



Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

Stepping Forward

A Guide To Local Health Needs Assessment

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The Achievers' Guide to Health Needs Assessment

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Introduction

Health needs assessment (HNA) is the first part of a process of identifying and meeting the needs of a population. It is not only the process of identifying the health problems and issues in the community. It is also an exploration of all the resources involved, how they are used, how they could better be used, and where they are lacking. Health needs assessment is used to inform decision making and should lead to change.

This toolkit is in synergy with two national strategies of recent times: the national primary care strategy, *Primary Care: A New Direction*, which was launched in 2001, and the national health information strategy: *Health Information – A National Strategy*, launched in 2004. The former, in particular, sets out a model of delivering primary care based on primary care teams (PCT) and networks (PCN) with one of the early tasks to be initiated being that of needs assessment of the population to be served. Primary care teams and networks are in a strong position to identify the needs of their populations and to provide services which are tailored to those needs. The multidisciplinary team approach of the primary care teams lends great strength to this process. Many professionals have a strong culture of population based need, whilst others have traditionally focused primarily on the needs of the individual.

This resource pack is intended as an introduction to health needs assessment for primary care teams and networks. Texts and workbooks on the subject are developing fast. Section 1 of the pack is based very largely on "Health Needs Assessment - a Rough Guide" produced by the Scottish Needs Assessment Programme and modified by Leicestershire Health Authority. It is by no means the most detailed guide, but its chief strengths lie in the simplicity and clarity of its approach. We are very grateful to the Scottish Needs Assessment Programme and Leicestershire Health Authority for their permission to reproduce it here.

Local examples have been included in Section 1 to give practical illustration of the process. These examples have been drawn from work in Ireland and in the UK both at practice team level and broader community level. The examples chosen have been included to give a feel for the breadth of HNA and its applicability to the local situation. A number of professionals, working currently in the primary care setting, will be comfortable to initiate HNA. However, consideration will need to be given to programmes of training and the resourcing of expertise in HNA as an ongoing feature in the local health offices (LHOs). Also the promotion of patient enrolment will have important benefits in this field as it will in patient care.

The pack is designed so that sections can be photocopied as wished, and updated when necessary. We hope that you will find, within it, a basic first resource to enable you to begin carrying out HNA within your PCT/N areas.

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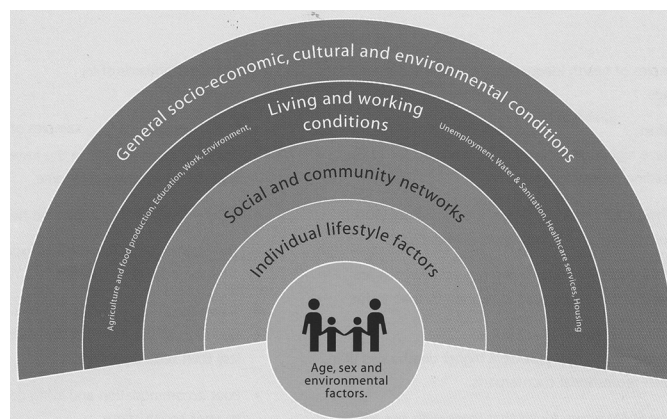
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Section 1

A guide to needs assessment in Primary Care

The broader determinants of health

Achieving full health potential does not depend solely on the provision of health services. Many other factors, and therefore, many other individuals, groups, institutions along with public and private bodies have a part to play in the effort to improve health status and achieve the health potential of the nation. It is important to consider this as an overall concept when setting about needs assessment.



Why bother with needs assessment?

Needs assessment is the process of measuring health needs in the population so that health services can respond to them. This is a document to help you get started on health needs assessment in small populations, such as GP practice populations, primary care teams/networks, small community groups.

Needs assessment will benefit you, your community and your patients. How can it do this?

By:

- **improving the health of people in your community/practice**
The aim of needs assessment is to identify changes which will lead to improvements in the health of your population.
- **helping to make best use of money, services and people who can help**
Needs assessment helps you to prioritise the changes you can make to improve health and how best to target new resources, including those outside the health services.
- **taking a problem solving approach**
In needs assessment your starting point is need rather than services. This helps you to take a wider view of problems and available resources.

- ***involving the community in planning services***
Needs assessment can help you find out the concerns and priorities of local people, and use this information in planning change. If the public is on your side, they may be able to help you to achieve the solutions.
- ***increasing understanding of local health issues***
Needs assessment gives you a better understanding of local health issues and how they are perceived by local people and other agencies.
- ***demonstrating the reasons for your decisions about health care***
Needs assessment helps you to show where you are using resources to best effect to address local health problems. It helps you to make an evidence based case for resources to meet the identified needs. This facilitates accountability to your local community, to the primary care teams/networks and the Health Service Executive/Department of Health and Children.
- ***helping you to take some control over an unpredictable future***
Needs assessment helps you to stand back from the pressures of your everyday life, and take a measured approach to developing what should happen.

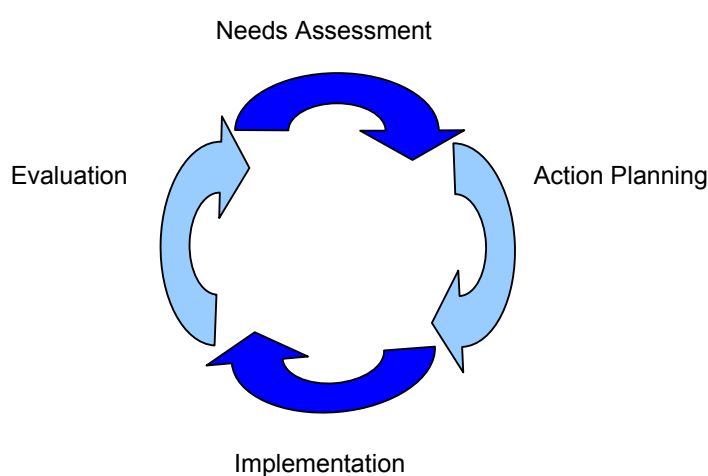
Guiding principles of needs assessment

Before getting started, there are a few guiding principles to remember, whatever your needs assessment is about. These are described in outline below.

1. ***You should be clear about your aims*** from the start in order to choose an appropriate approach. This gives the best chance of achieving what is needed! There are lots of things you might want to achieve through needs assessment. Some of the most common aims are listed in Box 1. It is possible that you may have more than one aim: for example you may want to find out about unmet needs in your population and also strengthen the primary care team/networks.
2. ***There are many different concepts of 'need'*** and no one definition is the 'right' one. It is important to be aware of which needs you are recognising in your needs assessment, and whether there are others that you will not be intending to address. Needs assessment is as much about art as science.
3. ***Different information sources and methods of investigation tell you about different aspects of 'need'***. Needs assessment using a compilation of different sources/methods helps you to build up a picture of need. Each source/method gives you one piece of the jigsaw. Assembling a number of pieces does not show the whole picture, but you don't always need all the pieces to see the essence of the picture. Therefore you will want to concentrate on gathering enough information to see the picture, rather than on collecting all available information.
4. ***The way you do needs assessment is important***, because some methods allow you to start to work on the solution to a problem while you are assessing it, for example by involving the people who are going to have to make changes in describing or understanding the underlying need. Other methods tell you a lot about a problem, but don't help to solve it.
5. ***The needs assessment should be owned by the people who will have to implement the actions***. This is essentially following the management principle that to make something happen, it is important that the people involved accept the need for change and that it reflects their priorities/needs.
6. ***Health needs assessment should be used within the appropriate planning system***. For example if you want to use it to influence the services provided by the primary care team, it has to fit within the teams development planning process. If you want to influence primary care health planning services, it will have to fit within the local and regional authority decision making system.
7. ***There are negotiations leading up to a needs assessment and actions that have to be taken afterwards if you really want to achieve change***. Use your preliminary negotiations to determine what sort of evidence of 'neediness' you will have to demonstrate to convince decision makers that there is a need; take action after a needs assessment to make sure that it is followed through to a conclusion.

8. **Health needs assessment is a systematic way of looking at need.** First you have to define and understand "needs", using evidence where possible to describe and prioritise the needs; then you must identify and choose solutions through an explicit method. Finally you produce an action plan to meet the needs that your community have identified and the solutions that have been agreed. This allows you to introduce openness and accountability into your decision-making through the use of needs assessment.
9. **Health needs assessment is a part of a cyclical process.** Patterns of need change over time, and if you take action to address the needs you have identified, you should evaluate how well the needs have been addressed. This will bring you back to assessing the needs that have not been met by your action (Figure 2).
10. **Health needs assessment is not an end in itself.** It is simply a means of using information to help you plan the future.

Figure 2: The needs assessment and planning cycle



Box 1

Stepping Forward

Possible aims of a needs assessment

- 1 To describe the 'comprehensive' picture of what is already known about needs to identify priorities for further detailed work.
- 2 To explore identified priorities in depth to inform planning of service provision.
- 3 To encourage an evidence-based approach in providing effective clinical care to meet needs.
- 4 To encourage community involvement in health planning.
- 5 To explore and act on wider determinants of health and encourage liaison with other agencies.
- 6 To investigate and advocate for needs of vulnerable groups and those with particular needs.
- 7 To ensure that the primary care teams make the best possible use of the resources they have available.

Getting started with the guide

This document guides you through the decisions and steps in needs assessment. Stage 1 tells you how to get started, and Stage 2 helps you to choose the approach to address your specific reason for needs assessment. Stage 3 gives a 'step by step' guide to the different approaches with examples.

Within each approach, a variety of methods and tools could be used. Some of these are briefly described in the sections on 'Routine data sources' and 'Techniques and tools'.

The bibliography gives a guide to useful further reading and refers to articles used in the production of this document.

Stage One: Initial considerations

To get started on a needs assessment you have to make a few preliminary decisions. These decisions are critical to the success of your needs assessment, so take some time over this initial stage and you will reap the benefits.

DECISION 1 : Who is going to do the needs assessment ?

Most of the approaches lend themselves to work by an individual or a group. Working on needs assessment as a group can have major advantages, and is the recommended approach for a number of reasons. Firstly, group members who work in the community will have valuable knowledge of local needs and services. Also, if the group includes the people who will have to implement any changes suggested as a result of the assessment, it encourages ownership of the results and implications by them. Thus plans arising from the needs assessment are likely to work. Finally, working on a needs assessment can aid team building.

Choosing a needs assessment group

You need to identify an individual who will lead the needs assessment process. This could be someone who already holds a leadership position or who has expertise in managing projects, but should certainly be someone who is keen on the project.

You also need project group members who :

- work in the primary care team, network, area or locality;
- have a particular knowledge, skill, or expertise to contribute;
- can represent local people and/or decision makers.

In different situations, the individuals who need to be involved will vary. Try to get the group together that you think is most appropriate for your local situation; then, when you have decided on your approach, check that your group has the right mix of representation and skills to do the needs assessment.

DECISION 2 : What is the scope of the needs assessment ?

Get the group together to decide what "needs" you are going to consider. Use the questions below to help with your decision.

- 1) Are you considering needs of a primary care team population or a network/geographical area?
- 2) Are you considering needs for overall health improvement or focusing on health care services?
- 3) If focusing on health care services, does this include primary care, secondary care, statutory sector services, voluntary services, formal or informal carers?
- 4) If considering broader influences on health, are you going to focus on interventions that prevent disease or things that promote positive well-being?
- 5) Do you want to focus on interventions within statutory and voluntary services or include interventions that people might do for themselves?

DECISION 3 : What resources will be needed for the needs assessment, and where will they come from ?

To undertake needs assessment requires time, information and the skills to use it, expertise relevant to the approach you choose, but above all you need enthusiasm!

The amount of time you need will depend on the size of the project you wish to do, so many people prefer to start with a small project. However, the amount of enthusiasm you will have for a project will be determined by how important you believe it is, and how likely you are to achieve your goal. When you have decided what you want to do, try to estimate how much time you will need and what other resources. This will help you to decide if the likely outcome is worth the effort!

Getting access to resources to help with your needs assessment will itself require some negotiation with your colleagues and others within the primary care environment. Resources for research may be available. Discuss this with the relevant University departments or with the Department of Public Health at the Health Service Executive.

Why bother with needs assessment?

DECISION 4 : When should the needs assessment work be done?

Your needs assessment will be aiming to influence a decision or process, so your project must be timed to produce the necessary results at the right time. First you must identify the decision or process you wish to influence, and when it will take place. Your absolute deadline must allow plenty of time for decision makers to consider your results.

Work backwards from your deadline to produce a project management timetable. A typical project management timetable would schedule the following stages:

- project planning
- information gathering
- analysis
- initial report production
- consultation on results
- final report production

Now that you have made all your initial decisions, you are ready to work with your group to choose an approach to needs assessment.

Stage Two : Choosing an approach

First decide which of the reasons in Box 1 (page 7) is most important to your group. This will direct an appropriate approach to performing the needs assessment.

1. ***To describe a 'comprehensive' picture of what is already known about need to identify priorities for further detailed work.***

This would involve looking at data already available (routine data) to chart the size and shape of the population and the most common causes of mortality, morbidity and use of health services. This is referred to in this document as a **'global information-based needs assessment'**.

2. ***To explore identified problem areas in depth to inform planning of service provision.***

Once you know what the areas of concern are in your population, you need to explore them in depth. This will involve collecting together data on the problem, generally and in your own population, and information on interventions which may be effective. This is detailed below as a **'focused needs assessment'**.

3. ***To encourage an evidence-based approach in providing effective clinical care to meet needs.***

If your aim is to improve the effectiveness of clinical care, you may want to take an evidence based guideline and determine whether it addresses an important area of need in your practice. You can then estimate the number of patients whose management will be altered and the resources that will be required. This is described below under the heading **'guideline based needs assessment'**.

4. ***To encourage community involvement in health planning.***

If your interest is in involving the local community in determining the problems to be addressed and contributing to the solutions, it is necessary to engage local people in the whole process. You could invite community representatives to read results of global or focused needs assessments but it is usually preferable to get people to describe problems and solutions in their own terms. Therefore the recommended approach is a **'community development approach'** described below.

5. ***To explore and act on wider determinants of health and encourage liaison with other agencies.***

This implies that your interest is in health and not just health services. You will need to take a broad perspective on 'health' and what influences people's health or well-being locally. It will involve working with other agencies to look at, for example, environmental hazards, housing quality and lifestyles. This entails a **'healthy alliances approach'**.

6. To investigate and advocate for needs of vulnerable groups.

In this case your interest is principally in helping a group of people who find it difficult to make their own case for help or services. Your approach will have to use available routine information, collect more detailed information where necessary, and organise the vulnerable group to use the information in defining their own problems and solutions. This combines elements of other approaches and is referred to as an **'advocacy approach'**.

7. To ensure that the primary care team makes the best possible use of the resources available.

There will always be many areas of health need and the choice of interventions to address need is increasing. It is important to achieve the most benefit possible within the resources available by targeting the efforts of the primary care team in specific areas. These priorities will be set on the basis of a comparison of the costs and benefits of a range of possibilities. The framework for tackling this type of issue is referred to below as an **'economic approach'**.

Combining and adapting approaches to different aims

This document suggests several approaches to meet the aims commonly expressed by primary care service providers and users. Of course, there are other reasons to undertake needs assessment, and you can adapt these suggestions to your own circumstances. You can combine different data sources and methods to address different questions. However, whatever your aim, the guiding principles apply and should be considered before you embark on the needs assessment.

As well as this focused clinical example of needs assessment there are ways of looking at broader issues with direct impact on health:

- The need for parenting classes including budgeting
- Early assessment for all children with speech and language difficulties, hearing problems and psychological problems
- Education and its impact in reducing malnutrition
- Support for families who have members dependent on care
- Social work support to be expanded to all members of the community – especially the elderly
- Safe environments in the home and community areas
- Dealing with addiction – smoking, drink, drugs and gambling
- Housing, water and waste disposal
- Community building involving young and old
- Facilities for communities e.g. libraries, swimming, safe play areas, community centres and transport for the elderly to encourage meetings
- Special needs of new communities.

Stage Three : Step by step guides

A. Global information based needs assessment

This is a method that collects together many different sources of readily available data to produce a picture of 'need' or health related problems in an area. Possible refinements would be to use a questionnaire based survey to augment the data, or to map the data gathered to produce a visual representation of relative need. This is performed without prior assumptions of where the areas of need lie. The data can then be used to identify potential areas of unmet need and define priority areas for further more detailed work.

Limitations

It is impossible to define and measure all 'needs' in any population. The main limitation of this method is that it measures only what is measurable. There is a risk that large amounts of data are gathered but no one knows what it actually means. It is a good idea to know what you want out of the data before you start to collect it. This means you must know what you mean by 'need'! There is also always a problem in trying to interpret small numbers of cases, which may vary widely over time. This makes comparisons of rates of disease between small populations very difficult. If you find an apparently high rate of one condition in your population, it would be wise to consult somebody with epidemiological expertise before drawing any conclusions.

How to do it

- | | |
|---------------|---|
| Step 1 | Define the population you are looking at and the questions you want to ask about them, e.g. for the PCT population, what are the main health care needs? Use the questions in box 2 overleaf as a guide to the sorts of questions you might want to consider. |
| Step 2 | Identify a named person to do the work. |
| Step 3 | Establish which of the readily available data sources will help you answer your questions. Section 4 describes readily available data sources. |
| Step 4 | Collect data. Try to get data on your own primary care team/network and other local primary care teams in the area for comparison. |
| Step 5 | Look at the data and try to interpret it to answer the questions you have set. Remember that the data is unlikely to answer all your questions and is likely to generate more questions than answers. |

- Step 6** Produce a list of the questions that you have managed to answer and the questions you have not answered.
- Step 7** Share the findings with other members of the primary care team/network. Their local knowledge will help you understand the findings and may help answer some of the questions you cannot answer from the data alone.
- Step 8** With the group, define priority health needs for further investigation. You could use a recognised technique for identifying priorities, such as nominal group or ranking matrix (see Techniques and Tools, page 49).
- Step 9** Design a further work programme to study priorities in sufficient depth to understand what actions should be taken to address them. Your work programme is likely to involve a focused needs assessment of priorities or one of the other types of needs assessment described.

Box 2

Some questions about local health problems to consider

- **What are the main causes of death?**
- **What are the main causes of hospital admission?**
- **What health problems cause the highest workload for primary care team/network members?**
- **What health problems are not presented to the primary care team/network?**
- **What health problems are more common here than elsewhere?**
- **Which groups of people do not access health services?**

A. Global information based needs assessment Example (1).

Using routinely collected data for needs assessment in teams and networks

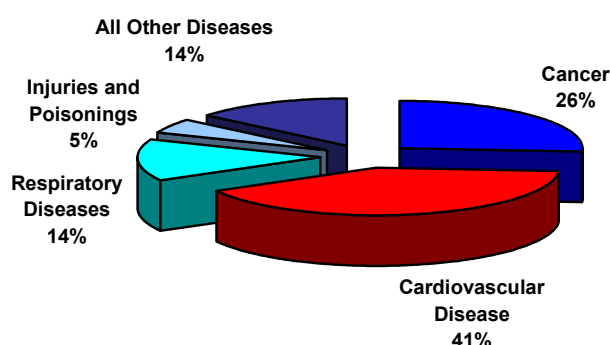
Question - What do people in our primary care team/ network or area die from? What are the commonest causes of mortality, and in which areas do we have more deaths than the rest of the eastern region? What are people admitted to hospital with?

Sources of information

- Central Statistics Office (CSO) collects and collates data on deaths. This data is only aggregated up to county level by the CSO.
- Within the eastern region, the HSE Department of Public Health has coded the deaths by district electoral division (DED), aggregated the data into Community Care Office areas and analysed the data in comparison with the whole of the eastern region. To date the data that is available is for the five years 1994-98. (Contact person: Dr S. Jennings)
- Hospital in-patient Enquiry System (HiPE) is a system of collecting data on discharges from Hospital.

First, looking at what people die from, the figure helps to understand the main causes of death within the region. This is unlikely to be markedly different at local level. It is a crude overview of the mortality.

Figure 3: Principal Causes of Death, 1995-1999, ERHA, All Ages



Next, looking at rates of *all cause mortality* (i.e. the overall mortality rate from all the causes and for all the age groups) at community care area level helps to identify what, if any, overall difference exists between your area and the region. Then, studying the main causes of death, flesh out the information further. Note that the standardised mortality ratio (SMR) corrects for imbalances in age, thereby allowing comparison between populations. The data in red (Table 1) signifies significantly high mortality ratios compared with the region as a whole.

Numbers of deaths are of limited use but can give an overview of the magnitude of the problem. Data can be looked at by gender and hopefully soon for the premature age group (under 65 years).

Table 1: The main causes of death in the Eastern Region.
Mortality data 1994-98. Data presented as standardised mortality ratio (SMR)

Standardised mortality ratio (SMR)						
	ALL Cause	ALL Circulatory	IHD	ALL Cancers	ALL respiratory diseases	Injuries & Poisoning
	SMR	SMR	SMR	SMR	SMR	SMR
CCA1	86.3	87.7	85.2	88.1	81.8	85.8
CCA2	85.1	84.3	85.6	88.1	87.5	74.9
CCA3	107.1	107.6	101.1	105.1	110.1	96.0
CCA4	109.9	107.6	103.4	115.5	105.9	98.2
CCA5	107.6	110.4	109.0	104.1	109.9	105.2
CCA6	107.5	102.0	107.4	108.2	113.3	125.5
CCA7	109.2	108.9	112.4	110.0	103.3	114.9
CCA8	94.5	95.8	98.5	97.9	91.7	83.2
CCA9 (Kildare)	98.0	101.1	105.5	93.1	96.7	112.8
CCA10 (Wicklow)	98.9	101.1	95.4	87.4	109.6	108.3
Number of deaths						
CCA1	4840	2115	1093	1282	635	173
CCA2	3819	1633	872	995	554	127
CCA3	4980	2132	1064	1258	704	181
CCA4	4690	1879	989	1362	569	196
CCA5	3242	1348	725	851	416	159
CCA6	5343	2126	1206	1432	747	263
CCA7	5840	2504	1380	1534	763	219
CCA8	4995	2038	1156	1456	589	221
CCA9 (Kildare)	4055	1708	962	1031	511	229
CCA10 (Wicklow)	3294	1426	717	759	495	144
Eastern region	45098	18909	10164	11960	5983	1912

All cause mortality is highest in community care areas 3,4,5,6, and 7 compared with the region as a whole. Drilling down below *all cause mortality* these same five CCAs continue to have significantly high mortality rates for most of the main causes of death. Notably these areas have high indices of deprivation. Kildare and Wicklow have high rates for certain causes of death.

Information about patterns of morbidity in an area is not as simple. Please see the listing of the data sources available at CCA level in Section 5. Data on hospital discharges are not available by geographical area but is available by permission at hospital level. Here, the main causes of admission to hospital for residents of the region is outlined in the table .

Table 2: Data on discharges of residents of the Eastern region from hospitals in the region
(Source: PHISv6)

Diagnostic category	Number of discharges	%
Digestive	29,617	11.2%
Neoplasms	26,206	9.9%
Circulatory	21,499	8.1%
Injury and poisoning	19,263	7.3%
Respiratory	16,612	6.3%
Ill-defined	19,006	7.2%
Total	263,900	100%

By looking at the different kinds of routine data, and comparing them both locally and nationally, a primary care team begins to identify where the differences lie, and how large a problem exists in the primary care team.

At this stage the overall picture can be presented to the group for discussion, and reasons for the picture explored. Some of the reasons for high rates may be more easily explained, e.g. the high rates of death in areas of high deprivation. Other areas will need additional and more focused work. The primary care team/network may wish to identify which areas need further exploration, and may be guided by national and local priorities.

A focused needs assessment may be the next approach.

A. Global information based needs assessment Example (2)

Assessing the health needs of local communities is central to effective targeting, delivery and improvement of the health services. This community based cross sectional health needs assessment in Tallaght sought to:

- estimate proportions with chronic illness and disability in the community.
- measure current health service utilisation.
- measure satisfaction with current health services provision.
- establish areas of unmet need.

A cross sectional study in the 13 district electoral divisions of Tallaght was conducted and primary or principal carers were selected for in 344 of 420 selected households. The households were chosen using a cluster sampling methodology which is frequently used in developing countries. Each cluster comprises 7 adjacent households which makes it easier for interviewers to achieve high completion rates. The fieldwork was carried out using pairs, one being an experienced researcher, the other being a student or person from the local community. The local radio station and Tallaght Press informed the community and posters were designed and displayed at the four health centres in the Tallaght area.

Eighty per cent of the selected households participated, indicating a keen interest in health related issues.

Tallaght has a relatively young and mobile population and most of the respondent primary carers were women. Over one third of the households had neither GMS medical card nor private health insurance cover for their health. The study revealed smoking rates at 40%, stress levels at 60% and violence and intimidation at 10% in the previous year. Over 60% worried about their teenagers socialising patterns and 46% found their attitudes and behaviours upsetting.

Over one in five households had someone with a chronic illness, mainly respiratory (32%), cardiovascular (24%) and arthritis (8%). Nearly 6% of people with a chronic illness were significantly disabled by the disease.

The study revealed that there is high usage of the hospital and primary care services. Nearly 38% of households members had used the hospital within the previous 12 months and 40% of these were for emergency purposes. Hospital day care services had the highest satisfaction rates at 81% and A & E the lowest at 65%. Patients with chronic disease or disability were high users of the hospital services.

General practitioner uses were equally high at 38% with 86% being satisfied with the services provided. Nearly 29% were unhappy with the current out of hours general practice arrangements in Tallaght at 18% were critical of the absence of convenient pharmacy services.

The health needs assessment revealed that over 40% of women smoked during their last pregnancy and only 39% had general practitioner and hospital shared antenatal care. There was a big demand for a local maternity service in the Tallaght area at 47%.

There has been extensive interest in the study and it is regularly used by Tallaght hospital for the development of services and informs all new recruits to the hospital about the state of health of the community. It is also of interest that the areas highlighted by patients, such as out of hours GP services, and pharmacy access have remained unchanged since the study was completed. The hospital has developed a respiratory service in response to the assessment findings.

Overall, the health needs assessment revealed that people living in Tallaght have valuable insights into healthcare, can articulate their health needs and are an important resource in the planning of the healthcare services.

Additional information in relation to this project can be obtained from Prof. Tom O Dowd, Department of Public Health & General Practice, Trinity College Dublin. Tel:01-6081087, ameaby@tcd.ie.

B. A focused needs assessment

The basic approach to focused needs assessment is to identify a specific area of potential need and to investigate it in depth. The focus could be a specific disease or condition, a client group or a service. Focused needs assessment uses both routine data and information specially collected. It is often used to study identified priorities.

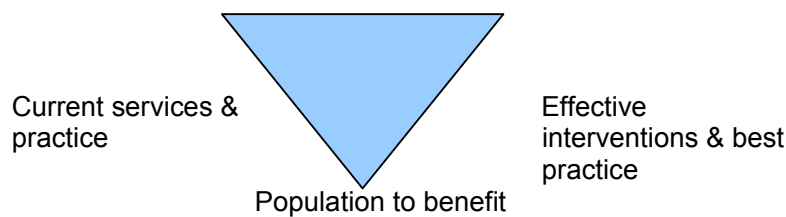
Limitations

Once you have defined a focus for your needs assessment, it implies that this is the area of greatest need, but there may be other related needs not covered by your investigation. It also usually uses a medical definition of 'need' e.g. need for a clinical intervention, and is almost invariably professionally focused. It works best where there is a lot of evidence of effectiveness. It is important not to be too ambitious in scope, as the aim is to focus as closely as possible on areas where you can improve health.

How to do it

- | | |
|---------------|---|
| Step 1 | Define in detail the condition/service/patient group to consider in your needs assessment. If considering a condition, this means establishing a case definition, e.g. chest pain would include MI and angina but not heart failure. If investigating a service this means determining the scope of the service e.g. does community nursing encompass all the roles undertaken by public health nurses, registered general nurses and community mental health nursing working in the community and practice nurses but not hospital liaison nurses? If investigating a patient group this means defining the group's characteristics, e.g. does elderly include all people over 65 or 70 years. |
| Step 2 | Use the triangle in figure 3 and the tables following to identify the questions to answer. |
| Step 3 | Choose information sources to help you address each part of the triangle. This is likely to include reviewing the literature, using routine data and published survey data, and possibly performing a survey. |
| Step 4 | Having gathered this information, compare current services with best practice to focus more closely on areas where you can improve health or health care. This tells you qualitative need for change in local services. |
| Step 5 | Use estimates of population to determine volume required for best practice services: this gives you quantitative need for change. |

Figure 3: A framework for focused needs assessment



A focused needs assessment for a *disease or condition*

Population to benefit	Estimate number of patients in the population with chest pain. Sources might include hospital admissions, practice records, prescriptions for anti-anginal drugs, prevalence estimates applied to local population.
Effective interventions	Define best practice in management of the condition e.g. investigation of presenting complaints, criteria for onward referral, appropriate therapy in primary and secondary care. Sources include peer reviewed literature, guidelines and views of local specialists in the field.
Current services	Profile the services currently available both in terms of the quantity and distribution of services available for the management of the condition, and in terms of the quality of clinical management. Sources of information for the quantitative profile are your own local knowledge, service specifications within health care service agreements, primary care team, general practice or community group profiles, hospital activity data. Sources for qualitative data are clinical management protocols, patient satisfaction surveys, and clinical audit reports.

A focused needs assessment for a *client group*

Population to benefit	Estimate the number and relevant characteristics of the population under study. In the elderly, the relevant characteristics include the age and sex distribution, and the nature and levels of their major health problems and other factors influencing their problems and the response to them. Sources of information will be census populations and related projections, primary care teams patient registers, practice age/sex registers, disease registers, local and national surveys and published literature.
Effective interventions	Define best practice in management of the health problems identified e.g. screening, prevention and clinical management in primary and secondary care, and social care interventions. Sources include peer reviewed literature, guidelines and views of other agencies e.g. social work.
Current services	Profile the services currently available in terms of the quantity, distribution and quality of health and social services available. Remember to include voluntary and private sector services and the views of local people and organisations e.g. Combat Poverty Agency. Sources of information for the quantitative profile are your own local knowledge, residential and nursing home registration authorities. Sources for qualitative data are inspection, audit and monitoring reports and information on local hospital services.

A focused needs assessment *for a service*

Population to benefit	Define the catchment population for the service. For public health nursing, this might be all people living in a geographical area, or all patients on a general practitioner list. For the primary care team this might be all the patients registered with the team. Identify the health problems managed by the service. Estimate the numbers of people with these problems in the catchment population. Sources of information will be service policies, census populations and related projections, practice age/sex registers, disease registers, local and national surveys and published literature.
Effective interventions	Define best practice in management of the health problems managed by the service. Sources include peer reviewed literature, guidelines and views of service based professionals.
Current services	Profile the services currently available in terms of the quantity, distribution and quality. Sources of information for the quantitative profile are your own local knowledge, local service specifications. Sources for qualitative data are inspection, audit and monitoring reports, and views of service users.

Box 3

Estimating the number of patients with a condition

- Use routine data if available
- Apply survey data on the proportion of the population affected to the population in your primary care team.
- Perform a survey of case notes or consultations to identify numbers of patients presenting with the condition.

B. Focused needs assessment

Example

A focused health needs assessment for a condition

This example is taken from a general practice setting, and illustrates how a particular condition was identified and investigated in more depth, and what changes were proposed and carried out as a result of the work.

A trainee GP had been placed in a training practice of 4 principal GPs and 2 practice nurses with a practice population of 10,000 people. At an initial meeting between the GP trainer and the GP registrar, topics for audit were reviewed. A patient from the practice had recently been admitted to hospital with a history of overdose and a diagnosis of depression had been made. The GP trainee indicated that she was interested in looking at how the practice managed patients with depression. The importance of management of depression and prevention of suicide in primary care had been highlighted recently by the Irish College of General Practitioners and seminars had been held on the subject. Recent GMS (Payments) Board data had identified a rapid upwards trend in prescribing costs for antidepressants, particularly newer agents. At a CME meeting one of the principal trainers had discussed depression with local colleagues where he had a sense that his practice was higher than other local practices in the number and cost of antidepressants prescribed.

A small team was identified to look at the topic and included a practice nurse, a public health nurse, clerical staff, and one of the principal GPs with a special interest in this area. The GP trainee agreed to lead the process. The scope of the work was limited to adult patients presenting to the practice with a depressive illness.

The practice age sex register was consulted, to identify the number of patients within specific age ranges. The numbers of patients in the practice who had been diagnosed as suffering from depression was estimated using repeat prescribing records, and by searching the practice computer for patients who had received antidepressants within the past 12 months. The GP with an interest in depression had undertaken an audit 2 years previously, which was used for comparison with recent information. GMS (Payments) Board data was consulted to compare prescribing trends within the practice over the past 3 years. Referrals to the psychiatric outpatients were identified.

The GP trainee undertook a review of the literature. With the help of staff associated with the training programme, she looked at effective interventions for the management of depression in general practice. Information was available that included guidelines for the management of depression in general practice with reference to beneficial assessment scales (such as the Edinburgh post-natal depression scale, the geriatric depression scale) and effective interventions (such as cognitive psychotherapy for the over-75 year age group).

The team reviewed the current services available to patients in the practice. This included the practice having direct access to a counsellor for 2 sessions per week. Out-patient psychiatric services were through the local psychiatric hospital services, with a waiting time of 1-2 months for a new referral. An urgent referral for an acutely depressed patient could be arranged within 1 week, but with a delay of up to 2 months for follow-up counselling sessions. The result of the audit carried out by one of the the practice's principal GP 2 years previously had indicated that the patients who had been seen in the practice for counselling had a shorter duration of antidepressant therapy than those referred to the Out-patient psychiatric

services, but there was insufficient recorded information on the severity of depression to make valid comparisons. The counsellor had presented summary information on the number and types of patients seen, and information about patient satisfaction with the service. The public health nurse had records of her case load, and the numbers of mothers with young children who she thought were a vulnerable group.

The team reviewed all the information and believed that more rapid intervention in mild cases of depression should result in better outcomes. They were particularly impressed by evidence of the success of counselling for post-natal depression, and the use of a postnatal depression score. They believed that improving the service provided might lead to fewer patients being maintained on antidepressant therapy, while they waited for out-patient or counselling within the practice. Empowering patients to access other services outside the practice, such as social networks was also seen as important, in view of the relatively high numbers of young mothers with depression who were being seen.

Using the practice age/sex register, the record of the numbers of consultations for depression within the practice, and recent referral numbers, the team estimated that an additional 2 sessions of practice counselling per week would enable all suitable patients requiring short interventions to be seen within 2 weeks of presentation. They discussed the optimum way of providing the sessions and the cost implications. The training of practice nurses was a possible option, but would entail additional practice nurse time.

The practice put the case forward to the Health Board to increase the number of counselling sessions available to the practice per week. It was decided to set up a pilot scheme for 6 months and to evaluate it at the end of this time.

C. A guideline based needs assessment

Needs assessment can help a primary care team to estimate all the changes that will be required to implement a guideline. This may include an estimate of the number of patients whose management will be affected if the guideline is implemented. A baseline audit of current practice is an important part of this needs assessment, both to see how far current management is at variance with the guideline and to allow future audit of change following its implementation.

Limitations

If the starting point for a needs assessment is a guideline, the guideline must address an important area of need for the population. It assumes that the guideline is correct, given current knowledge. The guideline may also not be appropriate for local circumstances and local resources.

How to do it

- | | |
|---------------|---|
| Step 1 | Choose a guideline that you think, if implemented, will improve the health of your patients (see box 4, overleaf). |
| Step 2 | Define the patients who would benefit from clinical management following the guideline. You may find it helpful to refer to some of the source evidence used to prepare the guideline. |
| Step 3 | From the guideline, select a number of indicators which will tell you how well the guideline is being implemented. |
| Step 4 | Use the indicators to conduct a baseline audit of current practice. This will help assess how much change in practice is needed for implementation of this guideline, and tells you which areas you will have to focus on to change practice. It will also form a baseline for future evaluation. |
| Step 5 | Estimate how many patients in your primary care team to which the guideline would apply (see box 3, page 23). |
| Step 6 | Using the estimated number of patients the guideline will apply to, identify the resources required to implement the guideline, e.g. staff time, equipment, drugs. |
| Step 7 | Identify any other changes required for the guideline to be implemented. An interview or questionnaire survey of key staff will help to do this. |
| Step 8 | Draw up an action plan based on the areas of change you need to focus on, the resources required and the other changes required to implement this guideline. |

Step 9 Implement the action plan.

Box 4

Choosing the guideline

- The guideline addresses an important health problem in your population
- Better clinical practice in this area is likely to lead to health gain
- The guideline is evidence based

C. A guideline based needs assessment Example

In this case study a GP practice uses a critical event (a death) as the starting point for considering need. The initial definition of patients who would benefit had to be modified and the practice used an evidence based guideline to help them to do this. The practice was able to use data already available to define, implement and audit change. The successful implementation of change came about following the adoption of ideas from practice staff.

A practice nurse reported to a practice meeting that one of her relatives had died at an early age of myocardial infarction. She wondered whether she should have encouraged him to have had his blood pressure checked. Two of the receptionists said that they knew their similarly aged husbands had not had their blood pressure recorded. The practice nurse was asked to find out what proportion of the practice had a record of BP measurement.

The nurse reviewed 200 patient notes and presented the findings to the next practice meeting. Of the practice population between the ages of 15 and 75, 58% had a record of BP measurement. The practice wished to improve this and discussed ways of doing this. Targeting the entire adult population would mean screening 752 people for each doctor in the practice and so it was decided to start by either focusing on a smaller group for BP screening or to improve blood pressure control in a group already at risk from ischaemic heart disease or diabetes.

One team member agreed to find the following information from a sample of notes:

	(per partner)
1. Total number of men aged 45-65	175
60% had BP currently recorded	105
Additional population to be found at screening	70
	(per partner)
2. Total number of diabetics	50
80% had BP currently recorded	40
Additional population to be found at screening	10
	(per partner)
3. Total estimated number of patients with ischaemic heart disease	260
70% had BP currently recorded	182
Additional population to be found at screening	78

The practice decided to concentrate initially on BP control in diabetes mellitus for the following reasons:

1. There is evidence that poor control of BP is a major risk in diabetes
2. Evidence based guidelines exist for managing diabetics with raised BP
3. It is clear what action should be taken: There is consensus based on evidence that diabetics should have BP < 140/80
4. The numbers at risk are manageable
5. The call recall system for the diabetic clinic was already in place. No new resources would be needed
6. The practice could routinely audit the process using the computer generated chronic disease management report

The diabetic clinic protocol was redesigned to include the element:

"if BP > 140/80 perform 3 readings at 5 minute intervals with the patient supine."

During the first 3 months of using the revised protocol the clinic structure broke down completely because the practice nurse consistently ran behind schedule. This disrupted the flow of patients to the dietitian and the chiropodist.

The problems with the clinic were discussed by all the staff at a practice meeting.

A receptionist was trained to take BP readings using the electronic sphygmomanometer and became responsible for measuring the BP during the clinic which subsequently ran to time

94% of diabetics had a recorded BP when audited after 1 year, 78% were < 140/80. The practice set a target of 98% for the following year.

D. A community development approach

This approach is about getting local people to participate in needs assessment. It helps you to find out what they think their needs are, and the priorities they have. Finding out the priorities, as the community sees them, is a good first step towards working with the community to address its problems. Qualitative methods are most useful for this.

In this kind of needs assessment the process used to collect data is as important as the data obtained.

Limitations

This approach should ideally be part of a process of community development with commitment from all parties at the outset. It works best in self-defined communities. The priority problems identified may not accord with those of professionals and results may be greeted with scepticism. It identifies what the problems are but does not usually quantify the number of people affected. It should be recognised that if qualitative methods are used, it requires special training and skills both to collect and interpret data. They are also labour intensive and time consuming.

How to do it

- | | |
|---------------|---|
| Step 1 | Identify the community for the needs assessment. |
| Step 2 | Decide on the team who will collect the data. This would usually include local residents, as well as professionals such as members of the primary care team/network, social workers etc. Try to achieve a balance between professionals and non-professionals. Using professionals increases credibility with other professionals but using local residents maximises community participation. |
| Step 3 | With the team, decide on the broad questions to be addressed: e.g. what are the determinants of health and ill health in this community. The information pyramid for rapid appraisal (page 51) is one way to guide the questions you might want to ask. |
| Step 4 | Decide whom to collect the information from. Try to include a cross section of people within the community. You could use 'key informants', who are individuals with knowledge of the community because of their job or social position. Alternatively, you could use a representative sample of local people. There are skills and techniques to selecting a sample from a population (see references for help on this). |

- Step 5** Decide on the methods to use to answer your questions. Usually more than one method will be required to get balanced answers to your questions. Remember to choose methods that will involve collecting data by asking local people. Qualitative research methods like observation, in-depth interviews, and pictorial methods like flow charts will be most suitable for this. This guide gives a brief outline of some qualitative methods but unless you are experienced in them, you should seek expert advice and help.
- Step 6** Collect the data using chosen methods and produce a preliminary analysis of findings.
- Step 7** With the team, compare problems, needs, and priorities identified by different methods to find those which occur most commonly or are thought to be most important.
- Step 8** Feed back results to community members to see if they agree with your interpretations and decide the priority actions to take. A ranking matrix or nominal group discussion (page 52) can help to set priorities. A community meeting is often used to do this.
- Step 9** Together with team members and local people who have participated, implement agreed actions.

D. A community development approach. Example

The St Matthews estate occupies an area of central Leicester which is surrounded by busy commuter routes into the city, leaving the area geographically isolated and obstructing access to other facilities. Housing consists of tower blocks and maisonettes built in the 1960s which are small, cramped, and dangerous for families with young children, having poor access for prams and pushchairs. The population of 4500 persons contains a wide age range with single, unmarried, usually female parents forming a large proportion. The majority of families receive social support and this area is renowned for allocating homes to families with social problems including a high number of pregnant teenage girls. The incidence of domestic violence is high; child abuse, neglect and racial problems are amongst the highest in the country.

The team comprised a general practitioner, research health visitor and community paediatrician. Residents of the estate played an important part in identifying health concerns on the estate, and a professional view was obtained from the members of the primary health care team (PHCT). Together the important questions were considered and a questionnaire developed.

A random sample of 50 families were chosen from the health visitor records of St Matthew's using random number tables. A control group of 50 parents was similarly randomly selected from a comparable locality. Qualitative and quantitative research methods were used. Each family was approached for interview by a research health visitor using a semi-structured questionnaire. For each health issue a question was asked about the level of parental concern and the answer numerically weighted on a scale. Parents were encouraged to suggest solutions to problems scoring highly and to comment on the level and type of provision that already existed. Each family was visited by the same researcher at home.

The lack of suitable places to play, was the most frequent and important problem identified by inner city families. Other significant problems were a lack of free time, isolation, smoking and alcohol consumption, and being a lone parent. Parents in the deprived area were articulate in providing solutions to their problems which centred on the provision of appropriate play facilities through which health and social care could be channelled.

The approach used in this research and the results obtained have formed an important part of the development work in the St Matthew's Project.

Additional information about this project and the methods used can be obtained from Dr E Anderson, Department of Child Health, University of Leicester, and additional information about the St Matthew's Project from Dr Angela Lennox, Department of General Practice, University of Leicester.

E. A 'Healthy Alliances' approach

The key point for a 'Healthy Alliances' approach is that your focus is on health, rather than on sickness. It is widely recognised that the determinants of health are much wider than simply health services, and involves many diverse influences such as physical, social and economic environments, occupation and employment, and lifestyle patterns. To get at information relating to these influences you will have to look outside Health Service information systems. It is also likely that any action to be taken will involve agencies outside the Health Service, for example, local authorities, police/gardai, environmental protection agencies, and local employers.

Limitations

When a number of diverse agencies try to work together there are often barriers to overcome, for example cultures of different agencies are often very distinct and planning processes may be radically different. Progress tends to be slow which is particularly frustrating for health professionals who are often used to making quick decisions. Health is not necessarily the top priority for other organisations, so it may be difficult to stimulate the action that you believe to be necessary.

How to do it

- | | |
|---------------|---|
| Step 1 | Identify your community. |
| Step 2 | Identify all the organisations involved in your community, particularly in those areas that will most influence health. It is important to think widely a brainstorming approach might be useful. Some possible organisations to consider are shown in box 5 (page 34). |
| Step 3 | This is the most challenging step of all. Get representatives of all the organisations you have identified together in a meeting. |
| Step 4 | At your meeting with the representatives, identify their concerns about the health of the local community and its major determinants. You could use an agenda based discussion or nominal group to do this. |
| Step 5 | Prioritise the health concerns identified. A nominal group or ranking matrix can help here. |
| Step 6 | For each priority health issue, help the group to investigate. This is likely to include reviewing relevant literature, using routine data e.g. census, road accident reports and consulting local people and professionals. |
| Step 7 | For each issue, identify the actions that would address the determinants you have identified. This should be jointly agreed with the group. |
| Step 8 | With the group, implement the actions required. |
| Step 9 | With the group, continue to monitor and evaluate determinants and actions taken. |

Box 5

Some organisations to consider in a healthy alliance. Most will be present in your Health Forum

<i>Organisation</i>	<i>Some possible contributions to health</i>
social work	care and support of vulnerable groups health education role
schools	health education supportive environment e.g. healthy food in canteen, school lunch policy
access	to sports facilities promote self esteem
community education	health education/health promotion support and advocacy for vulnerable groups
local enterprise company	health promoting workplace policies health and safety practices
local businesses	adequate staff remuneration health promoting workplace policies health and safety practices equitable access to healthy foods in shops
local authority planners	equity in access to facilities, safe and well-lit walking routes
local transport company	equitable access to food shops, sports facilities etc equitable access to health care road safety
public utilities e.g. water	safe water supplies equitable access to water and power
environmental health public health medicine local health services	safe environment understanding the determinants of health health care health promoting policies for staff and patients e.g. smoke free zones, canteen food
housing	adequate provision equitable access to good quality housing
private healthcare	health care
providers e.g. nursing homes caterers police	health promoting policies for staff and patients equitable access to healthy food e.g. in workplaces road safety crime drugs and alcohol

E. Healthy alliances approach

Example

Clondalkin Women's Network – Health Forum

Clondalkin Women's Network has been working on behalf of women's groups for over ten years. The network's role is to support women's groups through outreach, training, support, development, networking, research, representation and lobbying activities. A large emphasis is placed on anti-poverty work, and capacity building. The Network, which is made up of seventeen groups sees the work of the women's group as a process, involving disadvantaged and marginalised women.

A needs analysis study was carried out by the Network in 2001 in order to identify changing needs of the women in Clondalkin and how to respond to those needs. The research provided a working document for women's groups, community groups, voluntary and statutory agencies to debate and commit to the challenge of responding to the recommendations emanating from the research.

The research identified women's health was a priority for Clondalkin women. The Network now aims to build the capacity of women's groups to respond to their health needs and to the recommendations in the needs analysis study. In October 2003 a women's health forum was established through funding from Combat Poverty's Building Healthy Communities programme. Their objectives are:

- To develop a Women's Health Forum with representatives from locally based women's groups
- To train local women in lobbying and media skills and writing skills, to ensure confidence building throughout the training and identify other areas of training which the women may need
- To explore how lack of information and facilities for women is supporting the effects of poverty in their lives
- To address and work with key agencies and organisations on issues raised in the Needs Analysis Study

Agencies and organisations currently identified to work with are :

- HSE South Western Area
- Clondalkin Partnership – Sub-group on Health
- Tallaght Hospital
- Citizens Information Centre

Gaps identified that need to be addressed by the forum are:

- There is a need for additional health services in Clondalkin, the standard of services needs to be more consistent and user-friendly information is required in relation to women's health
- The medical card scheme should be extended to cover other vulnerable groups
- Bus transport between different areas of Clondalkin and to Tallaght Hospital needs to be improved in order to make hospital and local health services more accessible
- The accommodation issue for the Travelling Community is a very serious health issue. It is important that work commences on permanent accommodation immediately.

The group have met on several occasions since their inaugural meeting and have addressed the following issues: 1) Prioritising health issues, 2) Identifying training and support needs, 3) Networking with other groups dealing with health issues and 4) Building Alliances with groups in north county Dublin and the North of Ireland.

Their work is ongoing.

Additional information in relation to this project can be got from contacting Valerie O'Connell, Clondalkin Women's Network Ltd, Unit 3, Westward House, Main Street, Clondalkin, Dublin 22. Tel: 01-4056796

F. An advocacy approach

The principle of the advocacy approach is to help vulnerable groups to define their own needs and represent those needs in a way that influences decisions. It is particularly useful for vulnerable groups such as homeless people, travellers, people with disabilities and ethnic minority groups who may be missed by other approaches to needs assessment.

Limitations

Focusing on groups of people who are already vulnerable may be stigmatising. It is important to remember that people within a group have diverse needs and may not define themselves solely by their membership of one particular group. It is also often difficult to reach these groups.

How to do it

- | | |
|---------------|---|
| Step 1 | Define the group or groups whose needs you want to identify. It is important to recognise that your categories of people may not accord with how people view themselves. For example, it would be inappropriate to include all ethnic minorities as a single group. |
| Step 2 | Find a way to engage with the group, for example by working with people already involved with them, or through group leaders if they are identifiable. For example to engage with adolescents, you could work through a local youth project. |
| Step 3 | Identify members of the group to consult. Work with them to define the questions that are important for them. The questions in box 6 can be used as a guide. |
| Step 4 | Investigate the issues raised using a focused needs assessment approach (page 20). |
| Step 5 | Feed back the results to members of the group, and agree the priority areas to address and actions to be taken. |
| Step 6 | Implement actions. |

Box 6

Questions about vulnerable groups to consider

- What are the main health problems for members of this group?
- What are the barriers that prevent members of the group accessing health services?
- What services are easy for them to access and why?

F. An advocacy approach Example

This example is drawn from the Building Healthy Communities programme which is part of Combat Poverty Agency programme to support disadvantaged communities tackling poverty and health inequalities.

Lack of health infrastructure in the Mulhuddart area, whose population is expected to exceed 10,000 over the next three years, is a major concern for local people. Research was commissioned by a group known as the Primary Health Group Mulhuddart (PHGM) to look at the Mulhuddart community and explore ways that a disadvantaged community and special interest groups within it, can influence decision making and service delivery in the area of primary health and general practice.

A socio-economic profile of Mulhuddart showed a high level of disadvantage in the area and given the established link between poverty and ill-health, this would suggest that the people of Mulhuddart are experiencing higher mortality rates than those in better off areas. Based on health needs assessments of other disadvantaged areas in Dublin, there is likely to be a higher incidence of smoking, stress and chronic illnesses and a low take up of preventative screening services such as breast examinations and cervical testing in an area like Mulhuddart.

The research highlighted issues of concern in relation to existing health care provision which were:

- 1) HSE Northern Area (former Health Board) services provided from a range of locations are all situated outside the Mulhuddart area
- 2) No GPs are physically based in the Mulhuddart area. From information gathered, 4 GP practices cater for over 2,000 Mulhuddart GMS patients. It is unclear where other people attend. The exact ratio of GPs to the population of Mulhuddart is unavailable, although a recently published manpower report by the 'cluster consultations' residents referred to problems of access to both health centres and GP surgeries - having to go by bus and many people attending GPs in other areas, as a result difficulties experienced in trying to get GPs in Blanchardstown to take them on.

Due to lack of health care infrastructure in areas like Mulhuddart where the deficiencies are so great (i.e. no GPs locally based, no health centre, no suitable infrastructure, etc), the basics necessary to meet the criteria for the development of a primary care team are not present. Despite the commitment in the RAPID plan and the commitment of state agencies and government departments to prioritise RAPID areas and plans, there appears to be no formal policy approach either to recognising that there may be areas like this, or any practical strategies being proposed or implemented to address deficiencies of this scale in an incremental way. For this reason the chances of Mulhuddart being considered in the early stages for a primary care team seem remote.

The research also highlights some problems in relation to the creation of GMS GPs post in the area. Firstly there is no obvious way that the community can have an input into the process. Another issue is that there is no guarantee that if the post is created and filled, that the GP will base him / herself in the Mulhuddart area.

In order to begin to address the needs and gaps identified through the research and to begin to create the conditions which will assist Mulhuddart in meeting the criteria to develop a primary care team, 4 main decision making processes and structures were identified.

Table 3: Identifying Relevant Decision Making Structures and Processes

Aim	Decision Making Structures	Processes and approaches
Attracting and facilitating the establishment of a GP base in the area	<ul style="list-style-type: none"> • HSE - NA Primary Care Unit and General Manager • IMO • GP Partnership 	<ul style="list-style-type: none"> • Consultation processes • Open lines of communication • Joint approaches
Making available the necessary physical infrastructure to facilitate local health services provision	<ul style="list-style-type: none"> • HSE - NA • Fingal County council • Private developers • Through community reps and others on RAPID and CDB structures, SPCs, etc 	<ul style="list-style-type: none"> • Consultation processes • Open lines of communication
Assigning and locating the appropriate health personnel in the area	HSE - NA General Manager Planning and Development and Operations Depts in HSE - NA	Open and effective lines of communication with the General Manager
Lobbying decision makers and politicians to raise awareness of the needs of the Mulhuddart community in relation to primary health and to allocate the necessary resources	<ul style="list-style-type: none"> ▪ HSE Area ▪ Local Authority ▪ Primary Care Steering Group at National Level and in the HSE 	<ul style="list-style-type: none"> ▪ Lobby politicians – Councillors and TDs on relevant structures ▪ Communication with General Manager ▪ Communication and feedback structures developed with community and voluntary representatives

Additional information in relation to this project can be obtained from Anne Losty, Primary Health Care Group.c/o Greater Blanchardstown Development Project, Ladywell Road, Mulhuddart, Dublin 15. Tel: 01 820 1745.

G. An economics approach

Economic evaluation provides information about the relative cost-effectiveness of different interventions. This takes us beyond the narrow question 'Can't we do it more cheaply?' and tackles the more important (and complex!) issue of whether we are doing the most beneficial things in the first place. The economics approach is not an objective way of answering this question, but rather a framework for thinking through the issues.

Limitations

The exercise can require quite a lot of data. Some staff may find the questioning of current activities uncomfortable. The economic approach may identify solutions where the costs are felt in primary care and benefits elsewhere within the health service. Expect the exercise to generate as many questions as it answers.

How to do it

- | | |
|---------------|--|
| Step 1 | Determine an issue where you think you could make better use of resources. This might be a broad issue (such as management of skin diseases) or specific (such as whether to adopt a new guideline). Try to specify the issue as precisely as possible - this makes it much easier to address. |
| Step 2 | List all of the possible ways of addressing the issue, even if some of them seem to be beyond the capacity of the primary care team at present. This is the long list of options. |
| Step 3 | From the long list, select 3-4 of the options for more detailed study. Select this short list so that you cover the range of ideas generated in the long list. One option might be the 'dream' solution, another might be a very pragmatic small-scale solution, while the third is a compromise between the other two. Always include the continuation of the current service as one of your options, since this will form the baseline for comparison. |
| Step 4 | Define the key features of the 'ideal' service or intervention to address your issue. Use these features as criteria on which to base a ranking matrix (see page 50 for a description of ranking matrices). |
| Step 5 | Assemble whatever evidence you can about the performance of each of the options against each of these criteria. This might include a review of the literature or gathering practice activity data. |
| Step 6 | With your needs assessment group, undertake a ranking matrix to score each option for each of the criteria. |

Step 7 List all of the likely types of resource use that would be involved in each of the options, even if you do not think that you will be able to measure them all. Include things that do not involve direct financial outlay (such as your time and patients' time). Remember to include travelling costs.

Step 8 Try to quantify the resource use for each of the options (including the current service). If you cannot be precise, make separate estimates for the 'best case' and 'worst case' for each option. Value the resource use so that it can be combined in terms of euro. Where the resource use has no easily observed price try and link it to things that do. For example, rather than say the time of voluntary workers has no value because they are unpaid, include an estimate that reflects the value of their input such as the hourly rate for a comparable paid worker. Remember to include the costs of replacing current services if they are to be continued in another way.

Step 9 Bring the costs and scores data together in a table, such as the following:

Table 4: An Economic approach

e.g. Treatment of minor anxiety/depression	Option A: Routine GP care & anti-depressants	Option B: Practice counsellor & anti-depressants	Option C: Referral to a clinical psychologist
(all options include routine GP care, and cost of GP time is not included)			
Cost	€65	€265	€300
Total score, Comprising	13	20	21
Criterion 1: evidence of short term effectiveness	6	6	5
criterion 2: patient acceptability	4	9	8
criterion 3: potential long term benefit	3	5	8

(please note: this is an illustrative example only, costs and benefits will vary with local circumstances)

It can be helpful to present different scenarios taking account of the 'best case' / 'worst case estimates' to show what impact these might have on the data.

- Step 10** Feedback to the key decision-makers for further discussion. Is the extra benefit of option C worth the extra cost? Decide on the preferred option and prepare an action plan for implementation.

Box 7

Issues of economics approach might address

- Areas of care that use a lot of resources e.g. What is the most efficient use of practice nurse's time?
- Areas where there are different interventions or approaches to care e.g. should the practice change prescribing to take account of a proposed guideline?
- Common conditions e.g. What is the most cost effective way to manage low back pain?
- Areas where significant capital investment is considered , e.g. new building or expensive equipment

G. An economic approach Example

The purpose of this piece of work was to identify the most cost-effective service for older persons who are medically fit for discharge from an acute-hospital setting. The quality, quantity, outcomes and cost of the different options were assessed in order to establish the most efficient and cost-effective service.

The eastern region has a particularly high number of acute hospital beds occupied by older persons who are medically fit for discharge. In the majority of cases these older persons would prefer to be at home, however due to circumstances including the lack of community beds and resources, they often remain in hospital for longer than is medically necessary.

This needs assessment was established as part of an economic review of the effectiveness of the new 'Home First: Discharge from Hospital to Home' service. The aim of this new service is to provide a community based support framework for older persons needing additional care in their home after being released from the hospital setting. Older persons can lose some of their independence after being in a hospital setting and often require additional support to adjust back into their normal home based environment.

The four options examined were:

- a) Continue to keep the older person in an acute hospital bed
- b) Discharge the older person to a public or private nursing home
- c) Discharge the older person into the community with the 'normal' level of community services
- d) Discharge the older person to the 'Home Help: Discharge from hospital to home' programme

The cost and outcomes of keeping a person in an acute hospital bed can be extracted from the Casemix and the Activity Based Costing systems. The cost of providing a contract bed was used as a proxy for the cost of a nursing home bed. These costs were easy to obtain and hence did not necessitate the establishment of a pilot programme for these two options. A pilot programme was established for the remaining two options with clients randomly selected to each of the pathways. The principle outcomes assessed are client preferences, average weekly levels of care received, numbers of older persons still at home 6 months after discharge from the hospital and overall cost-effectiveness.

The data used came from a variety of sources including community care teams, public health nurses and the private care agency employed to provide the additional community based care. Individual care plans were used to monitor the level of care received and patient and carer surveys were also undertaken.

Neither option required the use of additional capital or equipment and hence the main costs included were labour. A complete needs assessment may include the cost of various items such as transport, lost productivity, time loss, impact on family and friends etc.

The main results of this economic needs assessment for the two options progressed can be seen in table 5 below:

Table 5: Two options of economic needs approach

	Patient preference	Level of care per week	% at home after 6 months	Cost-effectiveness
Control Group	No	1.5 hours	68%	Lower
Home First	Yes	22 hours	100%	Greater

This economic needs assessment illustrates that the preferred option by both the clients and the carers is the 'home-first' service. With this service the average client receives an additional 20 hours a week of care in their own home. It should be noted that some clients receive substantially less than this level of care with others receiving up to 40 hours per week. This result suggests that the service may benefit from a maximum dependency criteria if the financial cost of providing the service out-weighs that similar to a residential nursing home.

A key outcome was the fact that all patients released under the 'Home First' programme were able to return to their own homes and were still living there 6 months later compared with only 68% residing at home with the standard level of community services.

The 'Home First' scheme has now been implemented in a number of areas across the region.

Additional Information in relation to these projects can be obtained from Valerie Nagle – Health Economist , HSE Eastern Region. Tel: 01 6201680

Section 2

Routine data sources: What they do and don't tell you

Routine data sources are those that are already collected. Because you cannot dictate the information gathered, they may not tell you exactly what you want to know but they are often useful and should be readily available. It is important to understand the uses and limitations of these data. The 'who to ask for help' section (section 6) includes sources of help and advice to access and interpret routine data.

Census data

What this tells you

The census gives information on the demography of an area including age, gender, social class, living alone, overcrowding, car ownership etc. This helps generate a social profile and is often used to compare areas to help targeting of resources.

Plus points

Census data are quantitative, reliable and can help understanding of the wide social context. It is carried out every 5 years with the last census in 2002.

Problems

Census data give relatively little information on morbidity though more ill health is expected in areas of poverty.

Vital statistical data (mortality, births and fertility)

What this tells you

Total numbers of births and deaths per year and causes of death are available by county.

The Department of Public Health in the HSE Eastern Region have coded deaths by small area (District Electoral Division or DED) and analysed the data for the period 1994-99. This work continues.

Similarly, data for births is currently being geocoded at the Department of Public Health for the year 2002.

Plus points

This information is reasonably up to date and reliable.

Problems

The small number of births and deaths in an area in any year means the data may be readily skewed by a few unusual cases. Also the causes of death recorded on death certificates may be inaccurate. Again this information is available by DED, not practice or locality population.

Hospital activity data (HiPE)

What this tells you

Information is available on discharge rates by diagnostic categories and operative procedures. In-patient diagnoses are coded using the International Classification of Diseases (ICD). It is possible to look at the 'top ten' diagnoses or the total number of discharges with any specified diagnosis.

Plus points

These data are reliable, up to date.

Problems

Use of hospital services is influenced by factors other than morbidity, e.g. ease of access and the policies of local doctors. Data are 'episode based' which means it does not differentiate one patient with many admissions and many patients with one admission each. The data is not available by practice or geographical area such as Community Care Area.

Hospital cost data

Casemix and Activity Based Costing System

What this tells you

A comparison of activity and costs between the designated hospitals. Summary of total hospital costs by care and treatment area. Inpatient costs by speciality and category of use. The cost per discharge by speciality, the average cost of a day case, consultant-led OPD, day case, dialysis session or A&E attendance.

Plus points

Available from hospital casemix unit, activity based costing unit or finance officers.

Problems

Different HSE Regions may allocate costs in marginally different ways. The figure shown is an average across all patients using that facility. The costs include hospital overheads and thus do not reflect the resources that would be released if the person was not in hospital. Resource use after discharge and the value of patients' time is not included.

Practice data

What this tells you

Most practices have a wealth of information on paper or on computer. This might include the demography of the practice population, consultation rates, proportions of the population screened and immunised, data on rates of risk factors such as smoking, repeat prescriptions, disease registers. Public Health nurses hold information on their child population (such as surveillance findings and breastfeeding rates) the elderly population and people with disabilities. Some practices code diagnoses for each patient seen and this gives useful information about morbidity. A survey of patient records or of consultations over a short length of time could be used to count patients seen with defined conditions. This can be used to compare with other practices or with the rates of common conditions expected from published surveys.

Plus points

These data may be available for individual practices. Collecting and analysing it can encourage teambuilding. This data can be useful in initiating guidelines, carrying out baseline and repeat clinical audits, planning service changes.

Problems

The quality of practice data varies which limits comparison between practices. Small numbers of events in a practice each year make it hard to interpret differences. It is time-consuming to collect data or survey notes. This only gives information about morbidity presented to the primary care team which will probably under-estimate morbidity in the community.

Published survey data

What this tells you

Published community surveys of morbidity give rates of conditions or risk factors found, often for each age/sex group. These can be applied to the practice or locality population to give an estimate of the 'expected' number of people with each condition or risk factor assessed. This can be used where no data on these conditions are available for the population or can be

compared with the number of identified patients with a condition if it is thought that some are being missed.

Plus points

These data can give a good estimate of morbidity in the community and can show potential unmet need.

Problems

The survey population may differ from yours, so these data cannot tell you the true burden of morbidity in your population. The information also cannot be used as a baseline to evaluate any interventions.

Other data sources available in the UK

RCGP morbidity survey in general practice

What this tells you

The RCGP Morbidity Survey provides data from a representative sample of English and Welsh General Practices. These practices input Read coded diagnosis for all GP consultations. This gives estimates of the numbers of patients presenting with each diagnosis coded. This can be used to estimate prevalence or incidence of diseases and GP workload related to each condition.

Plus points

These data can give a good estimate of morbidity in the community and can show potential unmet need. They represent conditions seen in general practice, and the working diagnoses given. Incidence or prevalence rates can be obtained for different age groups, and applied to your own practice population to estimate likely morbidity.

Problems

Many patients in general practice have non-specific complaints, and GPs may vary in the diagnoses they give these patients. These data cannot tell you the true burden of morbidity in your population and cannot be used as a baseline to evaluate any interventions.

Important note

The HSE Health Protection Surveillance Centre (formerly NDSC) in conjunction with the Irish College of General Practitioners and the Virus Reference Laboratory has established a network of sentinel practices (n=33) which report the number of patients with influenza-like illness on a weekly basis.

Techniques and tools

If you want information that is not routinely collected, you will need to use a research tool e.g. a survey, or qualitative methods like focus groups. These are often costly and require time and expertise, but allow you to gather information geared closely to your requirements. Other techniques, e.g. nominal groups and ranking matrices, help you to systematically prioritise identified health needs or possible actions. Some tools and techniques are described briefly below, with some benefits and limitations of each. This is not intended to be a comprehensive guide to using these methods: unless you are experienced in them, you should seek expert help and advice.

Quantitative surveys

Quantitative postal or interview surveys count responses to the questions you have defined.

What this tells you

A survey can measure the number of people sampled who report defined conditions, report use of defined services, or who say they need defined services. Health status can be assessed using measures such as the SF-36.

Plus points

A well-conducted survey of a representative sample can give a reliable estimate of the true burden of morbidity in the population whose needs are being assessed. This quantitative information is useful to inform contract specification. Information about health status can be used to compare different groups or areas.

Problems

Surveys are time-consuming, expensive and costly. They can only answer pre-set questions so needs which have not been considered by the investigators in advance may be missed.

Focus groups

What these are

Focus groups are discussion groups using non-directive questioning so that respondents are not restricted to, the researcher's pre-determined ideas. They can give useful insights into perceived needs, use of services, understanding of health and health-care.

Plus points

Focus groups are a useful way to identify areas not previously identified because participants are not restricted to set responses. Thus they are good at identifying unmet needs. This also allows more participation of the community in needs assessment.

Problems

These do not give quantifiable information. Training is required to facilitate focus groups. To be representative you need a suitable variety of groups.

Qualitative interviews

What these are

Qualitative unstructured or semi-structured interviews are interviews which do not simply ask for answers to pre-defined questions, but allow respondents to explain their perceptions and insights. An interview schedule may be used to guide discussion, but related issues that arise are also discussed. They can give useful insights into perceived needs, use of services, understandings of health and health-care.

Plus points

Like focus groups, qualitative interviews are a useful way to identify areas not previously identified because participants are not restricted to set responses. Thus they are good at identifying unmet needs.

Problems

These do not give quantifiable information. Training is required to undertake these. To be representative a variety of different people should be interviewed, and this can be time consuming.

Participatory rapid appraisal

What this is

This is an approach which involves local people in assessing needs. Visual methods like mapping with residents, interviews with 'key informants' (individuals with knowledge of the community because of their job or social position), observation and documents about the community are used to gather information about both needs and resources in the community. The information pyramid below is one framework used to guide collection and analysis of data: information on problems and resources is gathered for each block of the pyramid. Identified problems and interventions are then ranked to find priorities.

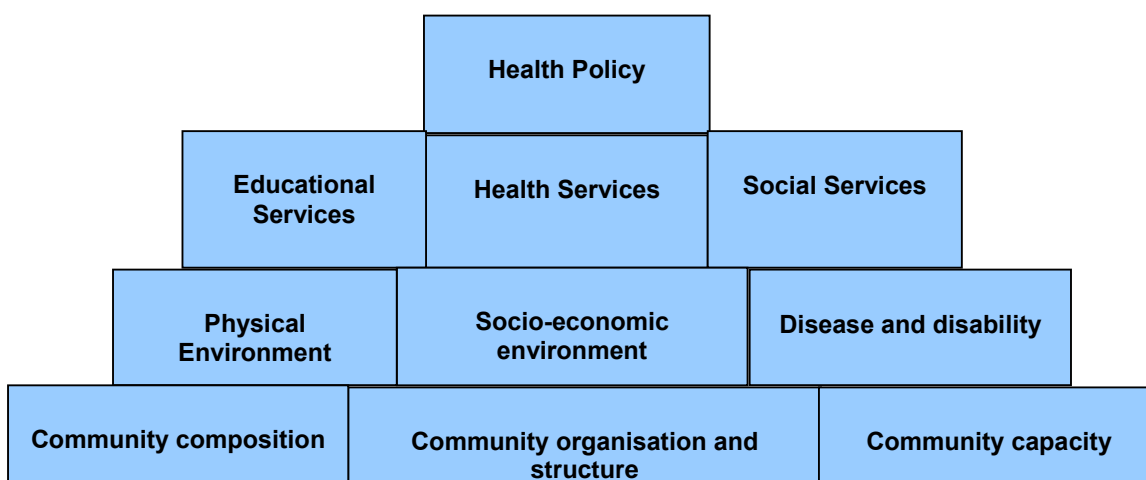


Figure 4: Information pyramid for PRA (Annett & Rifkin, 1995)

Plus points

This gives a broad perspective on health and the social context. It is a quick way to gather a lot of data, involves the local community and by raising awareness can stimulate community action. It finds the main perceived needs and problems in an area.

Problems

Training is required to perform a PRA and it needs protected time. It finds out what the problems are but does not measure the number of people affected. To work well, it requires a well-defined community.

Nominal group

What this is

This is a method of prioritising needs. A meeting of the people to be involved in setting priorities (e.g. PHCT/locality team, community group, healthy alliance group) is set up. Needs identified by participants are listed, discussed, then ranked by each participant until an agreed level of consensus is reached. This can be a structured way to use the insights the PCT often has into the needs of patients.

Plus points

Both qualitative (the discussion) and quantitative (the rankings) data are generated. This approach encourages team-building. Relatively quick results are obtained.

Problems

Training is required to facilitate nominal groups.

Ranking matrix

What this is

This is another method to prioritise identified needs or proposed interventions. It works by measuring different interventions against pre-determined criteria. Possible criteria could include: potential to improve health, available capacity to implement, equity implications etc. Participants in a ranking matrix exercise first weight the criteria, then give each intervention a score for each criterion. Each score is multiplied by the weight, and the scores are totalled for each intervention. In the example below, the criteria are all weighted equally and the outcome is that smoking education is the highest priority.

Proposed interventions			
Criteria	Smoking education	Counselling service in a community	Lobby for bus service
Potential health gain	5	2	1
Capacity to implement	2	3	2
Addresses inequalities	4	4	4
TOTAL	11	9	7

Table 6: Ranking matrix of proposed interventions (adapted from Annett & Rifkin, 1995)

Plus points

Using a ranking matrix allows explicit decision making as it is very clear on what criteria you have based your decisions. Community members can participate to get scores that represent community views.

Problems

You need to decide the possible interventions and criteria first. The group may disagree on scores, so you need to decide how to agree the consensus scores.

Section 3

Other resources or 'toolkits'

The health needs assessment guide chosen as an introduction for this pack is only one of the many that is available currently.

The Rough Guide to Needs Assessment in Primary Care was chosen because of its simplicity and practical approach. Other guides or books may appeal to individual PCTs as they become involved in particular projects. The following is a list of some of the other books and resources available.

- 1) ***Health Needs Assessment in Primary Health Care A workbook for primary health care teams. J Hooper and P Longwith 1998*** A very clear workbook that could form the basis of course for PCGs to develop health needs assessment together. It has a very useful resource pack in it. Available on the web at: <http://www.geocities.com/HotSprings/4202/index.html>
- 2) ***Health Needs Assessment Step by Step. C Acton and E Newbronner York Health Economics Consortium 1998*** A short practical guide that includes instructions for Emis, Microdoc and Genisyst users for extracting practice information that may be required. Also includes some information on presenting data.
- 3) ***A Toolkit for health needs assessment in Primary Care Sheffield Health Authority 1996*** Uses the LAPIS system to illustrate how to proceed with health needs assessment in Sheffield. This could be adapted for Leicestershire, which uses similar types of information in the Gazette.
- 4) ***Community Oriented Primary Care. S Gillam, D Plamping, J McClenahan, J Harries, L Epstein. The Kings Fund 1994*** The theoretical background with lots of examples of how community oriented needs assessments can work. Training courses are available from the Kings Fund.
- 5) ***Needs assessment in General Practice S Gillam, S Murray. Royal College of General Practitioners Occasional Paper 73 October 1996*** An overview with pertinent examples of different types of needs assessment
- 6) ***Needs Assessment. A series of 6 articles in the British Medical Journal BMJ 1998; 316 25th April - 30th May*** A new series of articles, clearly explaining different aspects, and with many references for those who wish to read further
- 7) ***Needs to know. A guide to needs assessment in primary care. Edited by Andrew Harris. Churchill Livingstone 1997*** A series of articles looking at the needs assessment from many perspectives. Not a work book, but provides excellent overviews of the topic.

BIBLIOGRAPHY

There are many texts which cover aspects of needs assessment in primary care, and in addition there are texts which describe research methods in some detail and community development and advocacy approaches. The list below is intended as a further reading guide rather than a comprehensive summary of relevant literature.

Annett H and Rifkin S (1995) Guidelines for rapid participatory appraisal to assess community health needs. Geneva World Health Organisation

Bain, M., Chalmers, J., Brewster, D. (1996) 'Data accuracy and completeness: general practitioner versus hospitals.' *Brit J Gen Pract*, vol. 46, pp. 495.

Bradshaw, J. (1972) 'A taxonomy of social need.' in Maclachlan, G. (ed.) *Problems and progress in medical care*. 6th edition. Oxford.

Charlton, B.G. et al (1994) 'Health promotion priorities for general practice: constructing and using "indicative prevalences".' *Brit Med J*, vol. 308, pp. 1019-22.

Clarke, A.M. & Thomas, F.G. (1990) 'The geography of the 1991 census.' *Population Trends*, vol. 60, pp. 9-15.

Colledge, M. et al (1996) 'Geographical information systems in general practice: a new tool for needs assessment.' *J Informatics in Prim Care*, Mar 96, pp. 7-11.

Crown, J. (1991) 'Needs assessment.' *Brit J Hosp Med*, vol. 46, pp. 307-8.

Cresswell, T. (1992) 'Assessing community health and social needs in North Derbyshire using participatory rapid appraisal.' *Med Sociology News*, vol. 17, pp. 27-38.

de Koning, K. & Martin, M. (1996) 'Participatory research in health: setting the context.' In de Koning, K. & Martin, M. (eds) *Participatory research in health*. London: Zed books.

Department of Health (1993) 'Involving consumers in local health care.' In *Consumers and Research in the NHS*. London: DOH.

Dickersin, K. Scherer, R., Lefevre, C. (1994) 'Identifying relevant studies for systematic review.' *Brit Med J*, vol. 309, pp. 1286-91.

Douglas, M.J. (1996) 'Needs assessment in primary care' MSc dissertation, University of Edinburgh.

Frankel, S. (1991 a) 'Health needs, health-care requirements and the myth of infinite demand.' *Lancet*, vol. 337, pp. 1588-90.

Frankel, S. (1991 b) 'The epidemiology of indications.' *J Epidemiol & Community Health*, vol. 46, pp. 257-9.

Gallagher, M. et al (1993) 'The nominal group technique: a research tool for general practice?' *Fam Pract*, vol. 10, pp. 76-81.

- Gillam, S. & Murray, S. (1996) Needs assessment in general practice. London: RCGP occasional paper.
- Harris, A. (1997) (ed) Needs to Know: a guide to needs assessment for primary care London: Churchill Livingstone.
- Hopton, J.L. & Dlugolecka, M. (1995) 'Need and demand for primary health care: a comparative survey approach.' *Brit Med J*, vol. 310, pp. 1369-73.
- Hooper, J. & Longworth F (1997) Health needs assessment in primary care. A workbook for primary health care teams. Calderdale and Kirklees Health Authority.
- Kitzinger, J. (1995) 'Introducing focus groups.' *Brit Med J*, vol. 311, pp. 299-302.
- ISD, SCIEH & Aberdeen University Department of General Practice (1996) Continuous morbidity recording in general practice: project overview.
- Marsh, G.N. & Channing, D.M. (1988) 'Narrowing the health gap between a deprived and an endowed community.' *Brit Med J*, vol. 296, pp. 173-6.
- Maudsley, G. & Williams, E.M.I. (1996) 'Inaccuracy in death certification-where are we now?' *J Public Health Med*, vol. 18, pp. 59-66.
- Mooney, G. (1992) Economics, medicine and health care. 2nd edition. London: Harvester Wheatsheaf.
- Morgan, M., Mays, N., Holland, W.W. (1987) 'Can hospital use be a measure of need for health care?' *J Epidemiol & Community Health*, vol. 41, pp. 269-74.
- Murray, S.A. & Graham, L.J.C. (1995) 'Practice based health needs assessment: use of four methods in a small neighbourhood' *Brit Med J*, vol. 310, pp. 1443-8.
- Murray, S.A. et al (1994) 'Listening to local voices: adapting rapid appraisal to assess health and social needs in general practice.' *Brit Med J*, vol. 308, pp. 698-700.
- NHS Management Executive (1992) 'Local voices: the views of local people in purchasing for health.' London: NHSME.
- Ong, B. N. et al (1991) 'Rapid appraisal in an urban setting, an example from the developed world.' *Soc Sci Med*, vol. 32. pp. 909-15.
- Plamping, D. (1994) 'Community oriented primary care.' *Prim Care Management*, vol. 4, pp. 10-13,
- Pope, C. & Mays, N. (1995) 'Reaching the parts other methods cannot reach: an introduction to qualitative methods in health and health services research.' *Brit Med J*, vol. 311, pp. 42-5.
- Royal College of Nursing (1994) The GP practice population profile: a framework for every member of the primary health care team. London: RCN.
- Scrivener, G. & Lloyd, D.C.E.F (1995) 'Allocating census data to general practice populations: implications for study of prescribing variation at practice level.' *Brit Med J*, vol. 311, pp. 163-5.
- Twinn, S., Dauncey, J., Carnell, J. (1992) The process of health profiling. London: Health Visitors Association.

Section 4

Education and training for health needs assessment in Primary Care Teams

Introduction

The Health Service Executive is structuring the various developmental needs of primary care. Health needs assessment is one of those areas. The purpose of this document is to give a vision for a proposed structure for education and training of professionals in primary care for health needs assessment (HNA).

Our Vision

Our vision is that all primary health care staff are aware of their role and responsibility in improving the health of their population. This necessitates a willingness to improve the health of their population as well as treat illness in individuals.

In order to achieve this vision, in the new primary care structure, there are educational and training needs among professionals and managers. While it is tempting to dwell on the need for skills in this area, it must be emphasised that making this really happen requires a cultural shift. Getting individuals skilled up is relatively easy. Effecting a change in people's attitudes and behaviour takes time and the commitment of senior people in primary care.

Health needs assessment - why bother?

Health needs assessment is now an accepted part of planning for and commissioning of any health service. Indeed it has a wider role in informing planning across agencies where there is an impact on health. By studying the needs in a community a PCT will be (a) able to respond more sensitively to local need, (b) inform the process of prioritisation and so target local health improvements and (c) use savings wisely.

The current position

Awareness of need for health and health services, coupled with the skills needed to carry out such an assessment, are largely to be found centrally, either in the HSE Departments of Public Health or in third level colleges. Increasingly most undergraduate and post graduate courses in health services encompasses elements of needs assessment. The aim of education and training for health needs assessment should be to:

a) raise awareness within primary care of the need for a proactive population approach to improving health status and b) impart appropriate skills and develop useful networks to facilitate selected individuals carrying out this work.

Skills needed at primary care team/network level are:

- 1) Information on data sources, data collection, manipulation and interpretation (qualitative and quantitative);
- 2) Profiling of practice/PCT using data available and then focusing down on one area/problem;
- 3) Basic familiarity with statistics;
- 4) Understanding need, supply and demand;
- 5) Strategy development, implementation and review;
- 6) An overview of prioritisation within healthcare;
- 7) An overview of health economics;
- 8) The role of clinical effectiveness in meeting need;
- 9) PCT/N role in developing and implementing HimP;
- 10) Awareness of local initiatives; and
- 11) Working with other agencies.

It is important to recognise that providers of primary care will have a sizeable learning curve in addressing this agenda. However, it is also important to note that primary care team members do not start from zero. Furthermore, professionals who have undertaken audit skills courses will also have confronted the areas of proactive care, and certain skills common to HNA.

Audience and levels of involvement

- The audience for training in HNA work is largely those professionals within PCT/Ns, though other professionals and managers/administrators in the region would also benefit from participation.
- It is envisaged that the groups to be targeted would be
 - a) Members of the PCT/Ns,
 - b) CCA/ Local Health Office
- It must be recognised that different levels exist in terms of
 - a) initial knowledge and awareness,
 - b) interest in personal and professional development
 - c) commitment on a day-to-day basis.

Way forward

In structuring an education and training programme for health needs assessment in primary care the following points should be considered:

- 1) That Primary Care Teams and Networks are made aware of the importance of HNA. Management should be asked to a) outline their organisational strategy for education and training for health needs assessment and b) outline who, in the PCT/N carries the responsibility for ensuring that robust needs assessment supports planning decisions.
- 2) PCT/N members should be encouraged to address the following issues:
 - a. that the majority of team members attend a general awareness seminar on HNA;
 - b. that individuals be identified who are key to this work in each PCT/N and that they be given basic and advanced skill courses;
 - c. that each PCT/N start a programme to skill up professionals in basic knowledge; and
 - d. that each PCT/N liaise, at an early stage and in accordance to regional communication structures, with the Dept of Public Health in order to initiate specialist input to HNA.

Section 5

Information for carrying out health needs assessments

Information area	Data items	Source	Comments
1. Indicators of need <i>Age and gender</i> <i>Socio-economic indicators</i>	Defined by age sex bands such as: 0-4 years 5-14 years 15-44 years 45-64 years 65-74 years >75 years There are many variables useful in the health context such as % unemployed Age education ceased House ownership/tenancy elderly living alone	General practice age/registers Central Statistics Office (CSO) HSE Central Statistics Office (CSO) Department of Public Health, HSE Eastern Region may be able to help with data at small area	Last census 2002
2. Mortality rates	All cause SMR All cause SMR < 75 years Mortality rates by cause: CHD Stroke Respiratory Disease All cancers Accidents and poisonings	Dept. of Public Health, HSE Eastern Region	Caution in interpreting for practices because of small numbers. Mortality rates need to be based on 5 years data or more
3. Births	Birth rate (per 1,000 population) Fertility rate (Births per 1,000 women 15-44 years) Stillbirth rate (per 1,000 total births) Low birth-weight (% births <2.5kg)	Dept. of Public Health, HSE Eastern Region	
4. Indicators of demand/need based on service use			
Primary care i) GP consultation rates ii) Prescribing	Total consultation rate Daytime visit rate Home visit rate Night visit rate	Data may be available in some practices	This sets out what is possible in some other countries. However very limited data in Ireland in this area. See next page

Information area	Data items	Source	Comment
Secondary care i) Hospital activity	Discharge data on disease and procedures	Dept of Public Health, HSE Eastern Region	Uses ICD codes, Currently using ICD 9 Coded by clerks at the discharge of patients. The quality of data depends on accuracy and completeness of medical records.
ii) Outpatient attendances	No. systematic availability of data	HSE Eastern Region	
iii) Accident and Emergency	A number of variables are collected about the patient and the type of incident	A& E departments. Dept of Public Health, HSE Eastern Region may be able to assist.	
5. Resource Indicators			
A) Staffing levels	GPs Practice nursing Administration staff Home Helps and Home Care Assistences Public Health Nurses Registered General Nurses, Community psychiatric nurses, midwives, PAM (Professions allied to medicine)	AHB CCA's/ LHO General Practice	Can be broken down into numbers of whole time equivalents per 10,000 per population
B) Budget/expenditure	GMS expenditure	GMS (payment) Board	
C) Prescribing	Practice prescribing data	GMS (payment) Board	Many variables of interest and prescribing indicators are available.

Information area	Data items	Source	Comment
7. Quality of care			
A) Screening/immunisation	% achieved immunisation targets Breast screening	Practice records Dept of Public Health AHBs BreastCheck	Check completeness and accuracy May be available
B) Special data	Locally collected from audits, surveys, focus groups, patient group surveys and reports	Practices Health Authority University Departments	Much is by word of mouth. No database exists currently.

Section 6

Who to ask for help

1. Eastern Region

Organisation	Address	Contact Name	Telephone No.
HSE Eastern Region	Department of Public Health Dr Steeven's Hospital Dublin 8	Dr Siobhan Jennings Dr Howard Johnson	01 6352071 01 6352040
HSE Eastern Region	Department of Planning, Commissioning & Change Mill Lane Palmerstown Dublin 20	Ms. Angela Fitzgerald (Director) Ms Mo Flynn (Senior Commissioner for Primary Care) Ms Bernadette Kiberd (Service Planner -Primary care) Ms Karen Burke (Service Planner Acutes)	01 6201835 01 6201664 01 6201833 01 6201655
HSE South Western Area	Primary Care Oak House Millennium Park Naas Co Kildare	Ms Pauline Bryan (Director of Primary Care) Ms Valerie Whelan (Primary Care Manager)	045 880400 045 880400
HSE Northern Area	Primary Care Swords Business Campus Balheary Road Swords Co Dublin	Ms Orla Treacy (Director of Primary Care) Ms Concepta De Brun (Primary Care Manager)	01 8131800 01 8131800
HSE East Coast Area	Primary Care Block B Civic Centre Bray Co Wicklow	Ms Niamh O'Rourke (A/Director of Primary Care) Mr John Fennell (Primary Care Manager)	01 2744215 01 2744200
University College Dublin	Belfield Dublin 4		
Royal College of Surgeons	St Stephen's Green Dublin 2		
Trinity College Dublin	Dublin 2		
Dublin City University	Glasnevin Dublin 9		
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Section 7

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Section 8

Glossary of terms

CEA	Cost effectiveness analysis. Used in health economic analysis. Compares different interventions in terms of natural outcomes, such as deaths avoided, cases detected etc.
Demography	The study of populations, especially with reference to size, distribution, mortality, fertility, ethnicity.
Evidence based guidelines	Guidelines in which the evidence for recommendations has been assessed and graded according to pre determined standards
Focus groups	A method of exploring potential areas of interest in greater depth with small groups of people See p 50
GMS	General Medical Services
GMS(P)B	General Medical Services (Payment) Board
ICD	International Classification of diseases
Incidence	The number of new events within a specified period of time. Incidence Rate: the number of new events in specified period/ number of persons exposed to the risk during this period
Morbidity data	Information about levels of illness or disease in a population
PCN	Primary Care Network
PCT	Primary Care Team
PRA	Participatory rapid appraisal. See page 51
Prevalence	The number of cases of a disease or condition in a given population at a designated time
Qualitative data	Observations or information characterized by measurement on a categorical scale
Quantitative data	Data in numerical quantities such as continuous measurements or counts
SF 36	Short form 36. A questionnaire based measurement of quality of life
SMR	Standardised mortality rate: the number of deaths in a population, adjusted for the age breakdown of that population