

## Chapter Five Commissioning strategies

# The role of needs analysis in developing a commissioning strategy

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by Colette Dartford



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## Abstract

This paper considers the role of needs analysis in developing a commissioning strategy, and proposes a methodology for undertaking it. The methodology outlines how agencies could use four categories of data – demographic data, prevalence and incidence data, risk factor data and service user data – in order to understand the needs of their populations, and specifically, the needs of vulnerable adults. The paper concludes that notwithstanding the limitations of needs analysis, it is nevertheless an important part of the commissioning of community care services.

Key words: methodology; data; populations; demography; prevalence; incidence; risk factors; needs analysis.

## Introduction

Needs analysis is a way of estimating the nature and extent of the needs of a population so that services can be planned accordingly. Therefore the purpose of undertaking a needs analysis is to help focus effort and resources where they are needed most. In this sense, needs analysis is an important element of commissioning, which is understood as “the process of specifying, securing and monitoring services to meet people’s needs at a strategic level”.<sup>1</sup>

As the above quote suggests, commissioning is a strategic activity which, according to the model proposed by the Institute of Public Care (see ‘Introduction’ in chapter 1), entails four cyclical stages: the analysis stage, the planning stage, the doing stage and the reviewing stage. Needs analysis is located within the first stage of the commissioning cycle – the analysis stage. This is because a robust needs analysis provides commissioning agencies with a range of information that can feed into and inform the planning stage of the commissioning cycle. For example, needs analysis can:

- **help estimate the current and future needs of a population**
- **indicate the geographical distribution of need**
- **identify those people who are at greatest risk of needing community services**
- **help identify the gap between met and unmet need**

Evidence from a needs analysis can indicate where resources might best be focused and where services might be located. Of course, commissioning decisions will not be based on the evidence of needs analysis alone, but within the context of other factors such as national policy and guidance, evidence regarding best practice, market analysis and risk analysis. A comprehensive review of these factors will help commissioning agencies decide which services will best meet the needs of their communities.

<sup>1</sup>SSI/Audit Commission (October 2003). Making Ends Meet.

This paper proposes a method, developed by IPC, of undertaking needs analysis to help inform the commissioning of community care services, and hopefully strikes an appropriate balance between complexity and simplicity.

## Methodology

A needs analysis should begin with a profile of the local population disaggregated by age, gender, ethnicity and location (demographic data). Once demographic data has been collected and analysed, prevalence and incidence data relating to the target population (the particular group of people for whom services are to be commissioned) should be sourced and applied to the demographic data. This allows commissioning agencies to estimate the size of the target population, its demographic profile and the type and severity of need. The third category of data required to undertake a needs analysis is data relating to the sorts of risk factors that may lead members of the target population to require community care services. Finally, a needs analysis should profile current service users and determine the extent to which existing services meet their needs and should help estimate unmet need. Therefore, a comprehensive needs analysis is based on a balance of national and local data and consists of four elements:

- **demographic data**
- **prevalence and incidence data**
- **risk factor data**
- **service user data**

The following sections will explore each of these categories in more detail and for illustrative purposes, the target population is taken to be older people although, where appropriate, other target populations will be referred to and examples offered.

### Stage 1: Demographic Data

Sourcing and analysing robust demographic data is the first stage of a needs analysis. This demographic data will allow commissioning agencies to understand the characteristics of their population in terms of age, gender, ethnicity and location, and provide a basis for applying prevalence and incidence data relating to the target population (stage 2). For example, agencies responsible for commissioning services for older people would need to know about their local population of older people in terms of:

- **current and future numbers**
- **age range**
- **gender**
- **life expectancy**
- **ethnicity**

#### Current and future numbers

Because commissioning decisions are long-term and strategic, a needs analysis undertaken for the development of a commissioning strategy will not only require data about the current numbers

within a population, but also data about how that population is projected to change over time. For example, when commissioning services for older people it is particularly important to know about future projections because the Office for National Statistics has produced demographic forecasts indicating an increasing population of older people and a relatively stable population of younger people. The implication of this demographic spread is that a greater demand for services is likely to coincide with a diminishing workforce within those services.

For example, in North Yorkshire, people aged 65 and over currently account for around 19% of the population. However, population projections suggest that by 2025, people aged 65 and over will account for around 55% of the population. The rise in the proportion of 65s and over during this period needs to be considered within the context of a general population rise over the same period of only 9%<sup>2</sup>. The implication for the demand on services for older people is that commissioners are going to have to consider whether the current pattern of provision is sustainable and if it isn't to think creatively about alternatives.

Population projections are an important data source in estimating future need and placing that need within the context of general population change. The Office for National Statistics produces long term sub-national population projections which represent an indication of the future trends in population by age and gender over the next 25 years.

They are trend based projections, which means assumptions about future levels of births, deaths and migration are based on observed levels over the previous five years. They show what the population will be if recent trends in these observed levels continue but do not take into account future policy changes. The latest sub-national population projections available for England are based on the 2003 mid-year population estimates (published 09 September 2004) and project forward the population from 2004 to 2028.

Finally, it is important to disaggregate the data about current numbers either by district, locality or ward. Generally speaking, population tends to be more concentrated in urban areas and less concentrated in rural areas, and it is important for commissioners to be aware of the geographic distribution of the populations whose needs their services are designed to meet.

### **Age range**

Once an overview of current and projected numbers of the population has been determined, the next step is to know about the age range of that population. This is particularly relevant when commissioning services for older people because the rate of growth tends to be greatest within this population, with significant differences between age groups. For example, the greatest predicted rise in population is in those aged 85 years and over. Following on from the example used earlier, the numbers of people aged 85 years and over in North Yorkshire is predicted to rise by 88% over the next twenty years. This has significant implications for the commissioning of services because this age group is likely to place the greatest demands on those services. A good example is in the case of dementia services with evidence suggesting that after the age of 65, the risk of suffering from the disease doubles every five years<sup>3</sup>. This means that by the age of 85, 25% of people will suffer from dementia and with significant predicted population growth within this age group, the demand for dementia services will increase substantially.

Again, it is important to understand age range within the context of the geographical distribution of the population. For example, those commissioning services for older people should know in which areas older people tend to live. This is not to suggest a necessary correlation between numbers

<sup>2</sup>2003 based sub-national population projections, Office for National Statistics.

<sup>3</sup>Audit Commission (2000). Forget Me Not: Mental Health Services for Older People.

and need, since other variables (such as deprivation) will carry greater weight. However, building a profile of the population in terms of current and future numbers, age range and location, is the first step in undertaking a robust needs analysis and as such, it should be done as thoroughly as possible.

### **Life expectancy**

When commissioning services for older people it is important to have an understanding of likely life expectancy. The population of Great Britain has been living longer over the past 20 years, but the extra years have not necessarily been lived in good health. Life expectancy and healthy life expectancy (expected years of life in good or fairly good health) both increased between 1981 and 2001, with life expectancy increasing at a faster rate than healthy life expectancy.

Life expectancy is higher for females than for males. In 2001 the life expectancy at birth of females was 80.4 years compared with 75.7 years for males. However, life expectancy for males has been increasing faster than for females with an increase of 4.8 years in male life expectancy between 1981 and 2001 compared with a corresponding increase for females of 3.6 years. The gap in healthy life expectancy between males and females is smaller than for total life expectancy. In 2001, healthy life expectancy at birth was 67.0 years for males and 68.8 years for females, a gap of 1.8 years. The difference between life expectancy and healthy life expectancy can be regarded as an estimate of the number of years a person can expect to live in poor health. In 2000, the expected time lived in poor health for males was 8.7 years. Females can expect to live longer in poor health than males so that in 2001, the expected time lived in poor health for females was 11.6 years<sup>4</sup>.

The Government Actuarial Department produces national life tables which provide statistics on expectation, making it possible to calculate life expectancy at given points in time, as well as from birth. These tables indicate that in 2005, a 65 year-old man residing in England can expect to live for a further 17 years, bringing his life expectancy to 82 years. Similarly, a 65 year old woman residing in England can expect to live for a further 20 years, bringing her life expectancy to 85 years. Life expectancy increases with age so that a 75 year old man living in England can expect to live a further 10 years and a 75 year old woman living in England can expect to live a further 12 years. For the purposes of commissioning community care services, these life expectancy statistics should be considered in conjunction with statistics about healthy life expectancy, with the difference between the two understood as the period of greatest risk for the target population needing those services.

### **Gender**

Although populations tend to consist of around 50% men and 50% women, it can still be useful to disaggregate a population by gender, particularly if gender is likely to be a factor that might influence the type of services that are commissioned. For example, among older people there are around three times as many women as there are men in the 75 and over age group and this might be important in considering the configuration and staffing of services. Gender differences are also relevant when commissioning learning disabilities services since males are more likely to have a learning disability than women<sup>5</sup>. Similarly, when commissioning mental health services it

<sup>4</sup>Office for National Statistics [www.ons.gov.uk](http://www.ons.gov.uk). Also see House of Lords Science & Technology Committee. (July 2005). Ageing: Scientific Aspects Volume 1.

<sup>5</sup>Professor Eric Emerson (2001). Learning Disabilities: The Fundamental Facts.

might be important to know that women are more likely than men to suffer from depression, neuroses and phobias<sup>6</sup>.

### **Ethnicity**

As with the other demographic factors identified above, ethnicity is a factor which may be important for understanding the needs of a population. For example, research suggests that people from South Asia (most notably Pakistan and Bangladesh) may have a higher rate of severe learning disabilities than would be found in the general population<sup>7</sup>. Therefore, agencies responsible for commissioning learning disability services should seek to understand the number and characteristics of the South Asian population within the wider community for which they are responsible. Similarly, when commissioning services for older people in an area of high ethnic diversity it may be important to consider the role of the ethnic elder. Research recommends that community services should be sensitive to the diverse cultural, religious and specific needs of black and ethnic minority older populations, especially as these populations are predicted to increase. Age Concern reports that information about older people's rights and how to access the range of available services may often not get through to these communities. It recommends that information should be widely disseminated to ethnic communities in new and imaginative ways, in appropriate languages, and with the opportunity to ask questions<sup>8</sup>. These are factors which agencies might wish to consider when commissioning services for older people in areas of ethnic or cultural diversity.

### **Summary of demographic data**

Table 1 summarises the sorts of demographic data that would form the basis of a needs analysis, together with a list of suggested sources and examples of the types of questions that might be

<sup>6</sup>Office for National Statistics (2000). Psychiatric Morbidity Among Adults Living In Private Households.

<sup>7</sup>Professor Eric Emerson (2001). Learning Disabilities: The Fundamental Facts. Also see Emerson, E. & Hatton, C. (2004). Estimating Future Need /Demand for Supporting Adults with Learning Disabilities in England. Institute for Health Research, Lancaster University.

<sup>8</sup>Age Concern and the National Council on Ageing (2002). Black and Minority Ethnic Elder Issues.

**Table 1: Demographic data for needs analysis**

Demographic Data Required	Data Sources	Target Population	Questions to Consider
Current numbers of people, disaggregated by district/locality/ward	2001 Census, ONS	All	In which areas are the target population most concentrated?
Projected numbers of people, disaggregated by local authority	2003 Sub-National Population Projections, ONS	All	Which age groups have the least/greatest projected growth and over what period?
Age Range	2001 Census (Theme Table 06)	Older People	Which localities/wards have the greatest concentration of older people? Which localities/wards have the greatest number of people aged 85 and over?
Life Expectancy	ONS Life Tables, Government Actuarial Department Ageing: Scientific Aspects, House of Lords, 2005	Older People	What is LE of people currently aged 65/75 etc?  What is the difference between LE at 65/75 etc and healthy life expectancy (HLE)
Gender	2001 Census, ONS	All	In which age groups are there significant gender imbalances?
Ethnicity	2001 Census, ONS	All	Which ethnic minorities live in the authority, and in which localities/wards? What is the age range amongst ethnic minorities?

considered. It should be emphasized that this is not an exhaustive list, but designed to stimulate thinking about what sorts of data are useful and why.

## Stage 2: Prevalence and Incidence Data

Having built up a comprehensive demographic profile of the local population, the next stage in a needs analysis is to source prevalence and incidence data relating to the target population (the particular group of people for whom services are to be commissioned) and apply this to the demographic data. This allows commissioning agencies to estimate the size of the target population, its demographic profile and the type and severity of need.

It is important to understand the distinction between prevalence and incidence data. Prevalence data reports on the total number of cases, old and new, existing in the population at any given time whilst incidence data reports on the number of new cases arising in a population over a given period of time, usually one year. Chronic incurable diseases such as diabetes can have a low incidence but high prevalence whereas short-term diseases, such as the common cold, can have high incidence but low prevalence. It is important for those undertaking a needs analysis to know which type of data – prevalence or incidence – is useful in which contexts. Therefore, a commissioning strategy for older people might consider, among other things, the prevalence of diabetes and dementia, and the incidence of strokes and falls.

The second point to bear in mind when considering which prevalence and incidence data is relevant to which target population, is that prevalence and incidence data is usually disaggregated by variables such as age, gender and /or ethnicity. For example, research suggests that:

- The prevalence of dementia increases with age<sup>9</sup> so different prevalence rates should be applied to different age groups.
- The incidence of falls increases with age<sup>10</sup> and this would need to be taken into account when calculating the risk of falls in a target population of older people.
- Alcohol and substance abuse is five times more common in men than women<sup>11</sup> so an analysis of need should apply prevalence rates differentially according to gender.
- People from Pakistan and Bangladesh have a higher prevalence of learning disabilities, especially severe learning disabilities, than is found in the general population<sup>12</sup>. A needs analysis for adults with learning disabilities should therefore identify these ethnic minorities in terms of the numbers of people (both current and projected), their age range (ethnic minority populations tend to be younger and may have different life expectancies to the general population), gender and location.
- African Caribbean adults are more likely to be diagnosed with schizophrenia (4.3 times for men and 3.9 times for women<sup>13</sup>) than other ethnic groups, again suggesting that differential prevalence rates should be applied to different ethnic minorities.

The examples above demonstrate the importance of having robust demographic data as a basis for needs analysis, and why that data should be disaggregated by key variables. Table 2 suggests some useful sources of prevalence and incidence data for different target populations. Again, this list is not exhaustive but is an example of the sorts of data that might be included in a needs analysis and the sorts of questions it might address.

<sup>6</sup>Office for National Statistics (2000). Psychiatric Morbidity Among Adults Living In Private Households.

<sup>7</sup>Professor Eric Emerson (2001). Learning Disabilities: The Fundamental Facts. Also see Emerson, E. & Hatton, C. (2004). Estimating Future Need /Demand for Supporting Adults with Learning Disabilities in England. Institute for Health Research, Lancaster University.

<sup>8</sup>Age Concern and the National Council on Ageing (2002). Black and Minority Ethnic Elder Issues.

<sup>9</sup>Audit Commission (2000). Forget Me Not: Mental Health Services for Older People.

<sup>10</sup>Scuffham, P. et al. Journal of Epidemiology and Community Health, Volume 57, No.9, Sept. 2003, pp 740-744.

<sup>11</sup>Men's Mental Health, MIND Factsheet.

<sup>12</sup>Emerson, E. & Hatton, C. (2004). Estimating Future Need / Demand for Supporting Adults with Learning Disabilities in England. Institute for Health Research, Lancaster University.

<sup>13</sup>Fernando, S. (1991). Mental Health, Race and Culture. MIND Publications.

**Table 2: Prevalence and incidence data for needs analysis**

Full references, together with a list of other sources, can be found at the resources section of the eBook.

Target Population	Prvalence/ Incidence Data	Examples of Data Sources	Examples of some questions to consider
Older People (OP)	Mental Health (eg dementia/depression)	Forget Me Not (Audit Commission)  NSF for Older People	How many OP are likely to suffer from dementia/depression and where do they live? How many are known to social services? How many are likely to suffer from the disease in 5/10 years time?
	Physical Disability	Health Survey for England 2000 (DoH)	Which types of disability are most common and at what ages? Which disabilities are most likely to lead OP to need services?
	Limiting Long-Term Illness (LLTI)	Census 2001 (Theme Table 06)	Which wards/localities have the most OP with LLTI?
	Sensory Impairment	Ageing: Scientific Aspects (House of Lords)	Sensory impairment increases with age – which wards have the highest numbers of people aged over 75/85?
	Cardiovascular Disease (eg stroke/heart attack)	Public Health Observatories	How many OP have had strokes etc and in which areas? What degree of disability are they likely to have sustained?
	Falls	NSF for Older People	Compare incidence of falls from research to number of new service users referred because of injury from fall
	Chronic Disease (eg diabetes/asthma)	Public Health Observatories	In which wards do OP with greatest levels of chronic disease live?
	Musculoskeletal Disease (eg osteoporosis/arthritis)	Ageing: Scientific Aspects (House of Lords)	In which wards do OP with the greatest levels of musculoskeletal disease live?
Ethnicity	Policy Research Institute on Ageing & Ethnicity	What are the particular health problems of black and minority ethnic elders? In which wards/localities do ethnic minorities live? What are their characteristics in terms of age/gender?	
Adults with Learning Disabilities (LD)	Current demand	Learning Disabilities: The Fundamental Facts	How many adults with moderate/severe LD are likely to live in the area? What is their distribution in terms of age/gender etc? How many adults with LD are known to social services? What is their distribution in terms of age/gender/ ethnicity?
	Future demand	Estimating Future Need/Demand for Supporting Adults with Learning Disabilities in England	What are the likely projected numbers of adults with LD? What is their distribution in terms of age/gender/location?  Is there a South Asian ethnic minority? If so, where are they located?
	Ethnicity	Learning Disabilities: The Fundamental Facts  Tizard Learning Disability Review	What are the likely projected numbers of people from ethnic minorities with learning disabilities? What is their age profile and where do they live?

Target Population	Prvalence/ Incidence Data	Examples of Data Sources	Examples of some questions to consider
Adults with Physical Disabilities (PD)	Physical morbidity	Health Survey for England 2001	How many adults are likely to have severe PD and what is their distribution in terms of age/ gender?
	Acquired brain injury (ABI)	Headway	Which areas have the greatest numbers of young men? (they are 5 times more likely to suffer ABI)
	Spinal injury	Apparelyzed	How many adults in the area are likely to have spinal injury and what are the causes/ outcomes?
	Cerebral palsy	Scope	How many people with cerebral palsy are known to health & social services?
	Multiple Sclerosis (MS)	Multiple Sclerosis Trust	Twice as many women than men have MS and some ethnic groups have higher prevalence – what is the distribution of population in terms of gender/ethnicity?
Adults with Mental Illness	Psychiatric Morbidity	ONS	How many adults are likely to suffer mental illness? What is their distribution in terms of age/gender/ethnicity/location? How severe is their mental illness likely to be?
	Ethnicity and mental health	MIND	Which ethnic groups suffer greater levels of mental ill-health than found in the general population? In which wards/localities do they live? What are their characteristics in terms of age/gender?
	Men's mental health	MIND	What are the differences in the mental health of men and women? How should these be incorporated into needs assessment?
Substance Misuse	Current demand	British Crime Survey	What are the likely numbers of substance misusers in the area and what is their profile in terms of age/gender/ethnicity? What substances do they abuse?
	Psychiatric morbidity (hazardous drinking /drug dependency)	ONS	What are the likely levels of hazardous drinking and alcohol dependence? What are the differences in prevalence according to age/gender?  What are the likely levels of drug dependence in the authority? What are the differences in prevalence according to age/gender?
	Geographic variance	Home Office	What does research indicate about the prevalence of substance misuse in a geographical area?  What are the differential prevalence rates for substance misuse among ethnic minorities?
	Ethnicity and substance misuse	Home Office	What is the profile of ethnic minorities in the authority in terms of age/gender/location?
	Gender and substance misuse	Home Office	What are the differential prevalence rates for substance misuse among women?

Table 2 offers a range of data sources and suggested questions for different target populations. Some of the questions are designed to estimate unmet need within an area, for example, within a target population of adults with learning disabilities you might consider:

- According to the research on prevalence, how many adults with moderate/severe LD are likely to live in the geographic area?
- How many adults with LD are actually known to social services?

The difference between these two figures can be understood as an indicator or estimate of unmet need. For example, research by Professor Eric Emerson suggests that for every 1,000 adults, between 4 and 6 will have severe learning disabilities. If this prevalence rate is applied to the adult population of Oxfordshire (605,488 in 2001), there are likely to be between 2,422 and 3,633 adults with severe learning disabilities (4 x 605.488 – 6 x 605.488). However, if only 1500 adults with severe learning disabilities were known to social services, the difference could be interpreted as an estimate of unmet need. This could either be expressed as a number, or range of numbers (922 – 2,133 adults) or as a rate (2.5 per 1,000 adults). Therefore, if a commissioning strategy is to include intentions about identifying and addressing the issue of unmet need within a target population, this is a relatively simple method of calculating it. Of course, if other variables are factored in, such as ethnicity, then a more detailed picture of unmet need can be developed, but the task would be a more complex one because each of the variables would have to be appropriately weighted. To continue with the example above, if Oxfordshire had a sizeable South Asian community, bearing in mind that research identifies higher prevalence rates of severe learning disabilities within that community, it could be expected that adults from South Asia would feature proportionally among those known to social services. If this was not the case, it might indicate a significant degree of unmet need within the South Asian community and ways of addressing that would need to be developed.

### **Stage 3: Risk Factor Data**

The third stage in undertaking needs analysis is to identify risk factors that may lead members of the target population to require community care services. These risk factors are identified through research and it is helpful if the person undertaking the needs analysis has some knowledge of the issues relating to the target population. For example, research indicates that deprivation is a risk factor for substance misuse but not for severe learning difficulties. Similarly, research indicates that gender is a risk factor for suicide but not for dementia. Table 3 lists some of the risk factors identified through research for different target populations.

**Table 3: Risk factor data**

Target Population	Risk Factors	Examples of Data Sources	Examples of some questions to consider
Older People (OP)	Deprivation	Index of Multiple Deprivation 2004	Which of the most deprived wards have the greatest number of OP?
		General Household Survey 2002	Which of the most deprived wards have the greatest numbers of OP aged 75/85 and over?
		ESRC Growing Older Programme	Which wards have the greatest numbers of OP living alone?
	Living Alone	Census 2001 (Theme Table 06)	
		MORI (Independent Living Survey)	
	Lack of transport	Census 2001 (Theme Table 06)	In which wards do OP without a car live? Are these wards well served by public transport?
	Poor quality accommodation	Census 2001 (Theme Table 06)	How many OP have no central heating? Do they live alone? In which wards do they live? How many excess winter deaths were there in the authority?
		English House Condition Survey 2001	
	Poor Health	Census 2001 (Theme Table 06)	How many OP report LLTI and what is their profile in terms of age/gender/location/ethnicity? How many excess winter deaths were there in the authority?
		General Household Survey 2002	
Ageing: Scientific Aspects			
Provision of unpaid care	Census 2001 (Theme Table 06)	How many OP provide unpaid care? How many hours of unpaid care do they provide? How many carers are in poor health? How many are unpaid carers? Do unpaid carers live in deprived wards?	
	Help the Aged		
	Social Policy Research Unit (York)		
Adults with Learning Disabilities (LD)	Mental Illness	MIND	How many adults with LD are at risk of suffering mental illness? What is their profile in terms of age/gender/ethnicity? How many adults with LD are likely to experience early onset dementia?
		Alzheimer's Society	
	Provision of care	MIND	How many people with LD are being cared for at home? What is the age/health of carers?
Adults with Physical Disabilities (PD)	Deprivation & Social Exclusion	MIND	How many adults with LD are in employment and how many receive welfare benefits?
		Social Exclusion Unit	How many adults with PD are in employment and how many receive welfare benefits?
	Provision of care	Joseph Rowntree Foundation	Does their disability isolate them from the community?
DoH		How many people with PD are being cared for at home? What is the age/health of carers?	

Target Population	Risk Factors	Examples of Data Sources	Examples of some questions to consider
Adults with Mental Illness	Deprivation & Social Exclusion		How many adults with mental illness are in employment and how many receive welfare benefits?  Does their illness isolate them from the community?
	Provision of care	NSF for Mental Health DOH	How many people with mental illness are being cared for at home? What are the age/health of carers?
Substance Misuse	Deprivation & Social Exclusion	Drugscope	Which wards/localities have the greatest levels of deprivation?
	Crime	Census 2001 Home Office	Which wards/localities have the highest levels of crime?
	Homelessness	Drugscope ODPM	Are there estimates for the numbers of homeless adults in the authority? Where is homelessness concentrated?
	Ethnicity	Census 2001 Home Office	What is the relationship between ethnicity and drug use?

Data about risk factors, when taken together with demographic data and prevalence and incidence data, can help commissioning agencies to understand the needs of their target population. For example, needs analysis would allow a commissioning agency to estimate how many adults with learning disabilities there were likely to be in their area; their age, gender, ethnicity, and the severity of their disability. A comparison between this and the numbers of adults with learning disabilities actually known to them would allow an estimate of unmet need. Future levels of demand for services could be estimated using population projections and specific research into factors such as the improved survival rates of children with complex disabilities, the improved life expectancy of adults with learning disabilities and the particular needs of ethnic minorities.

The demand for mental health services, including dementia services, could also be estimated with reference to research indicating that adults with learning disabilities are more likely to suffer from an episode of mental illness during their lives than the general population (40% compared with 25%) and more likely to suffer from dementia, with early onset. Indeed, the onset of dementia for people with learning disabilities frequently happens in middle age and commissioning decisions would need to be made not only about the level of future demand, but what services would be appropriate. Evidence from research also indicates that adults with learning disabilities are at greater risk of living in poverty and of being socially excluded than other groups. The majority do not find work and those that do are usually in low-paid work. Most adults with learning disabilities (around 60%) live with their families and 40% of parents caring for them are over the age of 60. When the carer becomes elderly, frail or simply cannot cope anymore, both the carer and the person they are caring for may require considerable support from health and social care agencies. Although a needs analysis cannot identify individuals at risk, it can identify the range of factors that put individuals at risk so that commissioning agencies can make strategic decisions about how that risk might be minimized.

#### Stage 4: Service User Data

While the three stages described above are concerned with data about demography, prevalence, incidence and risk, a comprehensive needs analysis should supplement nationally published data with local intelligence and data about local service users.

Local intelligence might relate to recent increases in the number of people from ethnic minorities or plans to build a large housing development, for example. These factors will not show up in demographic data from the 2001 Census but may be very important in understanding patterns of local need. It is crucial, therefore, that agencies undertake periodic surveys and make these available for inclusion in needs analysis designed to inform the commissioning of local community care services.

With regard to service user data, some of this will already exist in the form of routinely collected data sets, the results of local population surveys and published or unpublished research papers. Existing data sets are a good place to start an analysis of current service users because they provide information about service activity, cost and performance. It is also useful to profile existing service users in terms of age, gender, ethnicity and location, and compare this to the sort of profile that would be expected from an analysis of demographic, prevalence, incidence and risk data. For example, deprivation is a risk factor for several target populations, areas of deprivation are often the areas of greatest need. Therefore, it could be expected that people residing in deprived areas would be well represented among service users within these target populations and if this is not the case, questions might be asked as to why. A fit between geographical need and provision might also be expected and the degree of fit could be discerned by comparing the findings of a needs analysis with the findings of a service mapping exercise.

In addition to analysing existing data about service users, it may be necessary to supplement this with further research. For example, in trying to understand the degree to which a local service meets the needs of those who use it, a representative sample of service users (representative in terms of age, gender, ethnicity, locality and type of service being received) could be surveyed and the findings incorporated into the needs analysis. For example, adults accessing tier 2 substance misuse services could be asked whether drop-in centres were open at the times they were needed, whether they were located in places that were easy to reach, whether staff were available and able to answer their questions and whether they received the sorts of help and information they needed.

Similarly, it would be helpful for those responsible for commissioning older people's services to understand the reasons why people come into residential care. A sample of care home residents could be interviewed in order to try to identify the critical factors which meant they could no longer manage in their own homes. Although the stated reason might be a fall, the underlying reason might be that the confidence of the older person was so undermined by the fall that they felt they couldn't stay at home. If this is the case, commissioning agencies might decide to prioritise preventative services that have been shown to reduce the incidence of falls among older people, such as the installation of appropriate aids and adaptations. Intensive physiotherapy might also be an option if it led to a quicker recovery and reduced the period of dependence.

There are a number of methods that can be used to elicit this sort of service user data, but as the objective is to identify underlying as well as obvious causes of loss of independence, face-to-face semi-structured interviews would be more appropriate than, say, questionnaires. There is a good range of literature advising on the most appropriate methods of eliciting the views of service users and other stakeholders (see the resources section of the eBook). The important thing to remember when gathering local intelligence is that if useful, robust data is to be elicited, the methods of collecting it must be appropriate for the target population.

**Table 4: Needs analysis data summary (older people)**

<p><b>Demographic Data</b></p> <ul style="list-style-type: none"> <li>• Current numbers</li> <li>• Future numbers</li> <li>• Age range</li> <li>• Life expectancy</li> <li>• Healthy life expectancy</li> <li>• Gender</li> <li>• Ethnicity</li> <li>• Geographical profile</li> </ul> <p><b>Profile of local population</b></p>	<p><b>Prevalence and Incidence Data</b></p> <ul style="list-style-type: none"> <li>• Mental health</li> <li>• Physical disability</li> <li>• Limiting long-term illness</li> <li>• Sensory impairment</li> <li>• Chronic disease</li> <li>• Falls</li> </ul> <p><b>Profile of target population</b></p>
<p><b>Risk Factor Data</b></p> <ul style="list-style-type: none"> <li>• Deprivation</li> <li>• Living alone</li> <li>• Lack of transport</li> <li>• Poor quality accommodation</li> <li>• Poor health</li> <li>• Provision of unpaid care</li> </ul> <p><b>Profile of 'at risk' population</b></p>	<p><b>Local &amp; Service User Data</b></p> <ul style="list-style-type: none"> <li>• Local demographic intelligence</li> <li>• Service activity</li> <li>• Service cost and performance</li> <li>• Unmet need</li> <li>• Stakeholder input</li> </ul> <p><b>Profile of current service users</b></p>

**Conclusion**

The various stages of needs analysis described above involve identifying variables that are relevant to a particular target population, and using these to estimate need. A question that has not been addressed is how these variables might be weighed to identify those in greatest need or at greatest risk of not being able to manage in their own home. Generally, this is a matter of judgment and not one that can be guided by a definitive set of rules. For example, if the degree of risk posed by older people not having access to a car is being considered, this would carry greater weight if those people lived in a rural area with poor public transport coverage than if they lived in an urban area with good public transport coverage. Local knowledge would be required so that those undertaking needs analysis could weight the variable 'lack of transport' in those wards which were not served by public transport. Similarly, the variable 'no central heating' could be expected to carry greater weight for people aged 75 and over, who have limiting long-term

illness and are living alone. These people would be particularly vulnerable to illness or death during the winter months and commissioning agencies would need to know which wards have the highest numbers. Another particularly vulnerable group is older people in poor health who are providing many hours of unpaid care to other older people in poor health. The variable 'provision of unpaid care when carer is in poor health' should therefore be weighted accordingly, particularly when cross-referenced with other variables such as age (eg those aged 75 and over), no central heating and no transport.

So how might needs analysis inform commissioning decisions? Continuing the example of older people services, if an authority had an objective about reducing the number of excess winter deaths by x%, the following data would be required:

- Baseline figure for winter deaths
- The geographic distribution of winter deaths in the authority.
- Risk factors associated with winter deaths (eg fuel poverty, poor quality housing, low uptake of flu jab/old age/poor health).

An observable correlation could be expected between wards with the greatest occurrence of risk factors and wards with the greatest numbers of winter deaths. In order to address the objective it would seem appropriate to target services in those wards. These might include:

- Intensive promotion of influenza inoculations in GP surgeries.
- Initiatives to ensure uptake of all benefits, especially those relating to fuel payments.
- A review of care and repair services to ensure good access, availability and uptake, with perhaps a leaflet promotion in those areas of particularly poor housing stock.

These are just a few of the possible options once a comprehensive needs analysis has identified where they might best be targeted.

Finally, it is important to bear in mind that needs analysis is not a precise science and can be expected to raise as many questions as it answers. Its role is to provide estimates of need and indicate where the greatest need is likely to exist. It can also highlight issues that commissioning agencies might wish to address, such as discrepancies between need and provision, evidence of unmet need within particular sections of the population, or that some services may not be sustainable in their current format because of increased future demand.

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## References

- A full list of sources relevant to needs analysis can be found at the resources section of the eBook.
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## Biography

Colette Dartford joined the Institute of Public Care (IPC) as a research consultant in 2003, having previously worked as a policy researcher for the Higher Education Funding Council. At IPC, Colette had teaching, research and consultancy responsibilities, working with clients across the health, social care and housing sectors. Colette's particular area of expertise was needs analysis and she undertook a number of projects to identify the current and future needs of a range of client groups including older people, adults with physical and learning disabilities and adults with substance misuse problems. Colette also ran workshops and seminars on the role of needs analysis in developing commissioning strategies. Colette left IPC in 2006, but the Institute can be contacted on 01225 484088 or at [ipc@brookes.ac.uk](mailto:ipc@brookes.ac.uk).