Population Needs Assessment for Health and Social Care Partnerships: guidance on the use of data sources

Purpose
This document aims to provide an outline of an approach to population needs assessment for health and social care partnerships. The focus is on the data sources available to support this process. More details of these data sources are provided in an accompanying document.

Policy context
The current approach to health and social care integration has a strong focus on outcomes. The national health and wellbeing outcomes are as follows:

1. People are able to look after and improve their own health and wellbeing and live in good health for longer.
2. People, including those with disabilities, long term conditions, or who are frail, are able to live, as far as reasonably practicable, independently at home or in a homely setting in their community.
3. People who use health and social care services have positive experiences of those services, and have their dignity respected.
4. Health and social care services are centred on helping to maintain or improve the quality of life of service users.
5. Health and social care services contribute to reducing health inequalities.
6. People who provide unpaid care are supported to reduce the potential impact of their caring role on their own health and well-being.
7. People who use health and social care services are safe from harm.
8. People who work in health and social care services are supported to continuously improve the information, support, care and treatment they provide and feel engaged with the work they do.
9. Resources are used effectively in the provision of health and social care services, without waste.

As well as morbidity (disease) and mortality, outcomes may include specific areas such as the extent to which people are able to live independently in the community or to maintain their health and wellbeing. The purpose of population needs assessment is to help identify which outcomes need to improve, and to guide the choice of interventions to be prioritised in relation to the needs of the whole population.

Broad principles of population needs assessment
The purpose of population needs assessment is to gather the information needed to understand the type and distribution of services required for a population to gain the maximum benefit. This requires an understanding of the health and wellbeing needs of the population in order to support improvement through health and care services and other initiatives including self-care. The approach outlined here involves three stages:

- assess the level of need for health and social care services
- describe the current pattern and level of supply of these services
- identify the extent of the gap between need and supply.

The understanding gained from population needs assessment is then used to help make decisions about how to prioritise allocation of resources to meet the needs that have been identified, alongside other ways in which people's health and care needs are met, such as self-care or community support. Population needs assessment is one component of the larger process of joint commissioning.

There are traditionally three approaches to healthcare needs assessment, which are equally applicable to population needs assessment for health and social care. These are:

(a) epidemiological approaches: which use mainly quantitative data to estimate the size and composition of the population of interest, including information on place, over time, and by key population subgroups; the level of need (as indicated for example by the prevalence of disease, disability or adverse life circumstances) and the current provision of services to meet those needs;

(b) comparative approaches: which use comparisons across time or between different geographies or population groups to establish potential needs by identifying areas or groups where there is relative under-provision;

(c) corporate approaches: which gather mainly qualitative information to help understand the views of stakeholders (patients, public, professionals, policymakers etc) about current needs and priorities for future provision.

In general all three approaches are needed for population needs assessment and subsequent decision-making. The older people needs assessments carried out by the Scottish Public Health Network[1] and by NHS Ayrshire and Arran[2] both provide good examples of these approaches.

It is not straightforward to define "need"; it is different from "demand", since people with apparently high levels of need may not ask for or be provided with services. It is important to be aware that providing services often generates demand. For example setting up a new mental health outreach service may lead to a large increase in the number of people identified with mental health care needs. A useful definition of need is "the capacity to benefit from services". This definition is a reminder that the focus in needs assessment should be on interventions that can produce real benefits, and on identifying people who could benefit from receiving those interventions. It also emphasises the need for evidence that services are effective and likely to produce benefits.

Preparing for a needs assessment

Preparation for a needs assessment will include consideration of the local circumstances and background to the commissioning of the needs assessment, identification of stakeholders, agreeing the scope of the needs assessment, identifying the necessary time and other resources to carry out the needs assessment and considering what data sources are available.

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[1] http://www.scotphn.net/pdf/2013_10_01_FINAL_MASTER_ScotPHN_OPHSCNA_epid_report.pdf
[2] http://www.east-ayrshire.gov.uk/Resources/PDF/R/ReshapingCareforOlderPeople-OlderPeoplesNeedsAssessmentAugust13.pdf

It is important to identify, involve and engage key stakeholders early on the needs assessment process to ensure that the work will be the central means of decision-making and resource allocation and that the output will be fully integrated into the subsequent strategic planning processes.

Some needs assessments focus on specific populations defined by a particular condition (e.g. cancer), social group (e.g. homeless people, ethnic minority) or setting (e.g. workplace, school). This often makes it more difficult to identify relevant data sources. However for high level needs assessment within a health and social care partnership interest may focus on the whole population, or the adult population, and the sections that follow take this approach.

Available data sources
A range of different types of data sources is available for population needs assessment. Routine administrative data such as hospital admission data may help to assess aspects of service use. Data are available periodically from surveys such as the Scottish Household Survey. Estimates of particular needs may be available from surveys carried out locally as part of research studies. Sometimes it may be necessary to use research studies carried out elsewhere and apply them locally, though in this case careful consideration needs to be given to how applicable the study is to local circumstances. Sometimes high quality data from elsewhere is combined with local demographic data to provide modelled data. Examples include modelled estimates of smoking prevalence produced by the Scottish Public Health Observatory[3] (although it is important to note that such synthetic estimates should not be used to monitor progress). Some surveys are carried out by advocacy groups with an interest in a particular kind of need. These are often useful, though users should be aware of the risks of conflicts of interest. Finally, in the absence of any data it may be necessary to rely on expert opinion on the extent of local needs.

Whatever data sources are used, it is important to be clear about where the data came from and to be aware of the strengths and limitations of those data. One important approach to population needs assessment mentioned above is the comparative one. In order to make comparisons it is essential to ensure that indicators are defined in the same way in different areas or groups. The provision of nationally consistent indicators is one of the important strengths of health profiles.

Data may be crude or adjusted. Crude figures are based on simple counts without any further adjustments. Adjusted figures have been processed in a way that takes account of differences between different areas, times or groups. For example, age and sex standardised figures have been adjusted so that comparisons of such figures take account of difference in the age and sex composition of populations. A comparison of two populations with a very different average age may show that the older population has a higher prevalence of dementia. This will be reflected in higher rates of demand for dementia services. However in terms of understanding the reasons for this variation, age-standardisation may show that when the figures are adjusted for age, there is no difference in the prevalence of dementia between the two populations. For the purposes of needs assessment there is generally more interest in establishing the level of need. For this purpose crude (unadjusted) figures are more relevant. However if the purpose is to understand the reasons for variation then adjusted figures are more meaningful.

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[3] http://www.scotpho.org.uk/publications/reports-and-papers/497-an-atlas-of-tobacco-smoking-in-scotland-a-report-presenting-estimated-smoking-prevalence-and-smoking-attributable-deaths-within-scotland-

Inequality is an important aspect of need. For example low average levels of need may conceal wide variations, with some groups having much higher levels of need. Examination of inequality usually focuses on socioeconomic inequalities, but it is important that other population characteristics (such as age, gender, ethnic group or disability) may also be important sources of inequality. Most often, inequalities are examined using the Scottish Index of Multiple Deprivation (SIMD), an area-based measure of concentrations of material deprivation.[4] A simple measure of inequality would be the gap in a particular measure (for example mortality) between the 20% of the population living in the most deprived data zones and the 20% in the least deprived datazones. This is an absolute measure of inequality. A more detailed guide to measures of inequality is available from the Scottish Public Health Observatory.[5]

A. Assess current and future levels of need

The first step in population needs assessment is to gather information on the level of current need in the population being considered. This can be combined with information on previous trends to project likely future levels of need.

1. Develop a demographic profile of the population of interest

A first step in understanding the level of need is to describe the demographic profile of the population of interest. This profile should include current and projected future population sizes; the current and future composition of the population by age, gender, geographic location, urban-rural location, household composition including marital status and for specific population subgroups, such as ethnic group. Other information can be derived from the basic demographic profile, such as dependency ratio (the number of dependents <16 years plus the number over retirement age divided by the number of working age). Information is available (from the Scottish House Conditions Survey) on household tenure and on numbers of pensioner households.

Main data sources

The main data source to support the development of a demographic profile is the Census. National Records of Scotland (NRS) publishes a large amount of detailed information about the Scottish population which relates to the Census year (2011). The data are also used by NRS to produce mid-year population estimates and population projections for other years. (These estimates are also available through other routes such as Scottish Neighbourhood Statistics.) Population estimates are available down to data zone level (the data zone is the smallest geographical unit routinely used for population estimates, and is a small area with a median population of around 750 people). NRS also publish population projections by age and gender at geographical levels down to council. These figures are based on estimates of fertility, mortality, immigration and emigration. These components of population change are also available at council area. As well as the main (principal) projections NRS produces variant population projection based on varying the underlying assumptions, and these provide a useful indication of the range of uncertainty behind the projections. Population projections are not readily available for all population subgroups. For example Rees[6] used modelling approaches to produce population projections for by ethnic group in Scotland.

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[4] http://www.scotland.gov.uk/Topics/Statistics/SIMD
[5] http://www.scotpho.org.uk/publications/reports-and-papers/494-measuring-socio-economic-inequalities-in-health-a-practical-guide-
[6] http://www.gro-scotland.gov.uk/files2/stats/seminars/10-pams-seminar-oct2011-phil-rees.pdf

NRS provide demographic profiles for each council area.[7] These include a wide range of demographic information providing a broad overview of population, mortality, births, migration, fertility and households in each area.

2. Gather information on indicators of need in the population of interest

As discussed above, it is important to note the difference between need and supply (or utilisation). Unfortunately many indicators of need are based on a combination of supply, demand and need for services (for example numbers of attendances at a clinic for care of the elderly, or numbers of looked after children). It is often not possible to find an ideal indicator of need that is unrelated to supply and demand, but when using indicators of need it is important to consider how they might have been influenced by supply and demand factors.

For all of the potential indicators of need that are identified, it is important not only to think about the average level of need but also about the extent of inequalities. Expressing need as the absolute numbers of people likely to benefit is generally more useful than giving proportions. For example it may be useful to be able to say that there are 450 people in your area who are classified as suffering from fuel poverty than to say that 15% of your population suffer from fuel poverty.

Indicators of need may relate to life circumstances (such as the physical and social environment), to measures of health status (such as self-reported health) or to the presence of risk factors for poor health (such as smoking).

Describe life circumstances –physical, social and economic

Many indicators of the physical and social environment provide information about needs. Information on the physical environment could include such things as the number of people who live within 500m of a landfill site, or indicators of housing quality.[8]

In relation to the social environment the Scottish Index of Multiple Deprivation (SIMD) provides a summary measure which identifies concentrated areas of material deprivation. It combines data from seven domains (income, employment, education, housing, health, crime, and geographical access) to rank Scottish datazones in order of deprivation. Detailed information at small area is available on the SIMD website.[9] Individual components of the SIMD may provide important additional information such as identifying high levels of access deprivation. SIMD does not identify individual material deprivation and it does not identify material deprivation which is geographically dispersed, as often happens in rural areas. There is at present no ideal way of identifying such dispersed deprivation.[10]

There is also a range of data from surveys and other sources on wider social characteristics. These may not identify specific needs, but may be helpful to understand the characteristics of specific populations in need. Examples of these kinds of data might include information on internet use and community perceptions of safety (from the Scottish Household Survey). The Indicator of Relative

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[7] http://www.nrscotland.gov.uk/statistics-and-data/statistics/stats-at-a-glance/council-area-profiles
[8] from the Scottish House Condition Survey http://www.scotland.gov.uk/Topics/Statistics/SHCS
[9] http://www.scotland.gov.uk/Topics/Statistics/SIMD
[10] http://www.scotpho.org.uk/publications/reports-and-papers/1165-identifying-qdeprived-individualsq-are-there-better-alternatives-to-the-scottish-index-of-multiple-deprivation-simd-for-socioeconomic-targeting-in-individually-based-programmes-addressing-health-inequalities-in-scotland

Needs (IoRN) is standardised measure of functional dependency that can be used to understand the needs of older people for long term care and support.[11]

There are a wide range of indicators of social and economic disadvantage. These include measures such as the proportion of the population that claim pension credits (available by age, year and council area from the Scottish Neighbourhood Statistics website); the proportion of people over the age of 65 years that receive attendance allowance; the proportion of the population suffering from fuel poverty (Scottish House Conditions Survey), the proportion of people that receive disability related benefits such as disability living allowance or the percentage of working age population claiming Jobseekers Allowance. Needs in relation to support at home can be obtained from data on community care assessments (from a quarterly Scottish Government survey). Data on the number of carers are available from the Census and the Scottish Household Survey.

The Health and Social Care Data Integration and Intelligence Project (HSCDIIP) will provide a standard routine reporting facility and data visualisation tool for each Integration Authority, bringing together a range of relevant datasets. Further information on this project is available from ISD Scotland's website.[12]

Data gaps
An important data gap relates to the availability of socio-economic information at an individual level.

Describe health status
Indicators of health status provide information about current levels of health, disease and disability. More information about data sources for specific health areas is available from the Scottish Public Health Observatory (ScotPHO) website.[13] Some of these indicators are based on service utilisation (for example hospital admissions) and as noted above it is important to consider whether these may have been affected by supply or demand factors rather than need.

Overall measures of health status include measures of average life expectancy (LE, the length of time someone can expect to live) and of healthy life expectancy (HLE, the length of time someone can expect to live in good health). These are available from National Records of Scotland (NRS, for LE) and from the Scottish Public Health Observatory (for HLE[14]) at council level. NRS publishes data on overall mortality and for mortality due to specific causes like Coronary Heart Disease, stroke and cancer. NRS also publish statistics on excess winter mortality. Self-reported health is a useful overall measure of health status and is available at council level from the Scottish Health Survey.

Information on the prevalence of long term conditions (such as diabetes) is available from the Scottish Health Survey, but this provides little detail and is based on self-report. ISD's Practice Team Information programme provides data on consultation rates in general practice for specific long term conditions, but these are available only at Scotland level. The Quality and Outcomes Framework (QOF) provides information on the numbers of people in each general practice for a limited number of long-term conditions, but there is no breakdown by age, sex or other

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[11] see http://www.isdscotland.org/Health-Topics/Health-and-Social-Community-Care/Dependency-Relative-Needs/In-the-Community/

[12] at http://www.isdscotland.org/Products-and-Services/Health-and-Social-Care-Integration/

[13] www.scotpho.org

[14] http://www.scotpho.org.uk/population-dynamics/healthy-life-expectancy/key-points

characteristics. The Scottish Diabetes Survey collects detailed information on diabetes which is published at health board level. Modelled data[15] on diabetes uses accurate estimates of diabetes prevalence from detailed research studies elsewhere in the UK to estimate how many people in each Scottish Health Board might have undiagnosed diabetes.

Some Scottish NHS Boards have data extraction mechanisms agreed with general practices that allow them to collect more detailed information from practices on practice activity, including the numbers of people who consult for specific long term conditions. In the medium term these kinds of data extracts could be available for all NHS Boards through the SPIRE programme.

Information on people with cancer is relatively complete and accurate. Scottish cancer registry data is maintained by ISD and is based on multiple data sources (not just hospital admissions).

General practice data extracts could also be used to produce information about the numbers of people with multiple long-term conditions (so called multi-morbidity). A research study[16] has been published using primary care data extracts to estimate the extent of multi-morbidity at Scotland level. The needs assessment for older people published by the Scottish Public Health Network[17] also provides estimates of the prevalence of long term conditions.

Data on levels of disability in the population is less common, though data on claimants of sickness-related benefits are available at small area level. There are some data on self-reported disability in the Scottish Household Survey. There are very limited data on sensory impairment. Where local primary care data extraction is available there may be data available on deafness and visual impairment, though this may be incomplete. Although there is information available on the number of people who are registered blind or partially sighted, this is limited to those most severely affected, and substantially undercounts the true number with visual impairment. There are no estimates of the number of people with hearing loss from routine data. Estimates[18] from a relevant charity are based on surveys from elsewhere in the UK that are now somewhat out of date. Information on households where someone requires regular care is available from the Scottish Household Survey. Information on oral health is available from the Scottish Health Survey.

ISD holds national information on hospital admissions and discharges. It should be noted that this is also a measure of supply of services, so may be distorted by the availability of specific local services. Hospital discharge information is available at council area and covers both all-cause admissions and admissions for specific diagnoses. Information is available on the total number of admissions as well as on the number of people with at least one admission. Hospital discharge data can be used to generate specific indicators such as those related to falls in the elderly and to alcohol-related hospital admissions.

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[15] from the diabetes prevalence model produced by the Association of Public Health Observatories (APHO): for further information see http://www.scotpho.org.uk/health-wellbeing-and-disease/diabetes/data/undiagnosed-diabetes

[16] Barnett K, Mercer SW, Norbury M, Watt G, Wyke S, Guthrie B. Epidemiology of multimorbidity and implications for health care, research, and medical education: a cross-sectional study. The Lancet 2012; 380: 37–43.

[17] Available from:
http://www.scotphn.net/projects/previous_projects/health_and_social_care_needs_assessment_of_older_people_reports

[18] Action on Hearing Loss (http://www.actiononhearingloss.org.uk/)

Information on mental health and wellbeing is relatively sparse.[19] Information on mental wellbeing using the Warwick Edinburgh Mental Wellbeing Scale(WEMWEBS) score is available at council level from the Scottish Health Survey. Information is also available on poor mental health (GHQ12). Information on consultations for mental health problems in primary care is available at Scotland level from ISD's PTI programme, but the availability of local data is dependent on whether there are local initiatives to extract primary care data. There are data on the prevalence of dementia and depression from the QOF, but these are aggregate figures not available by age or sex. Hospital admission is reserved for the most severe forms of mental health problem and statistics on hospital admission do not provide a complete picture of the range of mental health problems. For dementia, estimates of the prevalence from a UK charity[20] are based on expert consensus and on research studies carried out in various locations.

Data gaps

There are a number of important data gaps in relation to health status. For example there is a lack of information on disability of various kinds as well as limited information about mental health and illness. There is no consistent routine information available nationally on the conditions for which people consult in hospital outpatients or A&E departments.

Describe levels of risk factors relevant to health and social care

Assessing the prevalence of risk factors in the population has the advantage of having a clear and direct link to possible interventions designed to reduce such risk factors. It is important to understand how the risk factor is linked to outcomes relevant to people (without this, reducing risk factors is of little benefit). It is also important to have good evidence that there are interventions addressing these risk factors that can produce real benefits for people in terms of better outcomes. Measuring risk factors may be appropriate, but it should be remembered that it also creates the risk of an undue focus on individual approaches to improving health at the cost of neglecting structural and community factors.

Tobacco consumption

Smoking is perhaps the most important individual behavioural risk factor for poor health and is linked to a wide range of poor health outcomes.[21] Smoking prevalence at council level is available from the Scottish Household Survey and the Scottish Health Survey. Estimates of smoking prevalence have been produced at much smaller local level using modelling approaches,[22] but these estimates were very approximate and are now slightly out of date. However they are still likely to reflect the geographical pattern of smoking. Methods are available to estimate smoking related mortality and estimates are published by ScotPHO.

Alcohol consumption

Self-reported alcohol consumption is available from the Scottish Health Survey at council level. The methods used to estimate self-reported consumption have been improved but it is likely that they still under-estimate true consumption. Information on levels of hazardous and harmful drinking are

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[19] see http://www.healthscotland.com/documents/2800.aspx for more details
[20] The Alzheimer's Society (http://www.alzheimers.org.uk/)
[21] http://www.scotpho.org.uk/behaviour/tobacco-use/key-points
[22] http://www.scotpho.org.uk/publications/reports-and-papers/497-an-atlas-of-tobacco-smoking-in-scotland-a-report-presenting-estimated-smoking-prevalence-and-smoking-attributable-deaths-within-scotland-

available from the Scottish Health Survey and may also be available in some areas by extracting data from primary care systems. A summary of data sources is available from the ScotPHO website.[23]

Healthy weight

Information on healthy weight is available at council level from the Scottish Health Survey. Some useful information may also be available through local primary care data extraction though under-recording is likely to be an important problem for these data. A summary of data sources is available from the ScotPHO website.[24]

Diet

Information on levels of consumption of fruit and vegetables is available from the Scottish Health Survey at council level. A summary of this and other data sources is available from the ScotPHO website.[25]

Physical activity

Information on levels of physical activity is available from Scottish Health Survey at council level. The Scottish Household Survey collects information on travel and transport. A summary of data sources is available from the ScotPHO website.[26]

Other risk factors

Information on levels of high blood pressure is available from Scottish Health Survey at council level.

Scottish Patients at Risk of Readmission and Admission (SPARRA)[27] scores provide an indication of the risk of emergency hospital admission among older people. These are available at council and at smaller local levels.

Consider likely future levels of need

An important part of needs assessment is to consider the likely future level of need as a guide to planning services. One simple way of doing this is to use population projections from NRS and to apply current rates of need to these projections. This can be used to estimate (for example) the number of older people likely to require home care in 2020. These projections take no account of changes to current rates (so if the proportion of older people requiring home care changes then the projections will be wrong).

More complex methods of projection are available which take account of cohort effects and of trends in risk factors. Even these methods do not account for changes like the introduction of new treatments, changes to the organisation of care or unexpected events like economic downturn or other social change.

Data gaps

The main data gaps in relation to risk factors relate to the relative lack of information about social care risk factors.

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[23] http://www.scotpho.org.uk/behaviour/alcohol/introduction
[24] http://www.scotpho.org.uk/clinical-risk-factors/obesity/key-points
[25] http://www.scotpho.org.uk/behaviour/diet-and-nutrition/key-points
[26] http://www.scotpho.org.uk/behaviour/physical-activity/key-points
[27] http://www.isdscotland.org/Health-Topics/Health-and-Social-Community-Care/SPARRA/

B. Assess current levels of supply of services

The first section of this document described the process of assessing the level of need for health and social care services in a particular community. This second section describes how to describe the current level of service provision so that planners can be clearer about the extent to which current services are meeting the need and so that they can begin to describe the gap between current provision and current need.

The first step is to describe the current pattern of health and social care service provision, focusing on infrastructure, the organisation of services and the composition and skills in the current workforce.

The next step is to identify suitable measures of current provision. For social services this might include levels of activity, such as:

- the proportion of older people with intensive care needs and/or lower levels of care needs who are receiving care at home;
- the proportion of older people receiving free personal care at home;
- home care provision for older people (from the Scottish Home Care Census or NHS continuing care census);
- respite care for unpaid carers;
- council provision of supported or sheltered accommodation
- information on care homes derived from the annual Care Home Census;[28]

As a proxy for activity, indicators might include levels of current expenditure, for example council spending on housing aids and adaptations such as showers or lifts, free personal and nursing care provision.

For health services measures of current provision might include data on:

- primary care consultations (either from local primary care data extraction or using national estimates from ISD's PTI programme);
- numbers of outpatient attendances (information by diagnosis is not available for outpatients);
- numbers of A&E attendances (in general information by diagnosis is not reliable or complete);
- numbers and diagnoses for emergency hospital admissions and multiple emergency hospital admissions;
- information on unscheduled care, with emerging new analyses based on linkage between hospital admissions, NHS24 and Scottish Ambulance Service data;
- length of hospital stay;
- waiting times;
- numbers of surgical procedures carried out;
- delayed discharge at Health Board and Local Authority level from the quarterly delayed discharge census;[29]

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[28] http://www.isdscotland.org/Health-Topics/Health-and-Social-Community-Care/Care-Homes/Census/
[29] http://www.isdscotland.org/Health-Topics/Health-and-Social-Community-Care/Delayed-Discharges/

- figures from the annual Balance of Care/ NHS Continuing Health Care census covering non-acute inpatient care;[30]
- data on end of life care relating to the proportion of the last six months of life spent at home or in a community setting.

All of these measures are available from ISD at relatively small area level. In relation to services to reduce risk factors, data are available on smoking cessation uptake, breast screening uptake and uptake of immunizations such as influenza.

ISD's Integrated Resource Framework (IRF) team publishes resource mapping analyses that describe the pattern of health and social care expenditure at Scotland and at partnership level.[31]

An important aspect of service provision is the extent to which access to current services is adequate. Information on experience of accessing GP practice and out of hours services is available from the Health and Care Experience Survey.[32]

ISD also publish information on the volume and type of prescribing. The addition of the Community Health Index (CHI) number to prescriptions now allows analyses related to patient safety and polypharmacy (the inappropriate prescription of multiple medicines, particularly to older people).

Data gaps
There are a number of important data gaps in relation to health service provision. These include (as noted above) information on reasons for attending A&E departments and minor injury units; information on the services provided in community pharmacy, optometry, by district nurses, primary care mental health teams and other allied health professionals as well as by voluntary and community groups. ISD's Community Health Activity Data Project[33] aims to improve and develop data on district nursing and community mental health.

Performance data
Performance data are important for many reasons, but their relevance to needs assessment is that they may help to identify services that are ineffective or inefficient. For example, information about patients' perceptions of service quality is available from the Health and Care Experience Survey,[34] which also includes a set of relevant indicators. Information on performance may identify opportunities to redirect resources to meet needs more effectively.

C. Assess the gap between need and provision of services
The first part of this document described how the level and nature of population need in a community might be assessed. The second part outlined the process of describing the extent to which current service provision meets that need. The final part of the needs assessment process is to describe and to understand the size and nature of the gap between need and provision and to inform the process of setting priorities.

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[30] http://www.isdscotland.org/Health-Topics/Health-and-Social-Community-Care/NHS-Continuing-Care/
[31] http://www.isdscotland.org/Products-and-Services/Health-and-Social-Care-Integration/Analytical-Outputs/
[32] http://www.scotland.gov.uk/Topics/Statistics/Browse/Health/GPPatientExperienceSurvey
[33] http://www.isdscotland.org/Health-Topics/Health-and-Social-Community-Care/Community-Health-Activity-Data-Project/
[34] http://www.scotland.gov.uk/Topics/Statistics/Browse/Health/GPPatientExperienceSurvey

Integrating and making sense of information

An important final stage of needs assessment is to bring together different information sources to build up a picture of (health and social care) needs. This requires an understanding of the strengths and weaknesses of data sources as well as analytic skills when dealing with quantitative data. Local public health departments may be a useful source of advice and help.

Setting priorities

The results of a needs assessment will be one piece of information that informs decisions about priorities. They should give an indication of the size and impact of a problem in health and social terms. This needs to be combined with information about the effectiveness and cost-effectiveness of available interventions. Decisions about priorities will need to reflect local priorities and circumstances and to be informed by available resources and by what is thought locally to be feasible in practice.

Finding resources

Responding to the results of a needs assessment may require new resources in the form of additional investment. However this is not the only option. If a review process identifies services that are ineffective or that could be provided in a more efficient way then there are opportunities to stop ineffective services and reinvest resources elsewhere or to redesign services so that they can be more efficient.