Making sense of health needs assessment

SINCE the late 1980s, the concept of health needs assessment has gained increasing prominence within the National Health Service (NHS). This has been prompted by a series of policy initiatives that have expanded the roles of both primary care and public health in the promotion of health as well as in the purchasing and commissioning of health care.[1,2] Throughout all of these initiatives, the importance of health needs assessment in securing an evidence-based, needs-led system of health care has been affirmed. Originally a requirement of purchasing and commissioning authorities,[3] health needs assessment has more recently come to be seen as integral to the process by which primary care responds to local and national priorities.[4,5] With the creation of the new health commissions, public health and primary care are now, more than ever, expected to work in partnership, and with others, towards the development of knowledge concerning local population health status and needs as well as appropriate service provision.[6] The new Labour government is committed to ensuring access to treatment according to 'need and need alone', and to locality commissioning in which GPs and nurses combine to plan local health services.[7] In the light of all these developments, the policy drive for health needs assessment is unlikely to diminish.

Despite such official endorsement, there is no generally shared understanding of health needs assessment, and the phrase continues to mean different things to different people.[8,9] To general practitioners (GPs), needs assessment is typically associated with the use of practice data to identify need. While this approach has the advantage of using local knowledge, it risks failing to recognize the needs of irregular attenders or non-attenders. For example, many patients with angina are not known to their GP,[10] while homeless people, or those with chronic mental illness, may need health care but do not demand it. Moreover, seeing needs assessment primarily in terms of health *care* can risk overlooking the wide range of other factors that impact upon health, including housing, diet, occupational social class, as well as environmental conditions.[11]

While comprehensive needs assessment may therefore start with practice-based knowledge, it should not be limited to this but should incorporate the views of other interested agencies and people, including, in particular, the local patient population. Despite increasing calls for patient participation,[5] research suggests that this remains the exception within primary care.[12] Working with divergent groups of people may be unfamiliar for many GPs, but it is essential if needs assessment is to reveal more than professionally dominated priorities.

Adopting a broad perspective on needs assessment means that any of the following activities may be involved: epidemiological research, locality analysis, development of general practice morbidity networks, evaluation of past activity, screening, review of current medical opinion, audit, evaluation of outcomes, rapid participatory appraisal, and postal survey.[8,13-14] In recognition of the importance of having effective treatments and necessary resources available to tackle any unmet need that is identified, evaluation of the clinical and cost effectiveness of interventions should also be an integral consideration.

The sources of data relevant to health needs assessment may be similarly diverse. From within the practice these might include: computer-based data, community nursing records, audit reports, health visiting profiles, mortality/morbidity registers, and PACT data. Outside of the practice, district, regional, and national data may be obtained from local public health departments and medical libraries. This can include census data, deprivation indices, cancer registry data, and national surveillance information.

Despite the apparent diversity, taken overall, these activities exhibit a number of characteristic features that may be used to set out the main elements of health needs assessment. First, the idea of a systematic approach is clear. Secondly, a population-oriented approach emerges, whether this population be targeted or general. Thirdly, activity is essentially concerned with an active identification of need rather than a passive response to demand. Finally, there is the related suggestion that activity goes beyond the immediate confines of general practice to take into account the views of others (representatives from other agencies and local people), and places a value on data derived from sources both within and outside of the practice. Bearing all this in mind, it is clear that health needs assessment should be approached in much the same way as doing a jigsaw, so that different pieces are put together to give a complete picture of local health.

Despite the increasing prominence of health needs assessment, there is little empirical evidence about practical experience in primary care. A recent report from the Nuffield Institute for Health,[15] based on a postal and telephone survey of 347 practices in northern England, suggests that most needs assessment currently being undertaken in primary care falls short of the approach outlined above. Although results showed that a majority of practices identified health needs assessment as important, this identification was typically based on an understanding of needs assessment as focused on individual care, based on primary care identified priorities, and involving practice-held data. Rarely had needs assessment looked beyond practice priorities or included local consultation. However, on the relatively few occasions when practices had carried out needs assessment that had involved the active identification of need and local consultation, it was considered a valuable exercise, which, although time-consuming, had led to improvements in clinical or management practice.

While further discussion revealed that a majority of practices appreciated, in theory at least, the appropriateness of a proactive, population-based assessment of need, a number of barriers to such care were identified: first, the futility of any activity that identifies 'unmet' need but lacks the resources to subsequently meet such need; secondly, patient-expressed need may not necessarily equate with 'real' need; finally, and most commonly, a clear misgiving about being asked to undertake extra work for which neither the necessary skills nor the resources existed (this was seen as particularly important given an already excessive workload). The possibility of undertaking added responsibilities, especially where this involved time-consuming consultation or the use of data not immediately to hand, was considered unrealistic. So, while theoretical support existed, the practical possibility of needs assessment was questioned.

Overall, the research revealed considerable confusion and some misgivings about health needs assessment in primary care, but also revealed broad support for the principles underlying such an approach to the provision of care. The recent Audit Commission report[16] revealed that fundholder's purchasing plans lacked systematic assessment of population need, while the Nuffield findings suggests this to be characteristic of primary care as a whole. However, examples of successful community health needs assessment, contained within this report as well as

elsewhere,[14,15] show that health needs assessment is both possible and effective. In this regard, it is perhaps noteworthy that of the five practices that had carried out such assessment in the Nuffield research, the majority had been involved in initiatives led by the local department of public health.

While such collaboration may bring about the transfer of appropriate knowledge and skills, it deals less with the problem of the lack of time and other resources identified by practices. The availability of such resources would therefore seem to be an essential consideration if primary care professionals are to be asked to undertake work that they currently consider both extra to, and different from, routine primary care activity. Greater efforts could therefore be made to integrate support for health needs assessment with that currently available for audit activity and postgraduate education. In addition, the examples of successful collaboration between primary care and public health departments at a district level might usefully be applied in the context of collaboration between practices in a locality. Whatever the scale, a team approach within individual practices, and a sharing of workload and resources between practices, will help in achieving a feasible approach to health needs assessment within primary care.

If the results of needs assessment are to lead to changes in services to address the needs identified, then adequate attention must be given to planning and implementation. This includes the need for setting clear objectives, the involvement of relevant stakeholders, and the agreement of criteria for prioritizing needs. However, the problems associated with such planning and implementation in relation to health needs assessment in primary care have been exposed.[17] Current funding arrangements for primary care not only fail to acknowledge the resource implications, but also make response through service development initiatives difficult. If needs assessment is to be effective, then the responsiveness of these funding arrangements must be improved, and the development of local health services more explicitly based on local needs.

Few would argue with the fundamental aims of health needs assessment in helping to ensure the provision of equitable and effective health care. The challenge in pursuing these aims in primary care is twofold: first, to increase the practical understanding of how needs assessments can be undertaken, what support is needed, and what benefits can follow; secondly, to ensure that the results of health needs assessments are sufficiently integrated into the planning and commissioning of local services for them to produce effective change.

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Nurse practitioners in general practice — an inevitable progression?

GENERAL practitioners (GPs) are used to working alongside nurses whose roles overlap with their own. Indeed, there has been a huge expansion in the number of practice nurses over the past 10 years,[1] and the role of the practice nurse has expanded into areas that were previously managed solely by GPs.[2] Practice nurses have made an essential contribution to increasing the range and quality of services offered to patients,[2] and have helped primary care keep up with ever-increasing demands and expectations. General practice must now begin to examine additional options in order to cope with the increasing workload from hospital closures and the 'primary care led' National Health Service.

In *Primary care: the future*,[3] it is argued that the role of nursing in primary care should continue to expand, with nursing staff increasingly sharing the case load of the GP. Some have interpreted such statements as a green light for the development of the nurse practitioner (NP) role, and others as a warning that it is time for GPs to defend their territory.