological solutions aimed at minimising data processing, ensuring the information is utilised under the COUNT (Collect Once Use Numerous Times) principle.

3. FINDINGS TO DATE

3.1 Summary of Findings from the 'Core' JSNA in 2008

The Core JSNA was divided into sections looking at the domain areas suggested in the national guidance. It identified numerous health inequalities which are to be addressed through the revised Health Inequalities Strategy. The key messages from the core document were:

- Levels of obesity and alcohol consumption are rising very sharply, with forecast increases in diabetes, cardiovascular and liver diseases – for example, if current levels of obesity continue, we can expect a 1% increase in diabetes prevalence by 2010.
- The population is ageing – for example the population of over 85 year olds will double by 2026 – and older people have a higher prevalence of chronic diseases and need for services;

- It is estimated that current systems under-ascertain the levels of chronic diseases by 50% or more.
- Current health improvement activity on diet, alcohol, smoking and exercise is not meeting the needs of Warrington; the JSNA shows that rates of improvement in life expectancy and mortality rates in Warrington are now slowing, and the gap between ourselves and England can be expected to rise if current trends continue.
- There are areas of the town where the residents consistently experience poorer levels of health, employment, educational achievement, lifestyle risk factors, crime and income. Whilst the health of the town's residents has improved, the gap persists. Residents in poorer areas have higher levels of chronic diseases, and consequently more pain, disability and premature death.
- The overwhelming message from the JSNA sections on children is the link with deprivation: poorer dental health, higher teenage pregnancy rates, lower birth weight rates, low breast feeding rates, higher levels of children in need, lower levels of educational attainment and higher levels of children on the child protection register.
- Warrington has currently a younger profile than national, but is forecasted to age at a faster rate than national, leading to an older age structure and less people of working age.
- There is paucity of information on the mental health of local residents, yet this is a very prevalent condition and one of the reasons for the greatest uses of hospital resources.
- The levels of alcohol consumption at harmful levels have risen steeply in the last five years.
- The rates of unscheduled admission to hospital remain well above the national average. Some of the main reasons for admission as recorded by ICD codes are vague e.g. "symptoms and signs".
- The health of older people is worse than the national average. In addition, there are predicted to be large increases in the prevalence of cardiovascular diseases and dementia. This has serious implications for health care and social care.
- 2.2% of the population in the 2001 census were classed as "non-white" or "other". Estimates for 2005 suggest a slight increase to 3.1%, mainly in the Asian population. Data on the health of ethnic groups is limited and analyses of access to health services by ethnic group was identified as an in which there is a gap in knowledge.

Findings were communicated to the public and to partners through consultation events. The core document was been used to inform the

development of Strategic Commissioning Plans, and has informed the review of the Warrington Health Inequalities Strategy by helping to set the context for understanding and describing health inequalities in Warrington.

3.2 Summary of JSNA Supplements 2009

In early 2009 it was decided that in addition to the development of technological solutions for enhanced data sharing and collaboration, the JSNA would be progressed with the development of a series of topic based supplements. These are available on the PCT website. www.warrington-pct.nhs.uk/publicinfo/jsna

A summary of the key points from the supplements is included below.

3.2.1 Supplement to Section 2 on Deprivation and Income Inequalities

This report looked in-depth at the relationship between income inequalities and health. The income domain of the latest deprivation indices was used to examine the correlation between income and various health outcomes. In addition to describing the inequalities gradient, the report quantified the extent of the gap in relation to key public health targets. The key findings were:

- 12% of Warrington residents live in areas which are amongst the 20% most deprived in terms of income deprivation in England. The affluent areas within Warrington are becoming more affluent and the proportion of Warrington residents residing in the most affluent quintile is increasing.
- There is a stark inequalities gradient evident in most health indicators examined. Health outcomes show a stepwise relationship with income, with the gradient correlating higher income with increased health across the income deprivation quintiles.
- Individual lifestyle risk factors are worse in more income deprived areas. Prevalence of; sedentary lifestyle, smoking, poor diet and overweight, are all higher in the poorer areas of the borough. Of particular concern is smoking prevalence which is increasing in the most deprived areas of the town, in contrast to the rest of Warrington.
- Emergency hospital admission rates for different age-groups and various conditions show steep income based gradients. Spatial and statistical analysis demonstrates that level of income deprivation experienced is a more powerful factor in determining likelihood of emergency admission, than is proximity to the hospital site.
- Access to elective surgery shows a positive association with income deprivation, which is encouraging as it suggests that, in the main, more deprived populations are getting greater access to selected procedures, in keeping with their higher levels of need.

- There is considerable variation in terms of mortality rates by age band and income deprivation quintile, with rates of premature death in the most deprived quintile in Warrington almost 97% higher than the average for England. As with other indicators examined, the relationship is stepwise which highlights that inequalities exist across the population.
- At General Practice level there is considerable variation in reported prevalence for various long-term conditions, and there is some association with deprivation for certain diseases, particularly in relation to Diabetes, Severe Mental Health and COPD.
- Statistical models suggest that reported prevalence of some chronic conditions is lower than expected given the socio-demographic profile of Warrington. It is estimated that current systems may under-ascertain the levels of chronic diseases by up to 50%.
- There is some association between disease management in Primary Care and income deprivation, although in the main this is positive, with a higher proportion of patients in the most deprived Practices having their conditions managed appropriately. There is however, some evidence to suggest that there is an association between exception reporting and income deprivation, with more deprived Practices having higher rates of exception reporting for certain conditions.
- Based on current estimated smoking prevalence, to achieve the smoking cessation targets, and prevent a widening of the inequalities gap in relation to smoking, almost 55% of the successful quitters need to live in deprivation quintiles 1 and 2.
- The 2005-2007 All Age All Cause Mortality (AAACM) rate for Warrington was 13% above the England average. This means that over the time period there were 671 'extra' deaths. 87% of the total excess deaths occurred amongst the 65+ population.
- 580 (86%) of the 'excess' AAACM deaths were amongst residents of deprivation quintiles 1 and 2.
- Over the same time period there were 141 'excess' Cardiovascular Disease (CVD) deaths in Warrington compared to national averages. 91% of this excess occurred in residents of quintiles 1 and 2.
- Although, there were no excess premature cancer deaths across Warrington as a whole over the time period, this is due to the 79 fewer deaths than expected deaths in quintiles 4 and 5 'masking' the higher rates of death in quintiles 1 to 3

3.2.2 Supplement to Section 2 on Fuel Poverty and Winter Health

This report looked at the distribution of fuel poverty within Warrington and examined the link with excess winter admissions and seasonal deaths. The key findings were:

- Levels of fuel poverty within Warrington are lower than the North West average, and in-keeping with national averages; with 6.1% of all households experiencing fuel poverty.
- No substantial variation within Warrington; ranging from 5.1% of households experiencing fuel poverty in areas in Appleton to 7.1% of households in areas in Fairfield and Howley.
- As maybe expected, rates of fuel poverty correlate with levels of overall deprivation
- Excess winter mortality (EWM) – results in 19% more deaths in winter compared with other months – accounting for approximately 108 ‘extra’ deaths per year.
- EWM in Warrington is higher than national and regional averages, and the trend over time is fairly steady.
- In keeping with the national picture, the main contributors to EWM are respiratory diseases and circulatory diseases.
- There is substantial variation in EWM at a sub-Warrington level, although the correlation between EWM and fuel poverty is not statistically significant at quintile level.
- Excess winter hospital admissions for specific conditions¹ results in 14% more admissions in winter compared to other months.
- There is wide variation in excess winter admissions at sub-Warrington level. Analysis suggests some link with levels of fuel poverty, but the association with overall deprivation is not statistically significant.

3.2.3. Supplement to Section 4 on Life Expectancy

This supplement looked examined trends in male and female life expectancy and assessed progress towards key national PSA targets. Analysis was undertaken at a sub-Warrington level, looking at local level variation in life expectancy and geographical inequalities. Work was undertaken to better understand the life expectancy gap between Warrington and England by disease area, age and sex. The key findings were:

¹ Influenza and pneumonia, and other acute lower respiratory infections, chronic, lower respiratory diseases, and falls

- Life Expectancy for both males and females in Warrington has improved considerably over the past decade. However the trend in recent years has not kept pace with national improvements and thus the gap between Warrington and England has started to widen.
- Female life expectancy within Warrington has decreased in recent years, whereas nationally it has continued to improve, thus leading to a widening gap.
- Local male life expectancy has continued to increase year on year. However, improvements have not been as substantial as those experienced nationally, thus the inequalities gap has not narrowed.
- The latest life expectancy figures suggest that the 2010 target (2009-2011 data) may not be met.
- Sub Warrington analysis highlights the stark inequalities exist within Warrington. With the more deprived wards of Warrington having significantly lower life expectancy.
- Trend analysis of local level data shows that the intra-Warrington gap does not appear to be narrowing for females, but shows some improvement for males.
- Systematic, regular monitoring of the internal gap has been put in place, along with detailed analysis quantifying the number of excess deaths by disease area and deprivation quintile. Progress will be monitored through the Health Inequalities dashboard.
- Years of Life Lost (YLL) analysis was undertaken in order to assess the degree to which particular causes of death may contribute to differences in local life expectancy. Key contributors to the gap in Life Expectancy between Warrington and England were identified as: Cardiovascular Disease, Respiratory Disease and Digestive Disorders.
- Emphasis on reducing risk factors for these diseases is crucial in order to improve premature mortality rates and narrow the life expectancy gap.
- Statistical modelling tools were used to estimate the effect on life expectancy of certain interventions. This has enabled an assessment to be made about the scale of the intervention required and impact that can be expected.
- The specific interventions modelled were: interventions to reduce infant mortality, Smoking Cessation, Antihypertensive prescribing, and statin prescribing.
- Analysis incorporated current targets around smoking cessation and additional activity modelled as arising from the roll out of the Vascular

Screening, and Enhanced Public Health Programmes, and suggests that if all interventions identified above are implemented successfully, life expectancy across the borough as whole would increase by 0.3 years for males and 0.2 years for females. It is estimated that any change in infant mortality will impact immediately on life expectancy figures. Changes in anti-hypertensive and statin prescribing are likely to have an impact in the short-term, and changes to smoking cessation figures is expected to impact on life expectancy in five plus years.

3.2.4. Supplement to Section 4 on COPD

This report looks at the current burden of ill-health due to Chronic Obstructive Pulmonary Disease (COPD) in Warrington. The key findings were:

- Age is an important risk factor for COPD. Warrington has an aging population and this is likely to impact significantly on disease prevalence. Statistical models suggest prevalence could rise to almost 4,500 people by 2021.
- Smoking is the main risk factor for COPD. Smoking prevalence within Warrington has decreased overall, but there is considerable variation within Warrington, with high and increasing prevalence in certain geographical areas and amongst certain age-bands.
- QOF reported prevalence is currently 1.7%; slightly higher than the England average of 1.5%
- Synthetic, modelled estimates of prevalence suggest that based on Warrington's socio-demographic profile prevalence is likely to be approximately 1.8%.
- Model estimates of prevalence suggest wide variation in potential under-diagnosis or under-reporting at Practice level when compared with actual figures reported through QOF.
- There is variation in performance on COPD disease management indicators at Practice level. Recording of FeV1 shows the biggest variation, with some practices achieving over 90% and some under 50%. Practice performance on other indicators such as Inhaler Technique and Influenza Uptake also vary, although the variation is not as marked as for recording of FeV1.
- Non-elective admission rates for COPD in Warrington are 18% above the average for England.
- There is considerable variation in admission rates within Warrington, following the pattern of deprivation, with Bewsey and Whitecross having admission rates which are almost 6 times higher than more affluent areas such as Lymm.

- There are approximately 84 deaths per year attributed to COPD. COPD mortality rates have decreased by 22% since 1995, but rates for Warrington currently exceed the average for England by 9%. Rates are highest amongst males.
- There is significant variation in mortality within Warrington, with a very strong, statistically significant correlation with deprivation.

3.2.5. Supplement to Section 4 Hospital Acquired Infections

This short report examined available data to assess progress on the current performance monitoring indicator for Clostridium Difficile. The key findings were:

- Changes to the Clostridium Difficile indicator came into effect in 2007, and expanded the age-range of patients to include all patients aged 2+. Previously the indicator had looked specifically at those aged 65+
- Routinely available data to enable benchmarking of performance in year, on the new indicator definition is limited. At year end, more detailed analysis of performance is possible.
- Based on data for 2008, there were 268 cases at NCHT, giving a proxy rate per 1,000 Finished Consultant Episodes (FCEs) of 3.04. This figure, along with that for St Helens and Knowsley, is the lowest rate for all the Cheshire and Merseyside Acute Trusts compared.
- For the period, January to April 2009 there were 66 cases at NCHT. This gives a proxy rate per 1,000 FCEs of 2.25, which is the lowest for the Cheshire and Merseyside Acute Trusts compared
- The majority of C. Diff infections at NCHT occur at the Warrington site, as it is the more acute site, with patients who are more elderly and more vulnerable.
- Overall the trend in the numbers of cases of C. Diff infection is downwards, but there are random variations over time, with a slight increase over the winter period, and the numbers are now becoming very small, so a small change in the number of cases per month represents a large percentage change in either direction.

3.2.6. Supplement to Section 6 on Mental Health

A comprehensive Mental Health Needs Assessment was undertaken during 2009. The assessment included analysis of quantitative data; incorporating the use of statistical models to estimate expected disease prevalence, and compare with actual reported figures and service delivery data to undertake a gap analysis. Qualitative research was undertaken, and included in-depth

interviews with GPs and carers to gain an understanding of issues faced. A summary of key findings is:

- The literature review and data analysis concluded that there is a strong correlation between deprivation and mental ill health, the exception to this was the prevalence of dementia. 63% of the mental health emergency admissions were determined by practice deprivation.
- The wider determinants of health have been shown to impact on a person's mental and emotional well being. Health inequalities are exacerbated by income deprivation, low educational attainment, low skilled poorly paid employment and high proportion of self reported ill health. All of which increase the likelihood of a person experiencing mental health problems.
- National prevalence estimates suggest that Warrington have approximately 25,000 people with a Common Mental Health Disorder. The literature review has shown that the majority of these people will require primary care intervention and only a small proportion of people will require secondary care intervention.
- Local disease register numbers are lower than the National Morbidity Survey estimated prevalence suggesting the under-diagnosis of depression within Primary Care. The literature review highlighted that under reporting locally may also be attributed to a person's reluctance to seek help.
- Primary prevention through mental health promotion has shown to have a significant impact on promoting mental wellbeing, reducing the burden on primary care services. Local public consultation found that 88% of the respondents felt that the PCT should be doing more to promote mental health and improve and protect mental well being.
- Population forecasts suggest that the population of the borough will continue to age at a faster rate than the national average. This will have considerable resource implications for the delivery of health and social care services. The impact of an ageing population on the prevalence of dementia is considerable.
- The predominant age group of patients accessing mental health services is 35 to 49 years. Age groups between 40 and 54 years have the highest prevalence rates for any neurotic disorder
- Warrington has significantly higher emergency admissions for mental health conditions than the national average. Hospital admissions analysis suggests that individuals with certain mental health conditions are more likely to be admitted as an emergency. Mood affective disorders accounted for 23% of all emergency mental health admissions

- Alcohol related disorders, mood affective disorders, anxiety and personality disorders, schizophrenia and substance related disorders have significantly higher admission ratios than the national average.
- Emergency readmissions are more common for certain conditions. Individuals admitted due to a specific personality disorder were admitted an average 1.85 times over the 3 years. Individuals with schizophrenia were admitted as an emergency 1.49 times
- The findings of this needs assessment are consistent with the findings of the report commissioned by NHS Warrington 'Developing an A&E mental health liaison service in Warrington for individuals deemed at risk from mental health, drug and alcohol misuse.'
- The report recognises that there are issues with the transition process from CAHMS to AMHS in particular for clients with certain hyperkinetic disorders, such as ADHD, ADD.
- Improvements could be made on the collection and reporting of service level data: Currently mental health services collate and report the number of referrals, caseloads and have clear KPIs for waiting times. It is clear that there are many data discrepancies within services thus not always possible to validate the referrals data. Additionally patient outcomes relating to the wider determinants of well being such as health, education, employment are not recorded or monitored
- STAR Recovery Tool used by the Community Mental Health Outreach Team provides robust outcomes data. It is a powerful tool supporting service users to understand their needs and recovery. This is a new approach and there is a need to ensure the patients outcomes and progress are recorded.
- The majority of carers interviewed expressed their satisfaction with the nature and level of support they had received from carer support services. Many spoke warmly of their relationship with support workers and identified positive outcomes from their involvement with support services.
- There were issues around carers' inability to acknowledge or articulate their own support needs. The majority of carers were unable to identify or discuss their own health needs and instead focused upon the needs of their relative.
- Issues around inequality of access to carer support worker services due to the high numbers of carers whose existence and circumstances are unknown to services were reported. GPs identified as primary contact point for identifying carers. The support needs of carers of individuals whose treatment is managed by a GP may thus be unidentified and unaddressed.

- Key issue highlighted from the research was around difficulties accessing support at times of crisis causing high levels of stress and anxiety for carers. Feelings of powerlessness in not having opinions listened to, and valued, by gatekeepers to services.
- Many carers reported poor levels of communication with their relative's key workers. This had led to feelings of frustration at their perceived exclusion from the care planning and decision making process.
- Carers reported the increased burden which a withdrawal of mental health service support placed on them as the subsequent sole providers of support. Carers and support workers spoke of the difficulties experienced in regaining access to mental health services post-discharge this also had significant consequences for the caring role.
- Key issue around current procedures for accessing GP and Out of Hours support in situations where acute symptoms cause the cared for to refuse to seek or access help. In attempting to access help, carers reported being unable to make representations on their relatives behalf and were thus left dealing with often distressing and volatile situations.
- The closure of the Gatehouse Centre emerged as a major issue for individuals in considering the impact and pressures of their caring role. The Gatehouse was an acute psychiatric facility offering assessment and treatment 7 days per week, which was open from 9.00am to 9.00pm. Carers reported their use of the Gatehouse to access help and advice for both themselves and their relatives.
- Waiting times for psychological therapies were cited by both GPs and carers as unacceptably long. It was felt that, in some cases, this had led to a deterioration in the service user's condition. This time lapse inevitably impacts upon the burden of care for carers of individuals with mental health problems.
- Variation in referral rates to support services amongst GP practices. Support workers from both statutory and voluntary services reporting greater levels of referrals to, rather than from, GPs. Recognition that current pathway for carers accessing support is dependent upon a referral from CMHT, self referral to voluntary agency (Carers Centre) or their making a specific request to their GP. The latter two options evidently depend upon possession of knowledge concerning available support options.
- Many carers had their relative living with them which had increased the pressure of the caring role. In some cases, where a breakdown in alternative living arrangements had occurred, carers felt that this was due to inadequate or unsuitable support.

- Reports from carers of the lack of support for both their relative and themselves once outside secondary mental health services.
- A third of young carers registered with Warrington Carers Centre (total estimate 100) are caring for a relative with mental health problems. In view of the vulnerability of these young people there are significant concerns amongst workers regarding the reduced funding allocated to provide support for young carers over the next three years.

3.2.7 Supplement to Section 5 on Educational Attainment

This supplement updated the section in the 'Core' JSNA which looked at the impact of deprivation on educational attainment. Results from a number of different educational assessments were analysed.

The key findings from the updated data highlights that very little has changed in the overall pattern documented in the Core JSNA, in that at every level of Primary and Secondary school education, children living in more affluent areas in Warrington achieve significantly higher results than children living in more deprived areas.

3.2.8. Supplement to Section 7 on Ethnic Health

The Core JSNA identified that data relating to the health of ethnic populations was limited. This supplement sought to bring together the data that is available to profile the health of ethnic populations within Warrington. Some of the main points from the report are detailed below:

- Warrington has a relatively small Black and Minority Ethnic (BME) population. 2001 Census estimated that the white population of Warrington accounted for 97.8% of the overall Warrington population. Office for National Statistics (ONS) 2005 experimental estimates suggest that this has decreased slightly to 96.9% white, with the biggest increases apparent in the Asian population
- Socio-economic data taken from the Census 2001 suggests that Warrington's socio-demographic profile of BME populations may differ from national averages - 16.5% of the non-white working age population in Warrington are in higher managerial & professional occupations. This is substantially higher than the national average figure of 8.7
- Self- reported health is better amongst BME population (2001 Census) - In Warrington 9.1% of the white population stated their health was not good whereas only 5.2% of the BME population in Warrington rated themselves in poor health.

- Limiting Long-term illness is lower amongst BME population - In Warrington 18% of the white population said they had a limiting long term illness, whereas 10% of Warrington's non white population reported having an LLTI.

Main findings from the 2006 Health & Lifestyle Survey in relation to ethnicity are included below. Care must be taken interpreting the results as proportions are based on very small numbers. Main findings are:

- Higher levels of obesity amongst BME groups - 22% of 'non-whites' reported to be obese compared to 18% of the white population
- Lower smoking prevalence - 16% of the BME population report to smoke currently, this is considerably lower than the white population smoking prevalence of 20%
- Lower rates of binge drinking - 21% of BME groups recorded as binge-drinkers compared to 32% of the white population.
- Slightly lower levels of activity - 46% of the BME population reported to lead a sedentary lifestyle which is slightly higher than the white population percentage of 42%
- Lower levels of CHD risk behaviours - 4% of 'non-white' respondents reported to have three CHD risk behaviours compared to 6% of the white respondents

3.2.9. Youth Consultation

A full report is available which summarises findings from consultative events with young people across Warrington. Workshops and consultation activities were undertaken focused on local issues and concerns that young people have about their local areas. Three key issues and areas of concern that were consistently raised at events were:

- Feeling safe
- Transport
- Things to do and places to go

3.2.10. Overview of Connected Care Community Research

A full report is available which provides detail of the consultation work that has taken place as part of the Connected Care² project which Warrington Borough Council commissioned on behalf of the Warrington Partnership. The work was undertaken in the Stronger Together area in Warrington (STiW) to obtain an understanding of the local populations' perception of their health, housing and social care needs. The process has enabled the community to input their views on a range of services in their local area. A key element of Connected Care is that local people, 'Community Researchers' undertake the consultation.

One hundred and thirty-seven of the STiW population aged sixteen and over shared their experiences of health, housing and social care services in interviews and focus groups carried out in their local area. The research was as inclusive as possible and included interviews with some of the most marginalised groups, such as people with complex needs, as well as focus groups with other members of the community, many of whom had not taken part in previous studies, such as members of the Mental Health Forum.

The consultation explored a number of cross-cutting themes including awareness and understanding of service provision and level of need; access to services; information about services; continuity and co-ordination between services; and quality of provision. A range of different groups contributed to the process and input their views including:

- unpaid carers,
- people with complex needs,
- people with long term conditions,
- older people,
- people with alcohol problems
- mental health service users

The full report highlights the key finding for each of these groups.

The next stage of the process will be to translate the findings into a specification for an integrated Connected Care service that addresses the issues raised by people living in STiW areas.

The plan will be to ensure that this work builds on and complements the many current initiatives that are already available across the STiW areas and the borough of Warrington.

A number of events are to be held which aim to bring together commissioners, providers and representatives from the community to raise awareness of Connected Care and develop service plans based on the findings and recommendations from the Connected Care audit.

² 'Turning Point' <http://www.turning-point.co.uk/Pages/home.aspx> were commissioned to undertake the work

4. ADDITIONAL DEVELOPMENTS IN 2009

4.1 Dissemination and Interactive Data

It is envisaged that in the longer term the JSNA Core Document, Supplements and Datasets will be held on the Warrington Data Observatory portal, once developed. In the interim, the reports are available to download from the PCT and WBC websites, and it is possible to interrogate the data via a new tool called Instant Atlas, which was purchased collaboratively with WBC. Instant Atlas is an interactive mapping tool enabling users to view relevant JSNA indicators in map, chart and tabular formats. In addition to the JSNA dataset, the Instant Atlas tool includes the outcome indicators chosen as part of the World Class Commissioning assurance process, in order to monitor progress. As well as providing information for specific local areas, data allowing, the mapping tool enables national and regional comparisons to be made on many indicators and enables benchmarking with peer groups.

Findings from the JSNA will continue to be disseminated to partners through the Local Strategic Partnership Research and Intelligence networks and at a sub-Warrington level through the 'Neighbourhoods' Research and Data group. Further information on the Neighbourhood Working agenda is available from the Warrington Borough Council website.

Communication of findings from the JSNA programme to the public will link into the on-going public engagement work planned within the PCT and WBC, and through NCA boards.

4.2 Qualitative Research

In addition to the quantitative data analysis that forms the basis of much of the core JSNA, investment in an academic qualitative researcher has helped to ensure that the views and experiences of patients and public are captured in a rigorous and robust way, meaning that data gathered through the research and engagement work programme is reliable, and conclusions and commissioning recommendations made on the basis of it are meaningful and valid. The JSNA programme during 2009 has therefore included far more in-depth qualitative research, as evidenced in the comprehensive Mental Health Needs Assessment that was completed.

Sound research and analysis underpin the PCT's Social Marketing programme, and this is closely linked to, and informed by the JSNA. The conduct of research which informs the delivery of social marketing programmes is directed by a defined protocol and framework. A steering group was formed in 2009 to take forward the Social Marketing programme, and stronger links established across the Warrington Partnership to ensure that community engagement and research activities are co-ordinated and linked to the JSNA process. During, the PCT developed its Social Marketing strategy which sets out a framework for the delivery of social marketing programmes within the Warrington population.

A comprehensive work programme to engage with vulnerable population sub-groups has been planned. An application for approval to undertake this extensive programme of engagement, involving in-depth scrutiny of the protocol for conducting this research, was sought from the Local Research Ethics Committee (LREC). The committee's decision was favourable and this work programme, committed to better understanding the specific health needs of BME groups and other vulnerable and harder-to-reach populations, will commence in early 2010. The data gathered will provide a unique insight into the issues faced by the some of most vulnerable sectors of the population, and will inform local service planning, aimed at better meeting these specific needs.

5. JSNA 2010

In consultation with commissioning leads and service heads across both organisations, a review of the JSNA programme and requirements for future supplements and other on-going developments through 2010 is currently underway.

The JSNA is an on-going programme, and development of robust data sharing and greater collaboration is an integral part of the process. The establishment of a local Data Observatory is planned for 2010, to build on the collaborative approach undertaken to develop the use of Instant Atlas for interactive dissemination of intelligence. The joint project team will continue to prioritise the necessary work and produce a proposed work plan, which will be overseen by the Clinical Leadership Team and joint Health and Social Care Board.