



Joint Strategic Needs Assessment North West Regional Review Executive Summary

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Acknowledgements

The North West Public Health Observatory would like to thank all regional JSNA partnerships for their support in providing ongoing JSNA documentation for this report. In addition, to JSNA members within those partnerships with whom interviews were undertaken, and to those who responded to the JSNA web questionnaire. This work was commissioned by the Department of Health North West.

Thanks also to Alyson Jones, Jennifer Mason, Lynn Deacon and Helen Carlin at NWPHO and Diana Leighton at the Centre for Public Health for contributions to proofreading.

Foreword

Joint Strategic Needs Assessment (JSNA) is the process through which public sector partners identify where best to invest their resources to secure the outcomes desired by the public they serve. It also provides the data and insight on which commissioning and delivery of health, wellbeing and social care services should be based.

This report reviews the North West region's first programme of work on JSNA and highlights ways in which we can further develop the approach to better focus resources towards meeting public expectations. The report comes at an important and challenging time for the public sector. The urgency to provide the best quality services is coupled with an increased challenge to provide value for money. This means that the focus on transformational change is essential, especially in delivering the shared social, health, economic and environmental aspirations of our communities.

There are a number of increasingly powerful drivers shaping the planning and delivery of public sector outcomes. Understanding these will be important in making best use of the JSNA approach.

In future, JSNAs should include a focus on action to:

- reduce inequalities by developing healthy places for people to live, focussing on creating economically active and socially supportive communities. The Investment for Health (I4H) approach provides a framework for this decision making. Asset based approaches provide a positive method for providing public services that build on community strengths.
- develop integrated public service delivery which will both reduce costs and increase efficiency.
- develop services that co-produce outcomes with consumers as equal partners.
- target and personalise all services more effectively using person based insight research and social marketing methodology.
- increase the 'social value' of public sector investment in each 'place' through more effective and sustainable use of public sector spend.
- move from a 'detect and manage' model of needs assessment and service delivery to a more integrated and intelligence based 'predict and prevent' approach – capable of modelling the investment required across whole public sector systems to prevent the need for social welfare system dependency and realise the shared improvement benefits for all.

This report marks a first step in highlighting issues of particular significance in the first round of JSNAs undertaken mainly between the NHS and Local Authority health and social care systems. To achieve the transformational changes now needed, the JSNA process should widen the scope of the intelligence on which it is based and drive an increased pace of innovation for commissioning and service delivery. It will need to secure further 'collaborative advantage' to increase efficiency, reduce costs and reorient services towards prevention. This will need to be underpinned by the continued integration of public sector capacity and capability – particularly in intelligence services and strategic planning.

**Dr Ruth Hussey OBE, Regional Director of Public Health /Senior Medical Director
DH/NHS NW**

1. Key messages

By the end of 2008/early 2009, there remained much variability in how Joint Strategic Needs Assessment (JSNA) was being implemented across local partnerships in the North West. While a great deal of progress has been made, for the region as a whole, there is a lot that local partnerships are doing with regional support to improve the ongoing process.

- ❑ There are many excellent examples of pre-existing partnership working that enabled the JSNA process to develop in a collaborative and inclusive way and where innovative outputs have been able to inform local strategic plans as well as community inclusion. However, in other areas, partnerships were only just being established and the JSNA process appeared to be less well developed and not as well integrated.
- ❑ A key way forward is to ensure good alignment across the multi-agency processes that are aimed at tackling the major challenges that affect local communities. For example, the JSNA process should be seen as cyclical and one that not only informs the Local Area Agreements (LAA), Children and Young People's plans, World Class Commissioning, PCT strategic plans, operational plans and the commissioning cycle in general, but also where evaluation of progress helps inform future JSNAs.
- ❑ Although the first JSNAs were produced in a changing environment with limited national guidance, many local outputs could have been better informed by the use of national (and/or regional) intelligence. In the future, centralised dissemination of indicators from the core dataset, while not being prescribed, will better enable local intelligence to be appended so that areas focus on clearly identified local needs.
- ❑ Local JSNA partnerships requested better sharing of local good practice that had achieved greater linkage between JSNA and strategic plans and processes. They also identified a need for building local capacity and capability in particular areas around inequalities analysis, identification of equity and diversity measures and utilising forecasting or predictive modelling techniques to identify future service needs.
- ❑ The information and interpretation within the JSNA should be presented in a range of formats that are suitable for different audiences – from commissioners to community groups. The greater sharing of localised examples of good practice for dissemination of and engagement with the JSNA process will enable the cyclical process to be developed across the region.
- ❑ Local evaluation of how the JSNA is impacting on local commissioning, LAA and operational plans and strategies is a crucial part of the process that was not evident in many of the JSNA. In order for the public health system and all relevant related agencies and partners to contribute to overall health improvement and reduction of health inequalities, partners need to satisfy themselves that their JSNA is fit for purpose.

2. Background

Local government, the NHS, third sector or voluntary agencies, and communities have increasingly been required to work in partnership to commission and develop health and social care service for their populations. In 2006, *Our health, our care, our say*¹ outlined how Primary Care Trust (PCT) Public Health, Adult Social Services and Children's Services (working in collaboration with Directors of Commissioning), should undertake strategic needs assessments. These assessments would then inform and support a range of Local Authority (LA) and PCT plans and strategies such as Local Area Agreements (LAAs) and sustainable community strategies, thereby ensuring robust and joint commissioning. The *Local Government and Public Health Act*² formalised the requirement for assessments of relevant needs to be prepared with JSNA by the responsible LA and each of its partner PCTs, while engaging closely with communities to improve provision and perceptions of care and contribute to reducing social and health inequalities.

In 2007, the Department of Health (DH) *Guidance on Joint Strategic Needs Assessment*³ stated that:

"Needs assessment is a systematic method for reviewing the health and wellbeing needs of a population, leading to agreed commissioning priorities that will improve health and wellbeing outcomes and reduce inequalities."^(page 7)

JSNA legislation now requires upper tier LAs and PCTs to consult with a range of organisations including: district councils (where applicable), third sector organisations, community partners, and a wide range of service and clinical staff.

".. it is about process, processes of a circular loop. It's got to keep feeding itself and it's about taking the findings, playing them back to the community, constantly letting them know what we're learning, what needs have been identified and using that to inform the next stage of the process so that it develops as it goes along."

Dr Renu Bindra, National DH Policy Lead on JSNA.³

JSNAs are an integral part of the three yearly LAA planning cycle and as such are seen as a continuous process that informs strategic plans. Department of Health guidance provided partnerships with practical advice about how to undertake JSNA. For example, summary JSNA reports are expected to provide local perspectives, including:

- analysing data to show the health and wellbeing status of local communities;
- defining where inequities exist; and
- using local community views and evidence of effectiveness of interventions to shape the future investment and disinvestment of services.

In early 2008, a survey of Directors of Adult Social Services, PCT Chief Executives and Directors of Public Health was undertaken by Birmingham University. The report *Implementing Joint Strategic Needs Assessment: pitfalls, possibilities and progress*⁴ provided an early national snapshot of local efforts to implement the new duty of JSNA and of emerging themes, barriers and success factors. This survey concluded that the test of the impact of JSNA will be the extent to which it can become fully embedded in local structures and partnerships, local commissioning strategies and local mindsets.

Following a series of regional events throughout 2008, the NWPCHO was commissioned to examine the overall JSNA process across all local partnerships in the North West. Joint Strategic Needs Assessment outputs from all 22 partnerships were reviewed for inclusion of datasets and evidence; partnership work; local processes undertaken; and themes and priorities identified. In addition, in order to better understand the ongoing JSNA process; interviews were conducted with JSNA teams whose remit covered 10 PCT/top tier LA areas in the region. Finally, a semi-structured web based questionnaire was emailed to PCT, LA and other JSNA leads to gain further insight into how JSNA was being implemented.

This review was undertaken from the first round of JSNA outputs⁵ in 2008, many of which were developed prior to national guidance being released; at a time when the LAAs were being negotiated; and when other local plans were

¹ Department of Health (2006). *Our health, our care, our say*. London: DH publications.

² HM Government (2007). *Local Government and Public Involvement in Health Act 2007* [online]. Available from: www.opsi.gov.uk/acts/acts2007/ukpga_20070028_en_1

³ www.dhcarenetworks.org.uk/_library/CSIP-JSNA.pdf

⁴ www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_086130

⁵ JSNA outputs here ranged from printed reports, dedicated websites, dissemination or communication processes, to partnership and joint team working.

being considered/under consultation. As such, the conclusions should be interpreted within this context since they were derived from a snapshot in time. There was not a homogenous picture across the region, with some JSNA partnerships already undertaking some of the recommendations, while some will have progressed since we undertook this review. It is therefore not the intention to say that the recommendations are not underway. However, all local partnerships should consider the details to assess which are already being covered and how the others might be achieved. In June 2009, a JSNA workshop will take the findings from this review and from subsequent local developments to determine what the North West believes would be the best way of developing JSNA. The overall aim will be to deliver the requirements as set out in the national guidance and to consider how the region can collectively and efficiently deliver this, while maintaining the flexibility needed for a local focus.

3. Conclusions overview

The main report, available at www.nwpho.org.uk/documents, details findings from the review. The conclusions of this North West review, which focussed on findings primarily from the local leads for the production of JSNA (either within PCTs, LAs or cross-working partnership teams), are broadly in line with other findings from regional and national surveys.

The conclusions presented here have been drawn from comments expressed from individual JSNA teams contributing to the review and from the overview gained from the review team. They do not apply to all local partnerships, as some areas were inevitably at a further stage of progress, and others will have moved on and/or did not or could not provide all the relevant information. The conclusion is organised around the four main theme areas:

- Processes, partnerships and wider engagement
- Current and future health and wellbeing needs
- Using the JSNA for commissioning
- Products, promotion and evaluation.

3.1 Processes, partnerships and wider engagement

In many cases, the ongoing JSNA process was undertaken in close partnership, with descriptions of long established, clear, joint, agreed visions, policies and ways of working together evident. This offers some areas another channel through which longstanding needs assessment, public engagement and commissioning continues to develop in partnership. By contrast, a small number of areas identified that partnership working was variable and less established or cohesive.

“Engagement with partners was made through a number of different channels, [including] ..Executive Team, Directors of Public Health, Directors of Adult Social Services, Directors of Children’s Services; and through others such as the Policy Performance and Intelligence groups.”

Despite the evidence of partnership working, lead authors are inevitable, which leads to one organisation (either the PCT or the LA) being largely responsible for the work and identification of key issues. As such, it was not always clear how joint partnership working was/is developing locally. For example, commitment to inter-agency working and the extent of other teams/partners involvement may not have been detailed or indicated. This may represent a lack of content within an individual report, a different style or indicate that one partner has taken a clear lead. While a few JSNAs clearly identified how adult and children’s services were core team members, in others these partnerships were not always evident. Similarly, only a few JSNA reports reflected how a wider group of partners may have been involved in JSNA discussions and decision making.

In addition, JSNA was not always perceived as an ongoing process, which moved towards the improved sharing of intelligence, more that it was merely the production of a written report, although this was not always the case. Better coordinated timing of the local and regional planning, LAA and JSNA processes and linking the input of JSNA into the commissioning cycle may provide a greater impact to the overall development of this process.

“..[our] JSNA is ... viewed very much as a process rather than a document. This means it is always developing.”

The active promotion of JSNA as applicable to a wide range of ongoing partnership work, policy and strategies, as well as using JSNA refreshers to inform, support or even lead operational plans were considered important. It was, however, considered too early in the JSNA process to see clear evidence of how JSNA will influence the joint working, strategies, plans and commissioning decisions that are working to bring about health and wellbeing changes.

“The Joint Strategic Needs Assessment was developed alongside the formulation of the local priorities for the 2008 Local Area Agreements. The JSNA will continue to be aligned with the LAA process and commissioning cycles within the local authority and PCT to ensure that it informs priorities.”

Despite the fact that the North West Regional Improvement and Efficiency Partnership (NWRIEP) and the Joint Improvement Partnership (JIP) are working to align integrated delivery of improvement and efficiency activity in social care, health and wellbeing, no JSNA made reference to these programmes. Therefore, JSNA do not yet seem to be being used to inform the planning of sub-regional Improvement and Efficiency Partnerships.

In most cases, JSNA reports provided little detail on how partnerships were involving local communities and community involvement was often seen as a future step. A few exceptions, however, showed a wealth of experience in liaising with a range of community groups and integrating them within the decision making process. Also, few examples were observed where JSNA had sought to contact hard to reach groups during the process. There were examples of good practice with innovative methods of dissemination for different audiences/target groups and/or highly targeted outputs in different languages. Some areas demonstrated long standing, close community liaison between LA adult and children’s services and NHS partners.

“The community was involved via street surveys and focus groups that took place across the borough.. ..engagement activity was undertaken with vulnerable groups including people with learning disabilities, homeless, substances misusers, people involved in criminal justice system, domestic violence and mental

health service users as part of the Equitable Access to Primary Medical Care programme...”

JSNA teams had varying ideas on whether they have access to adequate national or regional support and resources. A lack of standardisation in approaches was evident, although a rigid national framework would be poorly received by local partnerships, as it reduces flexibility. It was highlighted that a mechanism of sharing practice (including case studies), accessing information, making contacts and building partnerships across the region would be useful.

“A centralised source of general information and resources relevant to ongoing JSNA work would be of great value allowing those in the region to share practice, access relevant information, make contacts and build partnerships etc. This would be of even more value if it were rolled out nationally, including the APHO work.”

3.2 Current and future health and wellbeing needs

The collection, sharing, and analysis of data emerged as a key issue – not all JSNA reports showed a clear transition from data collation to intelligent analysis to better inform JSNA and commissioning plans. Clear gaps were apparent, both between and within the domains of data incorporated into JSNA reports, with coverage of social and environmental data or data that evaluates services being a particular weakness. Certain JSNAs chose to develop their own sets of data and criteria for data analysis, rather than following the more prescribed datasets recommended nationally. Individual reports highlighted examples of where either too much or too little data, as opposed to intelligent analysis, had been incorporated within reports, i.e. some provided detailed data audits while others provided no references to supporting data.

“Where data was held by different external partners and/or by a different department within a PCT/Council, data was sometimes not available or difficult to get hold of. Also, due to the relatively small numbers for some of the Health and Wellbeing indicators it was difficult to determine significance.”

“The biggest difficulty is that all of the data providers do not necessarily do things the same and thus trying to provide a consistent approach can be problematic.”

One data issue raised was that national data is too out of date to be of any value for detailed local analysis to inform the current commissioning process. Local and more up-to-date data are used by local areas to address local data gaps. A greater use of proxy indicators and/or inferring intelligence from a combination of existing national analysis/evidence translated to known local population characteristics should be considered. For example, geodemographics, as an example of ecological analysis, can identify ‘types’ of populations at greatest need and some insight into their likes, but this was rarely applied.

“Although general analytical capacity is adequate... a wider regional resource would be welcomed and particularly access to specialist analytical expertise as a supplement. This could be provided via a regional organisation such as the NWPHO and on topic areas such as national indicators e.g. NI39 or on alcohol issues specifically.”

Little evidence was shown with regard to the use of housing and migration statistics, recent change in the financial climate, and the likely effect of the recession on unemployment, health and wellbeing; nor on fuel poverty issues. While tackling inequalities is mentioned in a majority of JSNAs, analyses of inequity in access to services, based on underlying need, were rarely included. In addition, there was very little coverage of the six dimensions of equality; age, gender (including trans), disability, race, religion or belief, and sexual orientation. Given the well established research evidence for the relationship between the equality target groups and health outcomes, it might have been expected that strategies for addressing these would have been included. The main focus was on age, gender and ethnicity, no doubt due to the greater availability of data, but JSNAs would benefit from the recognition that all health outcomes need to be monitored for all equality target groups.

A centralised set of data, and additional tools that intelligently interpret data, for use by JSNA partnerships was considered to be useful as an additional resource, perhaps

providing local area profiling, identification of trends, provision of more up-to-date ‘uncleaned’ data or mapping facilities. Only a minority of JSNA partnerships were making use of innovative datasets, such as the use of geodemographics and qualitative research techniques that can either be used to segment local populations by lifestyle group, or, in addition, for social marketing purposes. Further, data is required by JSNA teams at as low a geographical level as is possible, enabling detailed local area analyses to be undertaken.

“A portal with various layers of data and intelligence would be beneficial, as data is all over the place in distributed systems and this needs pulling together to save time for others.”

Although several JSNA reports suggested that modelling, forecasting and/or projections had been considered as part of their process, there was little evidence presented within JSNA outputs to indicate exactly what had been investigated. Where evidence of forecasting was presented, it focused on projected changes in relation to the ageing population; no doubt due to ease of access to the data in this area. Interpretation of how the ageing population will impact on health needs was then given consideration. Currently there is limited resource available to support local forecasting of disease prevalence but those that do exist could have been used more extensively.

It was clear that partnerships do not typically have the ready ability to undertake forecasting and modelling work to any great extent; with forecasting data in particular seen more as a future than current consideration. While forecasting is an important way of anticipating periods of high service use/activity, it might create implications for the real-time sharing of information between health, social and care services if application is required for immediate identification of demands on services (e.g. Chronic Obstructive Pulmonary Disease admissions, Flu pandemic).

“Lack of forecasting and general social care data was a real issue for them and something they think needs addressing in their refresh/further development of the JSNA.”

“Projection data is a big gap and needs addressing as it is very important for future planning and to enable effective targeting of interventions with targets and groups.”

3.3 Using the JSNA for commissioning

Although all JSNA partnerships highlighted key priorities to varying degrees, they were in the main, high level health related outcomes or lifestyle change priorities; for example, to reduce smoking prevalence and to improve life expectancy. Priorities for commissioners, supported by relevant intelligence, with measurable targets and outcomes were rarely highlighted.

The evaluation of the Commissioning Strategic Plans by the Strategic Health Authority (SHA) provided additional evidence that priorities for commissioners could be improved in the majority of JSNA partnerships.

“JSNA has really led the way for transforming the commissioning process. JSNA enables this system reform, partly through enabling much better working relationships.”

“Joint intelligence working, particularly as will be required for improved commissioning, isn’t quite as good [as it could be] because different areas have different priorities, the drivers for which aren’t well centralised across the PCT/LA.”

In many cases the JSNA offered a statement of current position rather than a wider understanding of the needs and underlying problems in the community. Much more localised intelligence will be required to inform commissioning priorities effectively. Responses suggested that a systematic integrated approach needs to be promoted and encouraged as the mechanism for developing commissioning and planning cycles rather than as an additional tier of paperwork.

“The main purpose of the JSNA is to inform strategic planning and commissioning and, given that the structures and processes for doing this vary between different organisations, a one size fits all approach to JSNA is unlikely to be the most effective way of achieving this...”

It was widely recognised that business process and cultural change is required to embed needs assessments into the commissioning cycle, although how this will occur was not clear. Equally unclear was the role that JSNA is currently playing in informing local commissioning and related policy. Issues

were raised regarding measuring the effectiveness of the JSNA in developing commissioning in terms of timeframe and indicators to measure this.

“Engagement with commissioning teams is a priority for the coming months. This will enable us to understand how the JSNA can develop to better support commissioning decisions.”

There was mixed representation of and engagement with commissioning stakeholders in the JSNA process; with clear evidence of engagement in some areas and no detail presented in others. A number of areas were very positive that JSNA is influencing commissioning strategies but that timing is key and that further work in most partnerships will be needed to strengthen this, with a need to build improved links. JSNA was considered to be another form of existing processes that should be used to enhance links into the commissioning cycle.

“Many other plans and strategies, most notably World Class Commissioning, have already led to change in the commissioning process and too much emphasis is being put on JSNA for this.”

Development in this area was supported by reference from numerous partnerships to the need for a ‘cultural change’, and suggestions that JSNA and commissioning work took place in isolation. In addition, reference to the cost effectiveness of commissioned services and the information to support this type of analysis also indicated the need for further support and work in this area.

“Transformation of commissioning will take a long time particularly to measure effectiveness in terms of the JSNA’s contribution to it.”

“More data on the cost of services and value for money would definitely be useful, e.g. hospital tariffs. It’s a good way of getting people’s attention and useful given the move towards outcome based commissioning. This needs addressing as does the whole issue of health economics more generally.”

Practice based commissioning was, in the majority of cases, highlighted as an area that requires much more development. The need to underpin this with more focused locality based needs assessment, for example, in terms of

analytical capacity was highlighted. Evidence suggested that a number of partnerships are considering this for their next round of JSNA.

3.4 Products, promotion and evaluation

JSNA outputs considered alone emerged as highly individual. Some provided substantial audits of population, care and health data, while others had no data presented but were in an easy to read and highly accessible form for a wider audience, including the public. While several JSNAs followed a broadly similar format, such as, summarising data for their locality then considering key priorities, other individual innovative examples of highly structured outputs stood out. The outputs varied from highly detailed, to easy to read, to clearly understandable.

Many JSNAs could have been far more clearly laid out, however, it may have been that the outputs reviewed were still in draft format, or that formats indicated a narrow internal audience or lack of time provided for layout and/or design. Nevertheless, examination of JSNAs across the region showed clear differences between the styles, aims, process and goals of the partner agencies and authors leading on, or contributing to, individual JSNA outputs.

“Too much emphasis on the documented outputs of JSNA rather than the actual process isn’t helpful. ...careful that it doesn’t turn into a paper generation exercise.”

The range of approaches to JSNA outputs were highlighted within interviews, and various discussions highlighted potential good practice that could be shared. It seems clear that a non-prescriptive approach to JSNA has allowed individual partnerships to develop local styles of reporting, analysis and dissemination, with locally appropriate focuses on what was felt to be of importance. However, the wide variety of JSNA reporting styles also demonstrated some possible local confusion on the remit of JSNA. Additionally, it was not always clear whether the Association

of Public Health Observatories resource guides, or Department of Health guidance, had been considered in any great detail.

There were examples of sharing a JSNA model or framework between local areas, which at this point in time was mainly through off-the-peg products from a consultancy. This process has a number of advantages in that the final published reports are written in a clear accessible style. However, such an approach can limit local innovation and application of intelligence/joint working within the local context.

In terms of moving forward, some partnerships have identified priority areas to work on. These include locality based JSNAs that will influence practice based commissioning, the evaluation of the use of JSNA to inform commissioning and operational plans and further development of community involvement.

“Although too early to assess the impact of JSNA on commissioning decisions, it may be possible to look at whether the JSNA has had an impact on the behaviour of commissioners and the way that they are making decisions.”

4. Recommendations

The main report provides a summary of “What JSNA partnerships are saying” about the process, content, dissemination and next steps for JSNA as well as listing a series of recommendations:

JSNA partnerships across the region should:

- i. Consider the process to be cyclical and ongoing, with demonstration of how service development and the effect of the JSNA on populations of interest can be monitored and in turn inform future JSNAs. Regional or national guidance could be provided so long as this still enabled local innovative practice to take place.
- ii. More clearly identify that they are developing broader inter-agency partnerships, so that there is:
 - a. closer involvement of local communities, using a range of innovative methods
 - b. better links and integration with various local and sub-regional plans and programmes (e.g. Improvement and Efficiency Partnership Programmes)
 - c. inclusion of the NHS, all directorates from Local Authority (e.g. housing, transport, leisure, education/children), the voluntary/third sector and other agencies (e.g. judicial, fire and emergency services)
 - d. analysis that clearly identifies all commissioning priorities: adults, children and target groups.
- iii. Better address the wider determinants of health, inequality and equality and diversity needs of the local population with intelligence on:
 - a. socioeconomic status, deprivation and the Equality Targets Groups (ETGs)
 - b. relevant topics, relevant targets and outcomes
 - c. the health needs of different population sub-groups, for example using geodemographics analysis
 - d. inequalities in service provision for all ETGs
 - e. cost effectiveness of interventions and services
 - f. forecasting for future health needs
 - g. aspirations of local populations as well as their needs.
- iv. Ensure that the outputs from JSNA are disseminated appropriately for different audiences (e.g. communities and professionals). A collation of case studies that highlight particularly innovative approaches in engaging with the community at local area level would be beneficial.
- v. Evaluate and ensure that the JSNA as a product or as a process is influencing wider strategic plans, the commissioning cycle and has community involvement with the aim of improving/commissioning services to improve the health of the local population.

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Published June 2009

ISBN: 978-1-906591-80-9 (print)
ISBN: 978-1-906591-81-6 (web)

