

Understanding the Health of Communities:

Using a Health Needs Assessment Approach in Public Health Practice

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Foreword

Many practitioners and educators would argue that public health is here to stay but there remain many different perceptions of what it entails. A simple definition involves working with populations rather than individuals, yet working with a population is difficult until their needs have been identified, preferably with the people themselves.

This is what this publication is about, the search for the health needs of a group, community or locality that make up a population.

Approaches to finding out these needs will change over time. Changes in the relationship with the community, and within, it will develop. Information technology has helped the process of needs assessment develop in recent years and there will, no doubt, be other changes as yet unknown.

This publication provides a starting point for those who want to know more about, or be involved, in health needs assessment.



Introduction

Health needs assessment is central to health care. Doctors and various practitioners are involved in diagnosis, and any registered nurse should undertake a holistic assessment of the patient at the start of the episode of care, and at various points in the process.

Health visitors, school nurses and other community practitioners act in partnership with individuals who are well, and do not see themselves as having health needs. To consider actual or potential health needs, the practitioner works with the family, a community or a population and taking a public health approach, identifies needs with a view to addressing them.

This publication sets out to give an introduction to health needs assessment in the context of public health. It is concerned with the assessment of health needs of groups or communities, rather than individuals or even families.

Pertinent Issues

Any discussion of assessment hinges on clear definitions. How can you consider the extent of something if you are not sure what it is? A good starting point is defining and discussing what is:

Public health,
Health needs assessment.

Public Health

Public Health is usually defined as:

*'the science and art of preventing disease, prolonging life, and promoting health through the organised efforts of society'*¹.

Stereotypically public health is seen as concerned with drains and immunisation. Certainly developments in sanitary engineering had an immense impact on the improvement of mortality in the nineteenth century when contagious disease was a significant cause of death. The creation of the National Health Service can be seen as a major public health achievement², addressing ill health throughout most of the population of the United Kingdom. Discussions in the 1970s queried whether modern medicine was too individualised and concerned with illness, while taking little notice of the social, economic and environmental influences on health. The outworking of these factors was evident in the Black Report³, which argued for policies to address the inequalities that followed from the different influences. The report and its proposals were rejected by the government of the day.

The coming of a different administration in 1997 led to many changes with a clear national public health strategy threaded through policy documents. Material in the Acheson Report⁴ drew attention once again to the determinants of health and the evident inequalities and fed into many different policies such as *Saving Lives: Our Healthier Nation*⁵, *Choosing Health: Making Healthy Choices Easier*⁶ and *Our Health: Our Care, Our Say A New Direction for Community Services*⁷. A brief outline of some of the key documents can be found in Appendix 1.

Public Health - Underpinning ideas

Discussions of the changing face of public health are extensive as they evolve from the underpinning ideas and belief systems. Addressing inequalities in health is a central view that most would espouse. Many would see building relationships with individuals, groups and communities as vital in assessing need and working together on the intervention. Prevention and addressing the causes of ill health, not just the consequences, is a largely shared view. Drawing on the science of salutogenesis⁸,

with its emphasis on coherence and concern with how health can be created or promoted, practitioners will want to focus on activities that contribute to health, promoting a sense of well being, rather than just the negative elements linked to ill health.

Community practitioners will be influenced by the government policy of the day, yet need to reflect on their own view of public health, particularly as for health visitors, occupational health nurses and school nurses, it is in their registered title as a specialist community public health nurse.

In doing this, the *Skills for Health* standards for public health should be a helpful framework. This states practice should seek to improve the health of society by:

- taking a population perspective
- mobilising the organised efforts of society and acting as an advocate for the public's health
- enabling people and communities to increase control over their own health and well being
- acting on the social, economic and biological determinants of health and well being
- protecting from, and minimizing the impact of, health risks to the population.
- ensuring that preventative treatment and care services are of high quality, based on evidence and of best value.

Reflective Activity 1

Think about the way you and your team work. Consider the extent to which the above framework matches practice in your area.

Having a working understanding of public health is only the start. Practitioners will need to consider which health issues to address, leading the discussion to health needs assessment as a way of identifying the issues, and beginning to define priorities. Partnership is a key concept but raises the question of joint working, with whom? Which groups of people, communities or agencies? Looking forward, having identified needs and seeking to work in that area, there are philosophical and pragmatic issues of how needs should be addressed.

Should the focus of interventions be upon the individual or the group? Should the search for health improvements in health outcomes focus on encouraging the individual to make changes in their behaviour, or be something imposed upon a whole group or population by changes in the environment or by legislation? An individual approach was dominant throughout the 1990s and demonstrated in *Health of the Nation*¹⁰. The policies since 1997, outlined above, indicate the use of a collective approach, though some argue the policies are not consistent in their suggested route to improving public health with a leaning to individualism becoming evident in the later documents.

Wanless extended the definition of public health used earlier saying it was the:

*'science and art of preventing disease, prolonging life, and promoting health through the organised efforts of society and informed choices of society, organisations, public and private, communities and individuals'*¹¹ (Pg3)

If one supports this view it is not a case of opting for a collective or individual approach, since clearly both should be involved.

The Department of Health envisaged public health professionals working with other groups to monitor the health status of the community and identify health needs. This is the starting point to *'develop programmes to reduce risk and screen for early disease, control communicable disease, foster policies which promote health, plan and evaluate the provision of health care, and manage and implement change'*¹².

Taking this approach, the identification of health needs is central to public health and not an optional extra. Health needs assessment is as important as any intervention which follows if the population's health is to be developed, but like public health it needs discussion.

Health Needs Assessment

Very simply, health needs assessment can be seen as painting a picture of health issues that might be addressed in a given population, individual or community at a particular point in time.

Defining a Need

It is difficult to identify an objective view of a need. Discussion of what is need may focus on the oft-quoted Bradshaw's taxonomy of need¹³ considering:

Normative need. What professionals, experts, administrators or policy makers define as need in any given situation.

E.g. A proportion of adults in the area under consideration have a body mass index of more than 30, leading to the view that obesity is a need both in terms of preventative and reactive strategies.

Felt need. Need equated with want - what people feel they need.

E.g. If only new mothers had somewhere they could go and meet other mothers to deal with their feelings of uncertainty and isolation.

Expressed need. Demand or felt need turned into action.

E.g. The governors and the parent teacher association campaign hard for a lollipop person to control traffic outside the school as a way of promoting road safety.

Comparative need. A measure of need found by studying the characteristics of those receiving a service.

E.g. Area A seems to have similar indices of lone parents, socio-economic deprivation and children on the child protection register as area B. Surely both should have the same Early Start resources?

Reflective Activity 2

Examples have been given of different views of need. See if you agree with them and consider other examples from an area that you know.

Twenty-five years after writing the taxonomy, Bradshaw¹⁴ himself challenged the idea of the concept of need as useful in policy making. He felt it was too imprecise, too complex and too contentious. And he felt inequalities should be the focus of concern. Taking this view, it would appear there is no shared view on need and therefore needs assessment can be seen as *'messy, variable and multifaceted'*. (Pg133¹⁵).

Many practitioners will talk of profiling an area, caseload, community, school or locality. A profile is just such a picture, and needs assessment of any of these entities should go further, involving analysis of trends and differences with other areas, all working to the identification of priorities for health activities. The term 'needs' often implies a search for problems, but effective profiling should identify the strengths of a community as well as its difficulties, which fits with salutogenesis mentioned above.

Health visitors see the 'search for health needs' as one of their underpinning principles¹⁶. Its close links with public health practice is evident in needs assessment, being part of the proficiencies for entry to the specialist community public health nurses' part of the Nursing & Midwifery Council register¹⁷. It is clearly part of the school nurse role¹⁸ and in many other practitioners' job descriptions. It is interesting that it is not included in the list of school nurse activities considered in the RCN survey of school nurses¹⁹ and it has to be questioned if some health visitors and others see it as part of their regular activities.

In a world of targeted interventions, health needs assessment is the starting point for focusing these activities. It needs to be central to public health practice but is unlikely to be effective without a sound relationship between the health care professional and the community, school or caseload with which she is working.

Value of Health Needs Assessment to Practice

Perceived difficulties in relation to needs assessment which practitioners and students easily identify, include the following:

- Profiling is a time consuming chore required by managers.
- Information is difficult to come by and staff do not have the skills or time to engage in analysis.
- Needs assessment generates ethical issues of identifying needs that cannot be met by raising the community's expectations when the issues identified may not be addressed.
- Needs assessment is seen as an end in itself with little attempt to address any identified needs.
- Objectivity is difficult to establish. One practitioner's view of mental health needs may not be the same as that of another.
- It needs to be undertaken regularly and other pressures may make this difficult.

Advantages of Needs Assessment

Clearly this publication sees health needs assessment as vital with the benefits including:

- Provision of an overall view of the community/caseload. The needs assessment should give a rich and up-to-date view of the community that may be quite different from the last time it was undertaken and from what is expected. The value of the picture that emerges from a profile and the ongoing analysis is inevitably influenced by the time and commitment devoted to the process, which impacts upon its quality.
- Partnership with the community or people who are perceived as having the need, taking their view. This may generate a different perspective from that of the professionals. There are issues related to which groups should be consulted and how. Any community is not a homogeneous group, with different parts having different perspectives and needs. The activities of consultation and partnership are likely to build relationships demonstrating the value of the users as people whose views are valued. Unfortunately, this may only be true if activity follows from the needs assessment.
- Promotion of team working and a common understanding of the strengths and needs of the community within the team. Taking a multi-professional approach to needs assessment should promote interagency collaboration.
- Community practitioners know a vast amount about the areas, communities and individuals with which they work. Health needs assessment should make use of qualitative data, formalising it if necessary, and transferring information into health intelligence.
- A health needs assessment exercise should identify current needs and define, or at least influence, health activities that follow. The extent of the need, (and that might include developing existing strengths, together with the skills and capacity of the team and the concerns of the users), should help prioritise future initiatives. Health needs assessment may, indeed should, lead to a change in practice²⁰. A study of health visitors who had undertaken team based health needs assessment with a specific resource pack,

showed practitioners had an increased understanding of public health concepts, reflected on current practice and had a desire to work differently. Sadly, organisational support to facilitate this is not always available.

- On a wider scale, health needs assessment should feed into the commissioning process so that services which meet the needs of the community have been purchased or commissioned.
- Regular health needs assessment will contribute to the evaluation of previous activities and audit the current state of health in a community, school or caseload.

While many would agree that health needs assessment is a necessary part of public health, we must not deceive ourselves that it is a simple recipe book approach. Cowley and Houston argue that there are competing and contradictory agendas in needs assessment²⁷.

Raymond²² identified a range of perspectives summarised as:

- Citizens' perspectives
- Biomedical perspectives
- Social perspectives
- Economic perspectives
- Political perspectives.

Reflective Activity 3

Think what each perspective may involve. How might each perspective impact on needs assessment and what is done with the information it engenders? Then consult the Raymond chapter²²

Involvement in Health Needs Assessment

Needs assessment is not an exact science, Jenny Billings said there is no standardised procedure, but her five stages provide an incredibly useful framework for the process²³.

1. Clarifying the Purpose

All practitioners have busy working lives and health needs assessment may not be easy, so it is worthwhile at the outset of the process, considering why it is being undertaken at this specific time and what the objective of the activity is.

Potential reasons might include:

- A standard to profile the caseload every two years.
- A sense that the caseload is getting older and more dependent.
- An increase in Accident & Emergency attendance notifications coming to the clinic, and a desire to know if there are reasons for this that could be addressed.
- National increases in adolescent self harm leading the team to question if this is happening in the school and if the mental health needs generally are unmet.

These are the starting points. The purpose and process need to be clarified, as does who should be involved. Partnership with other health care organisations, practitioners, communities and users will increase the value of the findings but may make the project unwieldy.

Who should be involved may be influenced by the question 'how will information be used?' If the aim is to explore infant nutrition, with a view to changing health promotion in this area, working with parents and the local dietician may be most appropriate. Interest in secondary school students' mental wellbeing could involve young people and/or their parents as well as the Child and Adolescent Mental Health (CAMH) team. Practitioners may have ideas about what they want to do, but if they are truly seeking out health needs, decisions should follow the findings, not precede them.

2. Defining the Boundaries

Practitioners need to decide on the focus of the health needs assessment.

Is it to be:

- Population of a particular area or ward.
- Community; E.g. Bangladeshi families in a particular town
- The caseload, either that of the single practitioner or of the corporate team.
- A cohort; for instance all the children born in one particular year
- All individuals with a particular health condition.

The decision made will be influenced by the purpose of the project but the objective should be to keep it as focused as possible. Whatever the starting point, the project will grow and the coordinator needs to ensure that it remains manageable.

3. Getting support

Anyone undertaking any sort of needs assessment, whether as a student exercise or part of practice, needs support. In the workplace this should come from the

manager who should uphold the belief that it is a worthwhile activity that will develop practice, even when there are staff shortages and unexpected rises in the workload. Expert support from someone who has recently undertaken such an assessment is useful, providing someone who will discuss ideas and validate the findings that seem to be emerging.

Depending upon the status and focus of the assessment, information technology (IT) support and research methodology skills, may be required. Many health needs assessments will use secondary data that has already been collected for some other purpose. The collection of primary data should not be taken up lightly, but the team may decide it is necessary, in which case so is support.

4. Identifying, Collecting and Analysing Data

Practitioners hold a vast amount of qualitative data in their heads and quantitative data in their records. They may want to use this or access data that has already been collected by health and social care organisations, voluntary organisations, educational authorities, census data and other bodies.

Both qualitative and quantitative data is valuable, presenting different views. Ideally any data should be collectable, correct, complete, comparable and concise²⁴. One may ask if any data can meet all these criteria, but this should be the aim.

Practitioners seeking to develop profiles of caseloads, or communities often find accessing good quality data a challenge²⁵. Data may not be up-to-date and, when statistical information is available, it is likely to be national data or for a far wider area than that with which the practitioner is concerned. The development of public health observatories has made more data available, and the proposed *Informing Healthier Choices*²⁶ seeks to improve the availability and quality of health information and intelligence across England, making better use of existing data and sharing information between organisations.

Any practitioner needs to use epidemiological data which is now more freely available. Potential websites are highlighted in Appendix 2. Practitioners should be familiar with basic epidemiological terms, some of which are outlined in Table 1. (Pg16) Epidemiological data identifies associations and relationships between health issues and particular groups. It has often been concerned with cause and effect. The effect is clear with infectious disease but there is much evidence that social inequalities impact on health in a variety of ways.^{4, 27}

Many nurses view epidemiological data as correct and fixed, largely because it is statistical data, but it needs to be viewed critically in terms of the following²⁸:

- **Accuracy.** Is one episode of care noted more than once in different places or with re-admissions? The reliability of the data is only as good as the quality of data collected at the beginning of the process. Reflection by nurses on previous experience in relation to diagnosis in stressful hospital wards, multi-pathology around the time of death, and busy clinics in outpatients, usually support the idea that data is not perfect.
- **Completeness.** Are all incidents recorded in the statistical data? Some episodes of ill health will be handled without contact with health professionals, and hence not counted. Home accidents by elderly or very young people are likely to be underreported. With sensitive issues individuals may deliberately go out of area for health care interventions. Figures for attendance at clinics for sexually transmitted disease may not reflect the local area.
- **Timeliness.** Is the data up-to-date? Processing the information takes time. Recent figures on mortality, immunisation uptake and teenage pregnancy may already be 18 months out of date.

- **Validity.** Is the data enumerating what it seeks to count? The classic example is suicide statistics. A lone person found dead with a history of mental illness is far more likely to be classified as a suicide than a person from a caring family where an open verdict may be recorded to spare the family distress. If this really is happening the validity of the suicide figures is called into question. Practitioners need to consider whether this potentially happens in any other areas.

The categorisation of social data has the same difficulties with individuals not always being prepared to share information about their income, educational qualifications and mental health; and issues of accuracy, completeness, timeliness and validity remain relevant.

Some data will not have been collected before and the practitioner may decide it is important to have this information. Even where the data exists it may come in different forms, making comparisons difficult. Historically, health authorities did not correspond with local authorities, but with the coming of Primary Care Trusts (PCTs), boundaries were supposed to be the same as local authorities and boroughs. However, a school's catchment area may have little co-terminosity with the boundaries of the PCT and the areas covered by a specific PCT may also change.

In analysing the data collected from a variety of sources, (primary data the health workers have collected, or secondary data collected by others), the practitioner must consider it critically, looking for possible sources of bias and not using the material to prove a particular point.

If data can easily be criticized, one may wonder if there is any point in using it. In its defence, even less-than-perfect data will give a picture in broad brush strokes, and help to identify the priorities. The practitioner just needs to recognise that needs assessment is not an exact science.

The data, both qualitative and quantitative should lead to the identification of key needs for a community or caseload. It is unlikely there will be only one identified need. Some areas may have many, and others may have less well defined needs but a possibly 'insignificant' need as viewed by outsiders, may be of real concern to those in the area. The classic example of this is the story of the housing estate where despite obvious inequalities and massive health needs, the residents' priority was the problem of dog mess in the streets.

5. Developing Strategies to Meet Need

Throughout the possibly tortuous process of finding and analysing data, the practitioner needs to remember the purpose of the whole operation, which is to find out what the needs of the community or caseload are so they can, in part, be addressed.

Those who have been involved in the process may not initially agree on the priorities. Identification of priorities is an art and a science, involving critical evaluation of the figures, national and local, and reflection on the views of users of the services, and the practitioners. Choices will be influenced by the skills the health practitioners feel they already have.

To give an example: A school health team, parents and children were involved in identifying the health needs of a primary school. The parents felt the priority was head lice, which had been common throughout the school year. The school health team had identified that mental well being was a significant need with several referrals to the Child and Adolescent Mental Health (CAMH) team, and others coming to the school nurse drop-in. The school health team recognised they had health promotion skills and set out to run a head lice awareness week for children, staff and parents with displays and stalls dealing with health lice and building good

relationships. They aimed to recruit children and parents to parenting groups which, while dealing with practical issues such as head lice, exercise and nutrition, would also promote parent-child relationships. In doing this both parents, children and the school nursing team felt some of the health needs of the school were being addressed.

Identifying priorities is not always easy. Decisions will be influenced by the national and trust priorities. There are potential ethical issues of establishing a need that cannot be met with limited resources. Yet the data from the health needs assessment should be used to call for new resources and influence policy impacting on health. This is also a key area of the work of the specialist community public health nurse and their standards of proficiencies¹⁷.

Having completed the collection and analysis of data, identified a need, developed a strategy to meet the need, was it all worth doing? As the health needs assessment was taking place it needed to be evaluated, along with the strategy that it generated. Whether the strategy had positive outcomes will be part of the subsequent health needs assessment. By then however the health needs may have changed, starting the whole process over again.

Summary

Community health needs assessment is a key part of public health and of the role of the specialist community public health nurse in particular, and community practitioners in general.

It needs reflection on existing knowledge of the community and critical thinking about the data that would be useful and what it might indicate.

Health needs assessment is most useful if it is undertaken in partnership. This helps gather different perspectives and builds ongoing relationships. A set procedure may not help everyone, but the Billings²³ stages provide a useful framework involving:

- Clarifying the Purpose
- Defining the Boundaries
- Getting Support
- Identifying, Collecting and Analysing Data
- Developing Strategies to Meet Needs.

Summative Reflective Activity

Thinking about health needs assessment should generate further queries.

Note down those that concern you, reflect upon them and then discuss them with a colleague.

Do needs change over time?

How should this affect the way practitioners work, the allocation of caseload, and the construction of skill mix teams?

*Should there be a universal assessment tool for collecting key data?
The uniform collection of data would aid comparisons, yet areas, schools or caseloads may be very different with their own specific needs. Would a universal tool stifle creativity, with new needs being ignored because they were new? Conversely, would such a tool become so huge to include all potential needs?*

*Is filling in the Trust's caseload analysis true needs assessment?
Does the Trust's caseload analysis foster creative thinking about the local needs?
Does it encourage the development of strategies to meet the highlighted needs?
Is it another paper exercise that has to be done, but makes little impact on practice?*

*Is needs assessment different for school nurses, health visitors, district nurses and community children's nurses?
Yes is an easy answer.
How is it different and why?*

Table 1 Epidemiological Terms	
Birth rate	Number of live births per 1000 population in the relevant year.
Death rate	Number of deaths per 1000 population in the relevant year.
Disease	Factors or events which are capable of bringing determinants about a change in health.
Incidence	Number of new conditions or events occurring in a specified period of time.
Incidence rate	$\frac{\text{Number of new cases of disease over period of time}}{\text{Population at risk of disease in time period}} \times 1000$
Infant mortality rate	Deaths of infants under 1 year per 1000 live births.
Maternal mortality rate	Deaths of females attributable to childbirth per 1000 live and still births in a period of time.
Peri-natal mortality rate	Number of still births per 1000 births and deaths in the first week of life (early neonatal death) per 1000 births (live and still in the period).
Population projection	An extrapolation of population data using known patterns of birth, deaths and migration to predict figures.
Prevalence	The proportion of a defined population who possess a particular condition at a given point in time (point prevalence), or over a particular period of time (period prevalence).
Prevalence rate	$\frac{\text{Total number of cases of a disease at a given time}}{\text{Total population at risk at a given time}} \times 1000$
Standardisation	Controlling for the effects of age and other variables in a chosen issue.
Standardised mortality rate	$\frac{\text{Observed deaths}}{\text{Expected deaths}} \times 100$
Still birth rate	Number of still births per 1000 births (live and still) in period.

Appendix 1

Key Documents Incorporating a Public Health Approach include:

ENGLAND

The New NHS: Modern, Dependable 1997²⁹

This policy led to the setting up of Primary Care Groups that went on to become Primary Care Trusts. These, together with Health Improvement Programmes, aimed to identify and meet the health needs of local communities.

Saving Lives: Our Healthier Nation 1999⁵

This document set out to 'improve the health of everyone and the worst off in particular' (pg5). The focus on inequalities was clear and the policy specifically discussed the role of school nurses and health visitors, identifying settings for health-enhancing activities in schools, families, communities and the workplace.

Making a Difference 1999³⁰

Nurses, midwives and health visitors were highlighted in this paper which repeated the government's intention to modernise the NHS and improve public health. Health visitors were encouraged to develop a family-centred public health approach, and work with individuals, families and communities.

The NHS Plan: A Plan for Investment, a Plan for Reform. 2000³¹

The aim of modernising the NHS and meeting the needs of patients was central to the NHS Plan. The public health approach was suggested to address the inequalities in society.

Liberating the Talents 2002³²

This policy saw community nurses as having core functions in first contact care, chronic disease management, and public health. They should be involved in health protection and promotion programmes to improve health and reduce inequalities.

The NHS Improvement Plan. Putting People at the Heart of Public Services. 2004³³

Plans to improve the health of the population were re-emphasised, using another recurring idea, that of choice. The White Paper pointed out that the public expects high quality service, choice, convenience and local services that need to be appropriate to local circumstances. The appropriateness of the services is clearly dependent on knowing the locality, its demographic components and its health needs. These might be worked out in understanding the age range and ethnic diversity of the population as well as issues such as the levels of literacy and mobility.

The Chief Nursing Officer's Review of the Nursing, Midwifery and Health Visiting Contribution to Vulnerable Children and Young People 2004³⁴

This review looked at a particular population, children and young people, many of whom experienced inequalities. It highlighted that there was a need for earlier identification of vulnerability and more intensive preventive health care for vulnerable families. Various groups of children and young people were identified as having particular needs and there was a call for more action at community level to build health. Taking a wide perspective and linking with recommendations in *Every Child Matters*³⁵, the National Service Framework for Children, Young People and Maternity Services³⁶, there was a desire to strengthen services for children and young people.

Choosing Health: Making Healthy Choices Easier 2004⁶

The Department of Health claimed *Choosing Health* set out how to provide more of the opportunities, support and information people wanted to enable them to choose health. It aimed to inform and encourage people as individuals and to help shape the commercial and cultural environment so that it is easier to choose a healthy lifestyle. It was criticised for putting more emphasis on the individual, rather than the wider community environment, and therefore taking a public health approach.

Our Health, Our Care, Our Say: A New Direction for Community Services 2006⁷

Care in the community may not be a new idea but it was highlighted in this document, which set out the move towards a '*radical and sustained shift in the way in which services are delivered*' (pg6). It sought to bring health and social care together '*ensuring that they are more personalised and that they fit into people's busy lives*' (pg6). The aim was to give people a strong voice so that they are the major drivers of service improvement. Funding should move from acute to community services, and prevention should be overt in service plans.

Reaching Out: An Action Plan on Social Exclusion 2006³⁷

Again, focusing on children, this document highlighted inequalities and sought to provide opportunities, that, if taken, would mitigate the lifelong effects of social exclusion and prevent them being passed down to future generations. A community approach was taken by recognising that, in some cases, the behaviour of some, particularly the most challenging

families, caused real disruption to the community around them.

An Action Plan on Social Exclusion sought to contain

- Better identification and earlier intervention.
This 'health needs assessment' would involve developing and promoting better prediction tools for practitioners, such as health visitors and community midwives.
- Systematically identifying 'what works'.
Effective approaches would be identified, commissioned and utilized.
- Promoting multi-agency working.
- Personalisation, rights and responsibilities.
This would involve the programme building strong and persistent relationships with those who were at risk of exclusion.

Commissioning Framework for Health and Wellbeing 2007³⁸

This was published for consultation in 2007 and was part of the implementation of the White Paper, *Our Health: Our Care, Our Say: A New Direction for Community Services*. Its intention was to work with local communities to keep individuals healthy and independent. It sought to engage local populations and work towards Joint Strategic Needs Assessment (JSNA) by sharing information which would inform commissioning. While seeking views, the document talked of putting people at the centre of commissioning and understanding the needs of populations and individuals. Councils, PCTs and practice-based commissioners should all be involved in JSNA.

The interdependence between work, health and well being was stated, going beyond a solely biomedical approach. To make this happen, incentives, accountability and leadership were offered.

NORTHERN IRELAND

Investing for Health 2002³⁹

The goals were to improve the health of people by increasing the length of their lives, as well as increasing the number of years free from disease, illness and disability, and to reduce inequalities between geographical areas, and socioeconomic and minority groups. The way forward was based on partnership between departments, public bodies, and local communities, voluntary bodies, to tackle the wider determinants of health. Specific objectives focused on the reduction of child poverty, promoting emotional well being, improving neighbourhoods, and offering everyone the opportunity to work in a healthy environment.

Investing for Health Update 2004⁴⁰

This update highlighted the progress made so far in implementing the Investing for Health strategy.

SCOTLAND

Delivering for Health 2005⁴¹

This ongoing 10-year plan sought to tackle the 'sick man of Europe' tag that Scotland has held for some while. The vision encompasses a shift in the way of working, with increased emphasis on prevention, tackling the causes of ill health and providing care in a way that is quicker, more personal, and closer to home. Patients should be able to access more locally provided health care and for those in less well-off areas, the local primary care team will have dedicated resources to reach out and help people with higher risks of ill health.

WALES

Improving Health in Wales: A Plan for the NHS with its Partners 2001⁴²

This long term plan sought to improve the NHS in Wales through partnerships, particularly with social care. It set out a long term programme for improved health and well being, reduced inequalities and first class services for all.

Design for Life: Creating World Class Health and Social Care for Wales in the 21st Century 2005⁴³

This 10-year had the aim of: Life long health Fast safe and efficient services World class care. It built upon *Improving Health in Wales* and had a strong element on prevention-encouraging full public health engagement at local and national levels, all with a vision to improve health and reduce inequalities. The implementation is set out in three-year strategic frameworks; the current is *Redesigning Care 2005-2008*.

Appendix 2

Sources of Epidemiological and Other Relevant Data

Association of Public Health Observatories.

This body facilitates collaborative working of the Public Health Observatories (PHOs) and their equivalents in England, Wales, Scotland and Ireland.

<http://www.apho.org.uk/apho/index.htm>

It is a way of accessing local Public Health Observatories such as the West Midlands Health Observatory on <http://www.wmpho.org.uk/observatory/>

Community Health Profiles.

This flows from Choosing Health and makes available local authority health profiles that are designed to show the health of people in local authorities across England.

Department for Children, Schools and Families.

This can lead to vast amounts of information related to children including the number in receipt of school meals and the performance leagues of their schools.

<http://www.dfes.gov.uk/index.shtml>

Department of Health.

This gives information on hospital episode statistics, health and personal social services statistics.

<http://www.dh.gov.uk/en/Publicationsandstatistics/index.htm>

The Information Centre.

An independent NHS Special Health Authority that collects analyses and distributes national statistics on health and social care.

<http://www.ic.nhs.uk/>

Institute: Health and Life Sciences.

A useful starting point, the site draws on a variety of sources to provide a place to search for statistical data.

<http://www.intute.ac.uk/healthandlifesciences/>

National Statistics Online.

Free access to data produced by the Office for National Statistics, government departments and devolved administrations.

<http://www.statistics.gov.uk/>

Northern Ireland Government.

The Regional Information Branch provides statistics and research. It can be used in association with NISRA below. http://www.dhsspsni.gov.uk/index/stats_research/stats-pubs.htm

Northern Ireland Statistics and Research (NISRA).

NISRA is the principal source of official information on Northern Ireland's population and socioeconomic conditions. <http://www.nisra.gov.uk/>

NHS Wales.

Statistics are available here about the health of the population of Wales and Welsh health and care services.

<http://www.wales.nhs.uk/page.cfm?pid=739>

NSPCC Inform.

Government, official and research statistics on child protection and child abuse.

http://www.nspcc.org.uk/Inform/OnlineResources/Statistics/Stats_Home_asp_ifega26433.html

Neighbourhood Statistics.

This is part of National Statistics and allows you to find detailed statistics within specific geographic areas.

<http://www.neighbourhood.statistics.gov.uk>

Scottish Executive: Health and Community Care.

Statistics and links to sources giving information on health and social care in Scotland can be found here.

<http://www.scotland.gov.uk/topics/Statistics/Browse/Health>

Scottish Public Health Observatory.

Constituency and community health and well being profiles of all parts of Scotland are available on this site.

<http://www.scotpho.org.uk/web/site/home/home.asp>

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Val Thurtle is first and foremost a health visitor but has been involved in the education of all types of community practitioners. She believes health needs assessment is a central part of public health and is vitally important as a means of focusing health interventions to address the existing and potential health issues of a community, school or caseload.

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