Joint Strategic Needs Assessment 2018:

Appendix B

Proposed sub-county geographies

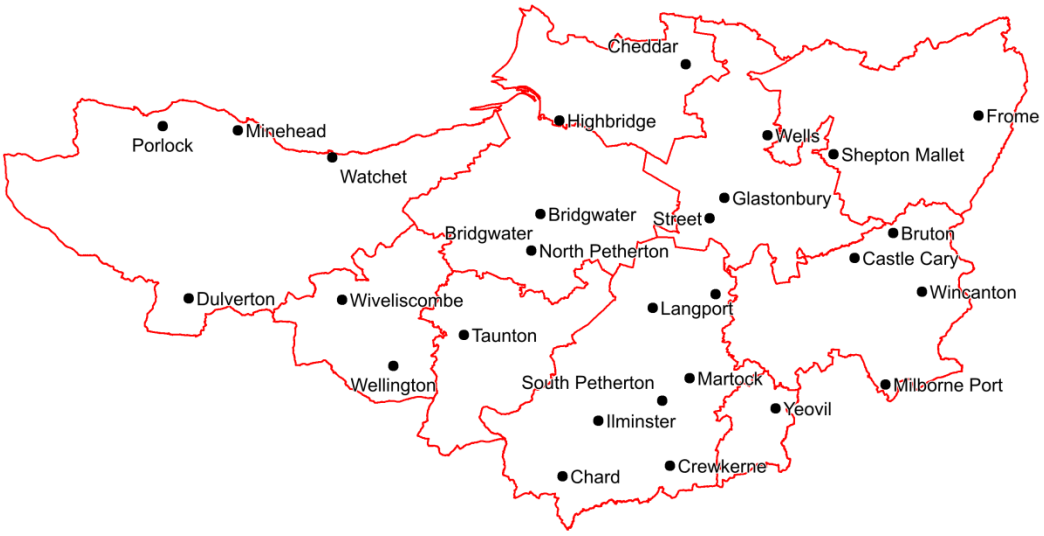

Figure 1: Proposed boundaries

Summary

The Health and Wellbeing Board, 28th September 2017, asked for JSNA information to be made available at a sub-county level. The JSNA Technical Working Group (TWG) set about creating geographies that best matched the following criteria:

- Fit within current District boundaries
- Are of approximately the same size
- Are centred around urban service centres
- Are relatively self-contained, so that the population in the areas tends to use services such as schools and GP practices located within them

- Are built from Middle Super Output Areas (census geographies of about 7,500 people), meaning that more data are available and individuals cannot be identified
- Are relatively balanced in terms of rurality and deprivation, so that *local* factors can be isolated more effectively.

The first set of boundaries was presented at the Cheddon Fitzpaine workshop in December 2017, and as a result of that engagement the boundaries have been refined to meet the criterion that they:

- Reflect local perception and catchment areas.

It should be noted that these boundaries have populations of about 40-80,000, generally larger than the 30-50,000 populations suggested in NHS New Care Models for integrating care for long term conditions[1]. The geographies shown here are the most appropriate for analysing need and *planning* services; *delivering* services may well require a different footprint, which will emerge from the analysis.

The boundaries here are not perfect, but on the basis of the criteria described and after considerable consultation, and changes made as a result, the Technical Working Group agrees that these boundaries are fit for purpose and as good as can practically be achieved.

The Board is asked to approve these boundaries so that work can be undertaken to analyse need at this scale and help plan locality-based commissioning and delivery of services.

Background

The inaugural meeting of the Somerset Joint Strategic Needs Assessment (JSNA) Technical Working Group (TWG) for the 2017/18 JSNA took place in September 2017. At the meeting, the scope of the current year's JSNA was agreed to be a summary of the evidence from previous JSNAs to inform the Health and Wellbeing Strategy from 2019. A request was raised to produce district summaries in addition to the Somerset wide version.

This was then taken to the Health and Wellbeing Board on the 28th September 2017. As a result of this the TWG was given the following relevant actions:

- Focus to be on place but people within place.

[1] https://www.england.nhs.uk/wp-content/uploads/2016/12/1693_DraftMCP-1a_A.pdf

- Look at data for district level in addition to county level.

At the subsequent TWG meeting this was considered. There was a consensus that Somerset's districts were generally too big for analytical purposes. The public health team were given the task of considering what would be the most appropriate geographies to advise the board. The remit included looking at things from 'scratch' so should not be from the perspective of what is already in place. It was also agreed to use a consistent methodology and to start with the district boundaries. It was felt that each area should focus on rural fringe areas surrounding core market town(s).

Initial geographies were developed and discussed by the TWG in November. The TWG would not have the authority to approve the geographies. However, there was agreement that it would be acceptable for these to be presented to the Health and Wellbeing Board engagement event taking place in December 2017. The geographies' purpose would be to provide the necessary detail to support delivery of the place-based approach of the new Health and Wellbeing Strategy once it was in place.

The geographies were refined following the engagement event and were subsequently presented at the Health and Wellbeing Board pre-meet in January 2018.

Considerations

The brief for the geographies was to be able to identify unwarranted or unexpected variation in need (or outcomes) across Somerset. The aim was refined to align existing boundaries and create a shared understanding of need across multiple organisations with the health and wellbeing system while adopting a place-based approach.

The geographies would need to have a consistent approach that would make them appropriate as localities for statistical analysis of need. This included being:

- small enough to be provide valuable insight
- large enough to enable statistical analysis and to include a cohesive/consistent group of people
- appropriate for comparing resident based data with GP Practice level data*
- central urban areas/market towns with surrounding rurality

**The majority of health data at a local level is available by GP Practice. It was therefore necessary to ensure that each geography included the same people living within them as were registered with a GP Practice within that same geography. This is because people do not necessarily register with the GP Practice closest to where*

they live and in urban areas such as Taunton GP Practices might be very close to one another

The geographies would not reinvent the wheel, reflect existing service use or locations, highlight thematic issues (such as deprivation and rurality which could be considered independently) and would not highlight very localised issues at the neighbourhood level.

Methodology

District county boundaries

The first element was to ensure that geographies were limited by the district county boundaries. This was because they are clearly defined and rarely change while they are also widely recognised areas. They also contained the existing GP Commissioning Locality groupings based on the location of GP Practices' main surgery. A further consideration is that many indicators are only available at this level.

Middle Layer Super Output Area (MSOA) boundaries

MSOAs are Office for National Statistics (ONS) census based geographies. The latest MSOAs were designed to include approximately 7,500 people each at the time of the 2011 census. Most statistical data (including the Index of Multiple Deprivation which is key to analysing inequality) is available and calculated based on Lower Super Output Areas (LSOAs). LSOAs are similar to MSOAs but included roughly 1,500 people. MSOAs are the building blocks of the JSNA geographies because:

- they are consistent as they are only ever revised with a national census and these are usually at least a decade apart.
- MSOAs are groupings of LSOAs and that means LSOA data can easily be aggregated to MSOA levels.
- Some data and indicators are only available at MSOA level, including some economic data.
- Some services and outcomes will only be used or experienced by very small proportions of the population. Using MSOAs should therefore prevent issues around data sharing due to risks related to identifying individuals and might facilitate data sharing in some rare cases.

Other factors

The only two rules that defined the geographies were that they would use MSOAs as the building blocks and would be contained within district boundaries.

How the MSOAs were then grouped was based on the considerations given above, namely that they would have:

- rural areas with core market town(s)/urban areas. This was guided based on ONS rurality classification of LSOAs and LSOA population density.
- they would have people who both live within the same area as they register with their GP. This was based on data from NHS digital showing the number of people at each GP Practice who live within each LSOA
- furthermore the South Somerset areas teams were used as the basis for geographies within that district as a reflection of how people interact with local services. This was partly due to a recognition that South Somerset was too big to adequately reflect people's experiences and was learning taken from the Somerset Pharmaceutical Needs Assessment
- consideration was given to balancing population size, rurality and deprivation

The Process

Some initial boundaries were drawn and these were then tested against the points listed above. These were then refined by testing different scenarios and different collections of MSOAs.

Validation

The primary driver was the proportion of people who were registered with a GP Practice and who lived within the same area. The final range was between 83% and 98%.

The following points were used for validation purposes but were not set rules. There were exceptions and these are listed below.

- Average IMD scores were calculated for each geography and were compared with the range of scores of the middle 50% LSOA across Somerset.
- The proportion of people living in rural villages and dispersed areas was compared with the Somerset average +/- 10%.
- The population size was compared.
- Subsequently the engagement event with the Health and Wellbeing Board led to some refinements.

A similar test to the GP registration and residence was performed to validate the final geographies with the proportion of school age children who live in the same areas as their school. Final range was 79% to 99%.

Exceptions

The exceptions to these principles above are listed below.

South Somerset geographies Yeovil's population was sizable and its population largely registered with GP Practices in the same area. This meant that Yeovil was less rural than the bounds set above: while Wincanton and Chard areas were more rural than the bounds set above.

The workshop engagement event led to the creation of a Wellington area within Taunton Deane. This meant that the remaining Taunton area also had a smaller proportion of people living in rural areas than the limits above.

West Somerset currently as both a district in its own right and also a very distinctive area of the county had an average Index of Multiple Deprivation score higher than the bounds above.

It should be noted that at a population level and where data is available, differences in deprivation and rurality can be accounted for in analysis in the same way that differences in age and sex can.