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From 1 April 2005, the functions of the Health Development Agency transferred to the National Institute for Clinical Excellence.

The new organisation is the National Institute for Health and Clinical Excellence (to be known as NICE). It is the independent organisation responsible for providing national guidance on the promotion of good health and the prevention and treatment of ill health.

The web address from 1 April 2005 is [www.nice.org.uk](http://www.nice.org.uk)

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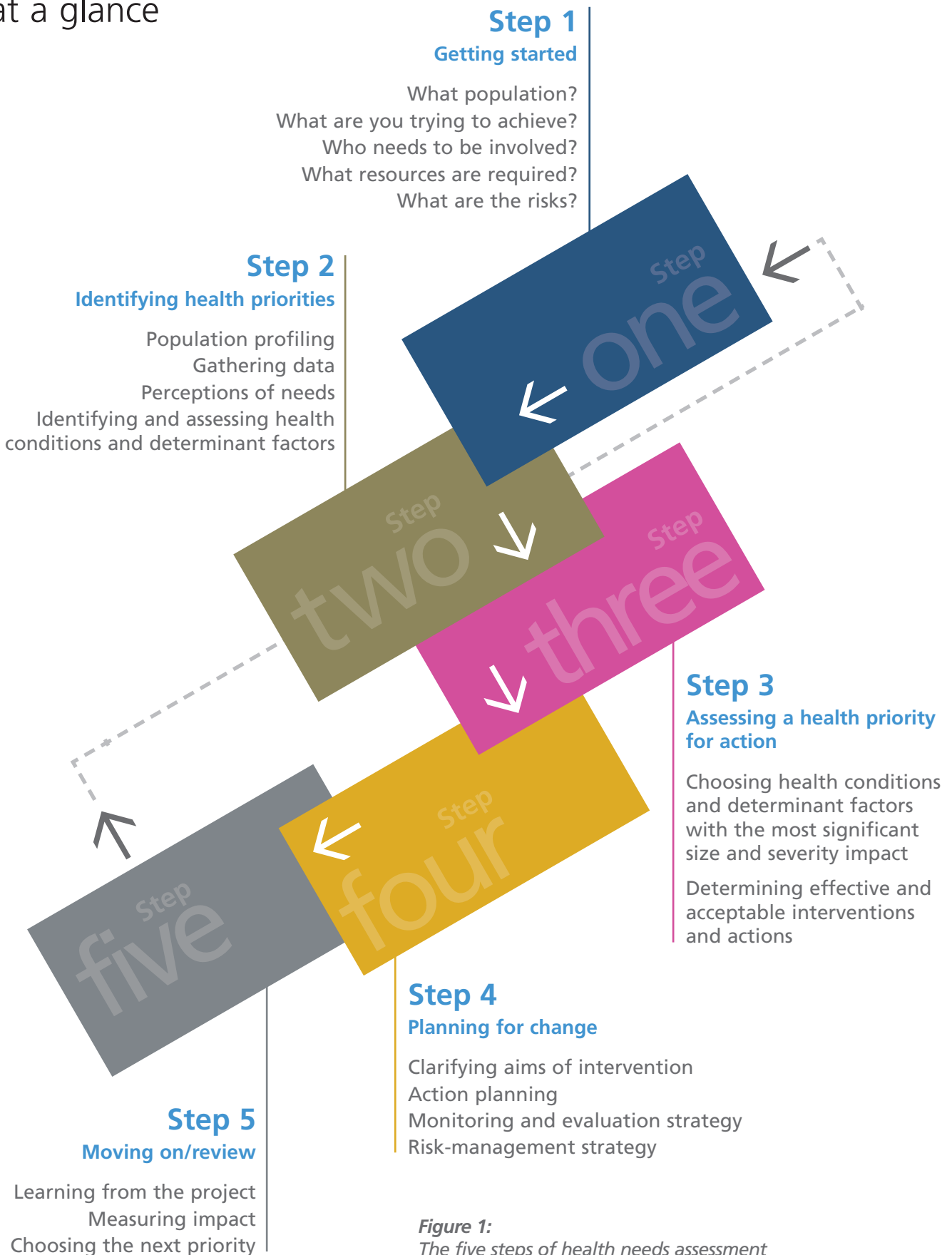
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Summary:  
Health needs assessment  
at a glance



# Summary: Health needs assessment at a glance



**Figure 1:**  
*The five steps of health needs assessment*

## What is health needs assessment?

Health needs assessment is a systematic method for reviewing the health issues facing a population, leading to agreed priorities and resource allocation that will improve health and reduce inequalities.

## Why undertake HNA?

- HNA is a recommended public health tool to provide evidence about a population on which to plan services and address health inequalities
- HNA provides an opportunity to engage with specific populations and enable them to contribute to targeted service planning and resource allocation
- HNA provides an opportunity for cross-sectoral partnership working and developing creative and effective interventions

## How does HNA support national and local priorities?

The government is committed to reducing health inequalities within the population. It has set a public service agreement to: **'REDUCE HEALTH INEQUALITIES BY 10% BY 2010 AS MEASURED BY INFANT MORTALITY AND LIFE EXPECTANCY AT BIRTH'**

[www.hm-treasury.gov.uk/media/70320/sr04\\_psa\\_ch3.pdf](http://www.hm-treasury.gov.uk/media/70320/sr04_psa_ch3.pdf)

HNA provides a vital tool to meet this objective, and is recommended in various policy documents to inform regional and local strategic plans.

## What are the benefits of HNA?

Benefits from undertaking HNAs can include:

- Strengthened community involvement in decision making
- Improved team and partnership working
- Professional development of skills and experience
- Improved communication with other agencies and the public
- Better use of resources.

## What are the challenges of HNA?

- Working across professional boundaries that prevent power-or information-sharing
- Developing a shared language between sectors (see Section 2)
- Obtaining commitment from 'the top'
- Accessing relevant data
- Accessing the target population
- Maintaining team impetus and commitment
- Translating findings into effective action.



# 1 Introduction





# 1 Introduction

**Health needs assessment (HNA) is a systematic method for reviewing the health issues facing a population, leading to agreed priorities and resource allocation that will improve health and reduce inequalities.**

The purpose of this guide is to provide practical assistance to everyone engaged in undertaking HNA, including strategic managers at regional and local levels, facilitators, and practitioners in primary care trusts, local government and the voluntary and community sectors.

This guide has been developed from the original *Health needs assessment workbook* (Hooper and Longworth, 2002), published by the Health Development Agency (HDA). This revised edition has been produced to:

- Present HNA within the current political and professional context
- Provide additional practical resources
- Highlight the important contribution HNA can make as part of HDA's Evidence into Practice approach to tackling health inequalities.

The Department of Health (DH) charged the HDA to support the Evidence into Practice approach to improving health outcomes, based on integrating evidence, learning and locally derived practitioner knowledge and local improvement needs. The systematic process used in HNA provides ideal opportunities for engaging with specific communities, gathering evidence from and about them, and utilising an evidence-based approach to effect service changes and improvements with their full involvement.

Various tools and guides have been produced by individuals and organisations in recent years

to assist practitioners undertaking HNAs. Many are listed in Section 6, Bibliography and references. Some are based on the approach outlined in the original HNA workbook (Hooper and Longworth, 2002), but offer more detailed assistance with particular types of HNA, or are designed for certain practitioner groups. Although project leads should acquaint themselves with the various HNA tools and guides that have been produced, using the core process in this guide will ensure a consistent and robust process is followed and enable easier comparison between HNAs. The systematic process promoted in this guide has been well tried, tested and refined over several years by practitioners, many of whom have actively informed this edition.

This guide outlines five steps that will enable a simple but robust process to be undertaken. This process is flexible, but the steps should be adequately covered to ensure a quality process – eg health profiling alone is not HNA, nor is undertaking a rapid appraisal exercise, but both can contribute. An HNA should always lead to positive action, and implementation and dissemination strategies are an essential part of the process. This guide attempts to keep the core information to a minimum, but signposts to additional resources are included throughout.

Although for clarity the process is described as linear, in reality frequent cross-checking and revision across steps will be required.

The case studies provided in this publication are examples of HNAs undertaken with a range of populations. They are intended to be illustrative, and experiences may differ when undertaking similar HNAs.

# How does HNA support national priorities?

The aim of the government's health inequalities strategy is to narrow the gap in health between different social and economic groups and areas. It has set a national public service agreement target to:

**'REDUCE HEALTH INEQUALITIES BY 10% BY 2010 AS MEASURED BY INFANT MORTALITY AND LIFE EXPECTANCY AT BIRTH'**

[www.hm-treasury.gov.uk/media/70320/sr04\\_psa\\_ch3.pdf](http://www.hm-treasury.gov.uk/media/70320/sr04_psa_ch3.pdf)

HNA provides a vital tool in helping to meet this objective through targeting populations most in need of improved support and services.

HNA linked with commissioning has been an integral task of health authorities since 1989. *Saving lives: our healthier nation* (DH, 1999) stresses the importance of the community's role in identification of health needs and priorities; and *Shifting the balance of power within the NHS: securing delivery* (DH, 2001) gave specific responsibility to primary care trusts. The Wanless report *Securing good health for the whole population* (Wanless et al., 2004) also emphasises the importance of high levels of public engagement in order to achieve optimum gains in health outcomes and a reduction of health expenditure in the long term. The HNA approach provides an ideal opportunity for different agencies to build trust with communities to ensure genuine partnership involvement in reconfiguring services.

HNAs can usefully inform:

- Health equity audits (see Section 2, page 17)
- Local delivery plans
- Community strategies
- Specialised services commissioning
- Health and social care joint planning and commissioning
- General practice strategic development plans.

HNAs are sometimes conducted by voluntary, community and charitable organisations to collect information about their target communities for funding and project planning purposes. When public sector agencies are conducting HNAs, they should check with voluntary and community organisations to see what information they have collected and, where appropriate, to involve them in project teams or stakeholder groups.

## Benefits and challenges

Benefits from undertaking an HNA can include:

- Strengthening community involvement in decision making
- Improved public patient participation
- Improved team and partnership working
- Professional development of skills and experience
- Improved patient care
- Improved communication with other agencies and the public
- Better use of resources.

The value of HNA to general practice and the General Medical Services contract lies in the contribution it can make to improving data quality, which is important to meeting quality

indicators; developing chronic disease registers; and providing information for an evidence base of need which can support funding applications to provide enhanced services. It also supports the clinical governance agenda and information required for National Service Framework targets.

HNAs are a requirement of professional competency for the UK voluntary register of public health specialists and for Part 2 Faculty of Public Health examinations, but they must demonstrate a robust process involving sound epidemiological and social science methodologies (see Section 3, page 27 and Section 4, pages 52-53).

Challenges that may be encountered when undertaking an HNA can include:

- Working across professional boundaries – tackling territorial attitudes preventing power or information sharing:
  - develop positive working relationships with colleagues within other sectors
  - develop an understanding of organisational structures/priorities/objectives
  - ensure others are clear about the benefits to their organisation/profession of conducting HNA.
- Lack of a shared language between sectors:
  - consider definitions in section 2 of this guide (see pages 12-17)
  - consider ways of jargon busting to keep communication accessible to all involved (see Plain English Campaign, Section 4, page 50)
  - consider impact of different language within sectors and be creative about using language that relates to the sectors involved (eg is it possible to undertake a community needs assessment versus a health needs assessment if the issue of 'health' is viewed negatively by some sectors?)
  - develop dialogue with and between sectors in the early planning phase (step 1, page 22) to explore developing a shared language.
- Lack of commitment from the top:
  - identify and establish who needs to be in agreement with the HNA at 'the top'
  - consider ways of communicating the value and benefits of the HNA to key senior stakeholders
  - promote examples of successful HNA work in other organisations (see Case studies).
- Difficulties in accessing relevant local data:
  - consider trawling professional contacts for suggestions on accessing relevant data
  - explore the national, regional and subregional data available from health observatories (see Section 7) and consider their usefulness/relevance to your project
  - consider experiences from Case studies for different ways of accessing required data.
- Difficulty in accessing the target population:
  - consider whether the target population has been over-assessed, and discuss with key stakeholders whether information is available elsewhere
  - review intended methodology for accessing target population and consider if there are other, more creative ways, of accessing population (see Tools and resources)
  - explore examples of other HNAs that have accessed similar populations (see Case studies).
- Difficulty in maintaining team impetus and commitment:
  - review progress and positively reinforce achievements
  - ensure all team members are aware of achievements and progress; assist members in breaking down the HNA into bite-sized chunks in order to build on work undertaken
  - check out team commitment to the task, and identify solutions as a team to improve motivation/impetus.

- Difficulty in translating findings into effective action:
  - review findings in line with other known targets/objectives at national, regional and subregional levels
  - consider findings in terms of short- and long-term action – clarify what can be achieved in the short-term and build on progress towards long-term goals
  - explore resource implications, and whether findings can assist in developing debate/discussion on resource allocation.

'Too often in the past we have devoted too much time and energy to analysing the problems and not enough to developing and delivering practical solutions that connect with real lives.'  
(*Choosing Health*, page 14, DM, 2004)

## Resources required to start an HNA

Before committing to an HNA project and proceeding beyond step 1, ensure you have the capacity to meet the challenges and to employ the resources that may be involved. A project lead with strong management skills should be appointed– but the lead does not have to have all the skills required for HNA, as other members of the team, or consultants, can be brought in to assist. There are also many other sources of help available – see Section 7.

Health needs assessments are worthwhile undertaking only if they result in changes that will benefit the population. It is therefore essential to be realistic and honest about what you are capable of achieving.

Check that:

- Clear aims and objectives for the project have been identified
- There is an established need for the project (eg a recent assessment has not already been done)
- The right people are involved – this should include **who knows** about the issue; **who cares** about the issue; and **who can** make change happen
- There is sign-up to the project from senior managers and policy makers
- A lead coordinator with project management skills can be appointed
- Access to the target population and their willingness to engage with the project has been established
- A committed and skilled project team can be appointed (see pages 50-53 for possible skills required)
- Key stakeholders can be identified
- The proposed project team has adequate resources – time, space, equipment, skills and funding – to conduct a good quality HNA.



## 2 Common language



## 2 Common language

**The following terms underpin the health needs assessment process described in this publication. It is important that HNA project teams and stakeholders adopt a shared language for key terms at the start of a project, to ensure there is agreed understanding of objectives.**

### Health

Health is defined as a positive concept that emphasises social and personal resources, as well as physical capabilities. It involves the capacity of individuals – and their perceptions of their ability – to function and to cope with their social and physical environment, as well as with specific illnesses and with life in general (WHO, 1984; Baggott, 1994).

### Inequalities in health

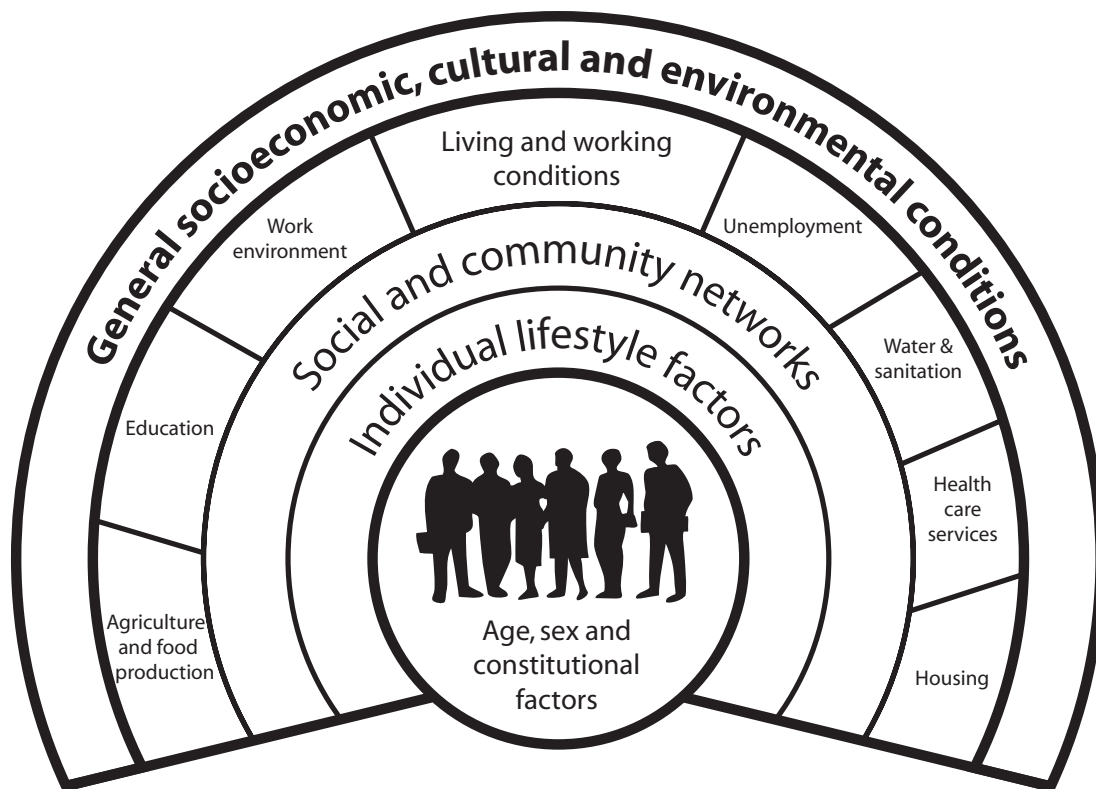
All government departments are now committed to closing the gap between the most advantaged sections of society and the least advantaged, as defined by childhood mortality and life expectancy. HNA can be a useful tool in this process through targeting services and support towards the most disadvantaged groups (DH, 2003a).

### Health needs

These can be:

- Perceptions and expectations of the profiled population (felt and expressed needs)
- Perceptions of professionals providing the services
- Perceptions of managers of commissioner/provider organisations, based on available data about the size and severity of health issues for a population, and inequalities compared with other populations (**normative needs**)
- Priorities of the organisations commissioning and managing services for the profiled population, linked to national, regional or local priorities (**corporate needs**).

An HNA should involve comparing and balancing these different needs when selecting priorities (see also definitions of need by Bradshaw, 1994; Stevens and Rafferty, 1994). The information can then be used as a basis for bringing about change through negotiation with stakeholder groups.



**Figure 2**  
*Influences on health*  
[Dahlgren and Whitehead (1991); from Acheson (1998)]

## Determinants of health

This is a concept based on the model of Dahlgren and Whitehead (1991) (see Figure 2 above), which suggests that there are complex, multi-layered influencing factors with an impact on the health of individuals. At the centre are factors including age, gender and genetic inheritance. In the second layer are behavioural patterns such as smoking, diet and physical activity. In a third layer are social position, economic resources and the material environment. The fourth layer includes the wider or underlying determinants, consisting of social

and community networks, work environment, housing and living conditions, education and transport. In the outer layer are the economic, political, cultural and environmental conditions present in society as a whole.

Tackling health inequalities requires action within all these layers of influence, and HNA can be used to identify, assess and prioritise where effective action should be targeted. The HNA should therefore involve a multi-agency team in collecting information about specific populations, along with cross-sectoral stakeholders capable of, and committed to, undertaking a range of actions to improve health and service delivery.



# Population

HNA populations can be identified as people sharing:

- Geographic location – eg living in deprived neighbourhoods or housing estates
- Settings – eg schools, prisons, workplaces
- Social experience – eg asylum seekers, specific age groups, ethnicity, sexuality, homelessness
- Experience of a particular medical condition – eg mental illness, diabetes, respiratory disorders.

Often a target population will be identified through a combination of main and subcategory groups, eg older people living in a deprived rural area and recovering from a stroke.

# HNA selection criteria

HNA is worthwhile undertaking only if it results in changes that will benefit the population. It is essential to be realistic and honest about what you are capable of achieving. Four criteria should be used in selecting issues for intervention:

- **Impact** – which health conditions and determinant factors have the most impact, in terms of size and severity, on the health functioning of the population?
- **Changeability** – can the most significant health conditions and determinant factors be changed effectively by those involved in the assessment?
- **Acceptability** – what are the most acceptable changes needed to achieve the maximum impact?
- **Resource feasibility** – are there adequate resources available to make the required changes?

# Levels of prevention of ill health

There are three levels at which interventions can be effective in tackling ill health for individuals and within populations:

- **Occurring** – preventing the problem occurring at all (primary prevention)
- **Recurring** – preventing the problem progressing or recurring by detecting and dealing with it (secondary prevention)
- **Consequences** – preventing the consequences or complications of the problem (tertiary prevention).

# Diseases and health conditions

Diseases and health conditions experienced within a population are important when they affect health functioning. Diseases and health conditions can sometimes be caused or exacerbated by a determinant factor, such as poor housing or smoking. In the process of undertaking HNA, actions or interventions that can reduce disease and ill health should be considered at all three levels of prevention (see above)

# Health functioning

Health functioning can be defined as the individual's or population's experience in terms of whether the health condition or determining factor:

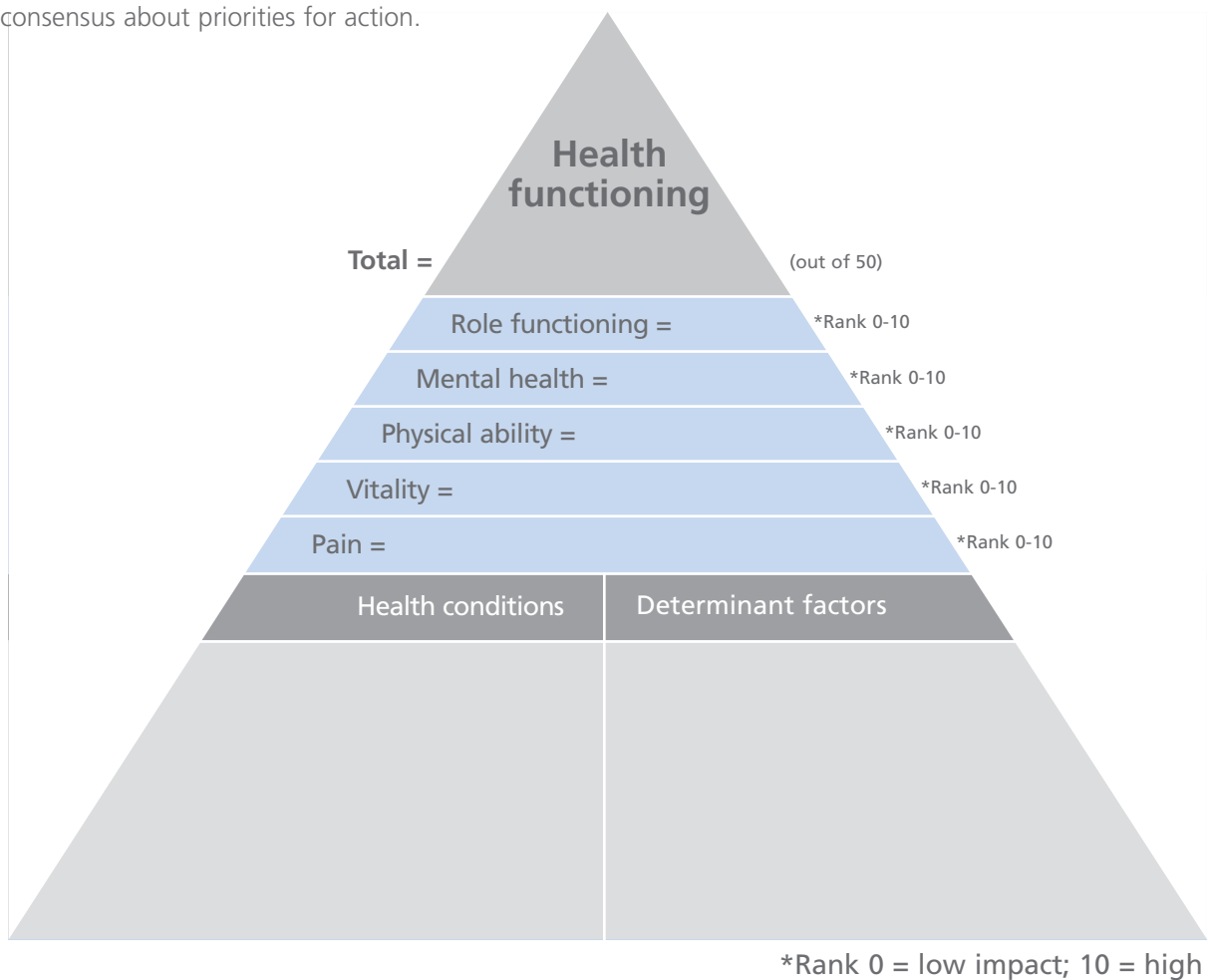
- Negatively affects social **roles** of caring, partnering, friendship, sexual relationships, employer/employee
- Negatively affects the population's level of mobility (**physical ability**)
- Causes physical **pain**
- Contributes to **mental illness**
- Negatively affects energy levels (**vitality**).

# Health triangle

The health triangle is an analytical tool that can assist in:

- Identifying potentially important health issues for the population
- Reviewing the associations between health conditions, determinant factors and health functioning (see previous definitions)
- Structuring the collection and presentation of data to compile a useful profile.

The health triangle should be used with the target population and all main stakeholders to achieve consensus about priorities for action.



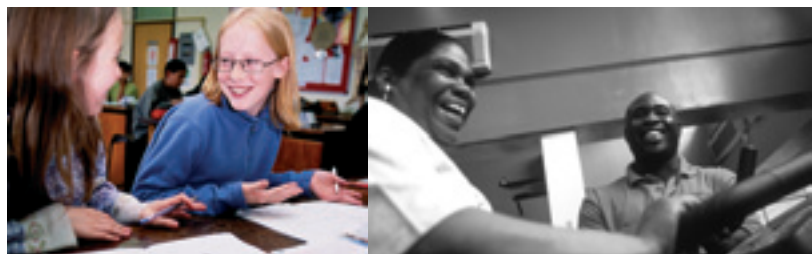
Note: A high impact score for health functioning indicates a priority for action

**Figure 3**  
*The health triangle*

[adapted from the original model used by Hooper and Longworth (2002)]

## Partnership

Local collaboration by statutory, voluntary, community and private sector organisations in planning and implementing economic, social and health programmes. Local strategic partnerships may commission HNAs.



## Stakeholders

The different partners or sectors who should be involved in decisions about health, regeneration and other programmes. Stakeholders for HNA may include representatives from local business, education, police, housing, transport, social services and leisure, as well as from health agencies. Most importantly, they should include members and representatives from the target population.

## Community engagement

A general term used in this context to describe the active participation of local people in defining priority issues and being part of the solution-determining process.

## HNA and other assessment tools

HNA is one of several approaches being used across sectors to help improve health and reduce health inequalities. Other frequently used tools include health impact assessment (HIA), integrated impact assessment (IIA) and health equity audit (HEA). Although there are similarities in these approaches, a key difference is their starting point.

- **HNA** starts with a population – when the health needs of that population are known, proposals are put forward for the development and delivery of improved programmes and services.
- **HIA** starts with a policy or project, and predicts the impact on the health of the population.
- **IIA** starts with a policy or programme, and predicts the impact on economic, social and environmental outcomes.
- **HEA** starts with a defined population, and is a process whereby local partners systematically review inequities in the causes of ill health and in access to effective services for that population. HNA might be an action undertaken in response to inequities identified by HEA; or might be used to inform HEA about inequities in the population and how they might best be addressed.

Each of these approaches involves a variety of similar research methods, but it is important to select the assessment tool according to your aims and objectives. Similarities and differences between these tools are covered in more detail by Quigley et al. (2005).

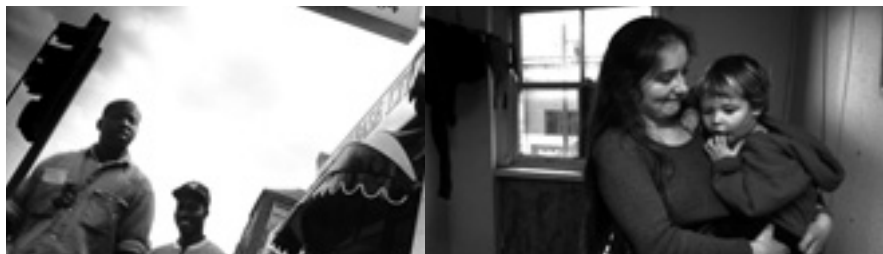




### 3 The five steps of health needs assessment



### 3 The five steps of health needs assessment



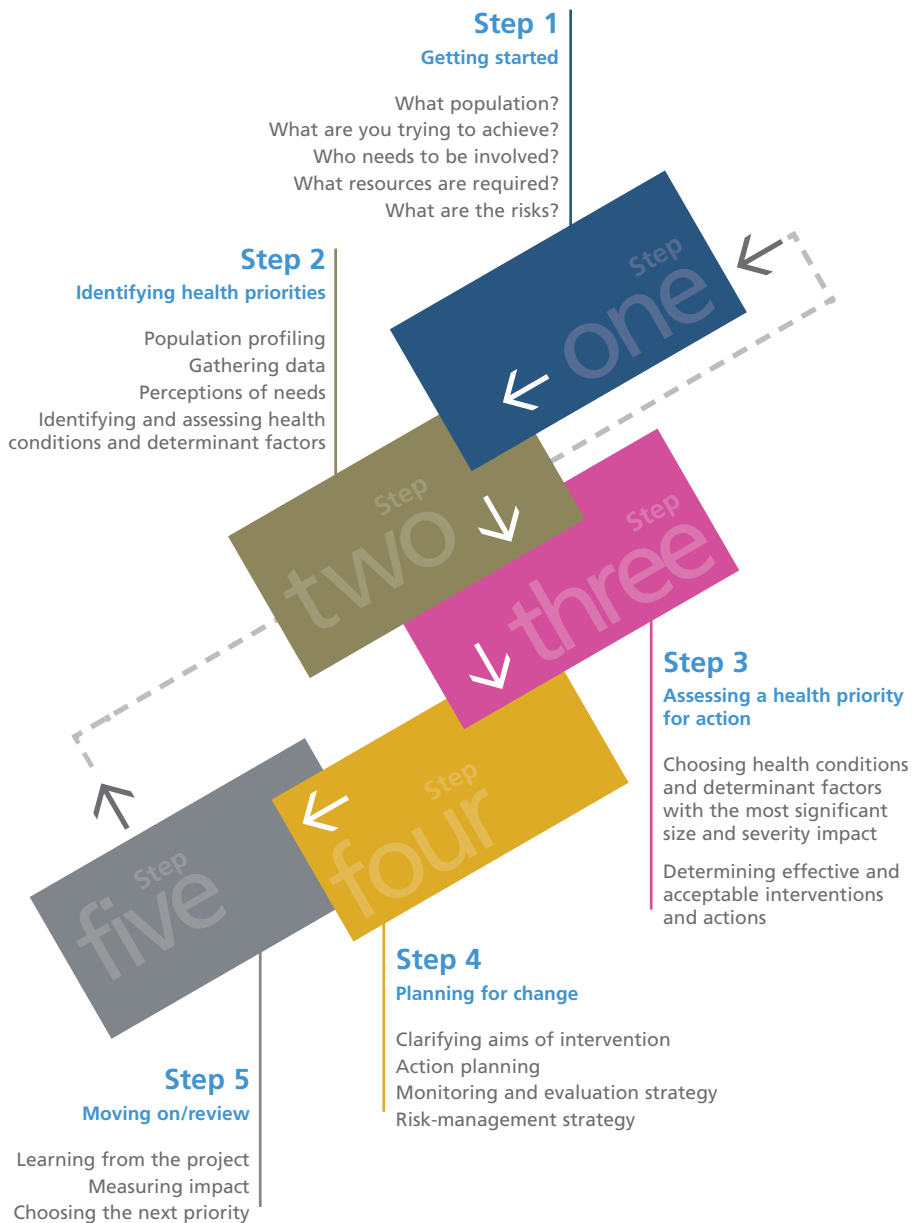
The five-step project planning process outlined here presents a set of practical activities and quantitative and qualitative research exercises that will ensure a robust and systematic assessment, with tangible outcomes, is undertaken. The information gained can be used to inform service delivery and improve health outcomes for a targeted population, as well as leading to other potential benefits, as outlined in Section 1. The process includes some exercises and models, eg the health triangle (Figure 3, page 15), to assist the project team in identifying priority health conditions and underlying factors affecting the health of the population, and in reaching a consensus on appropriate interventions for positive change. This five-step process is based on the model outlined by Hooper and Longworth (2002), which provides further information relating to the steps on pages 25–89. Additional help with many of the practical skills and methodologies associated with the steps are provided in Section 4.

As each project will be unique, and will differ in complexity, it is difficult to provide time estimates for the HNA process – a project may take anything from a couple of weeks to several years. The time that individual members of the team can allocate to the project should be considered at the beginning to ensure the scope of the project is realistic.

See the five steps diagram opposite.

Although the step approach, as presented in this publication, may indicate a linear process, in practice the process requires cross checking and regular revisions. It is therefore important to be aware of the key elements within all the steps from the start of the project. Some activities, such as evaluation and risk management described in step 4, will need to be applied throughout the whole project, as well as to the interventions selected to implement health improvements.

## The five steps of health needs assessment





# Step 1

## Getting started

To undertake this first step, you should assemble a group of people who are interested in the project to consider the following questions. Ensure that you record your decisions for future referral, report writing and evaluation purposes. Invest some time in making sure people have a shared understanding of the common language (see Section 2) – this will avoid a lot of potential confusion later on.

By the end of this step you should:

- Have a clear definition of the population you are going to assess
- Have a clear rationale for the assessment and its boundaries
- Know who needs to be involved, and how
- Understand what resources are required, and how to keep the project on track.

### WHAT POPULATION AND WHY?

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Have you clearly defined your main population? eg **all people living in a disadvantaged neighbourhood**.

Have you clearly defined any subpopulation groups? eg **children under five and their families** living in a disadvantaged neighbourhood.

Why have this population and any subpopulation groups been chosen?

- Are there any specific issues about this population that makes it significantly more important than other local populations for assessing health needs?

- Does this population have significantly worse health than others locally – are there significant health inequalities?

How does the population you have selected relate to national, regional and local priorities for improving health and reducing health inequalities?

### WHAT ARE YOU TRYING TO ACHIEVE?

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- Set clear aims and objectives for your HNA – ensure these have not already been addressed by other agencies by checking across sectors (statutory and voluntary)
- Check that the aims and objectives are realistic in terms of current or projected resources available
- What relevant information is available about this population?
- Ensure you have checked existing policy directives and priorities relating to the selected population, and that you understand the remits of the organisations involved
- Ensure the target population has not already been assessed to death!

These points will help clarify not only what you are trying to achieve, and why, but also what is outside the scope of the assessment.

### WHO NEEDS TO BE INVOLVED?

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Consider the following:

- A project leader who can lead and oversee the HNA process, ensure methodological quality, and be a coordinating link



- A team to undertake the assessment – consider what skills will be needed at different stages of the project
- Key stakeholders – consider the range of stakeholders who should be involved and be clear about their remit. Ensure the stakeholder group includes representation and involvement of the target population as well as multi-agency representation to drive through change
- Senior managers and policy makers – ensure you have their agreement and commitment to support any necessary changes arising as a result of findings from the HNA.

Consider:

- Who knows about the problem/issue?
- Who cares about it?
- Who can do anything about it?

This can help clarify who needs to be involved in different steps in the process.

### WHAT OTHER RESOURCES WILL YOU REQUIRE?

---

Consider:

- Time
- Meeting space
- Access to the population
- Access to data
- Skills
- Funding to conduct the project.

### WHAT RISKS MIGHT YOU ENCOUNTER, AND HOW WILL YOU OVERCOME THEM?

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Try to anticipate as many barriers and threats to the project as possible, and consider strategies for overcoming these (see pages 7-9 Benefits and challenges and pages 43-44, Process evaluation).

### HOW WILL YOU MEASURE SUCCESS AND ENSURE THE PROJECT STAYS ON TRACK?

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As soon as you are confident you are going to proceed with the project, you will need to develop a monitoring and evaluation process for each step in the process (see pages 43-44, Monitoring and evaluation strategy, for more detailed advice).

### REVIEW – STEP 1

At the end of step 1 you should be clear about the population you are working with, and have clarified the aim of the assessment and its boundaries. You should also know whether or not you have the capacity to undertake the type and scope of project you are considering.



## Illustrative case study – Step 1 Getting started

### Health Needs Assessment for a Sure Start Programme in West Newcastle upon Tyne

<p>What population, where located and why chosen?</p>	<p>Children under four, their families and carers living in a defined geographical area of West Newcastle upon Tyne. The area was chosen as the three wards made up the third, fourth and seventh most deprived in Newcastle and North Tyneside according to multiple deprivation scores</p>
<p>What were the aims and objectives?</p>	<p>The HNA was part of the Sure Start programme planning process. To work with parents-to-be, parents and children to promote the physical, intellectual and social development of babies and young children – breaking the cycle of disadvantage</p>
<p>Who was included in the project team?</p>	<p>The HNA was led by the Public Health Nurse for West Locality and an experienced community development worker employed by Riverside Community Health Project established in offering family support in the area</p>
<p>Who was included in the stakeholder group?</p>	<p>Local workers in health, social care, education and many representatives from local non-statutory services, local parents, grandparents, carers and children</p>
<p>What resources were required?</p>	<p>The Public Health Nurse and Community Development Worker were allocated some time within their present jobs to undertake this work. A request for early funds was successfully made which helped pay for the community development workers' extra hours and some of the additional consultation</p>

## Step 2

# Identifying health priorities

**By now you will have a working definition of the population you will be assessing, and have clarified the aim of the assessment and its boundaries. The next step is to identify the health priorities for that population.**

By the end of step 2 you should have:

- Identified the aspects of health functioning and conditions and factors that might have a significant impact on the health of the profiled population
- Developed a profile of these issues
- Used this information to decide a limited number of overall health priorities for the population, using the first two explicit selection criteria of HNA –
  - **Impact** – they have a significant impact in terms of severity and size
  - **Changeability** – they can be changed locally.

Within any population, there is a potentially huge number of issues that could be tackled to improve health and reduce inequalities. The process of choosing priorities is at the heart of the health assessment process. It involves making hard decisions. Involving people in the debate that leads to these decisions is crucial if they are going to be carried through and acted on. This highlights the need to check that the right people are involved before you start.

In choosing priorities, you are trying to screen out issues that do not meet the first two HNA selection criteria – impact and changeability (see Section 2, page 14). Consider each criterion in turn to narrow down the list of issues that could be tackled. If an issue is not seen as having a significant impact, you do not need to consider it for changeability.

This step involves a series of field activities and assembly of data to gather information about health issues affecting the defined population. The information sources for any needs assessment include:

- Perceptions of the population
- Perceptions of service providers and managers
- Data on the size of the potentially important aspects of health functioning/conditions/factors and population characteristics
- Relevant national, local or organisational priorities.

*Note: useful skills, tools and resources relating to these activities are in Section 4 (see also page 36 of Hooper and Longworth, 2002). The field activities will require careful planning to ensure the quality of the findings.*



## POPULATION PROFILING

Gather general information about the target population:

- How many people are in the target group?
- Where are they located?
- What data are currently available about them?
- What are the main common experiences and differences within the group?

How does the population perceive its needs?

- Hold workshops or focus groups for those involved in this assessment, such as representatives from the population and providers
- Interview key people
- Send out questionnaires (see page 38 of Hooper and Longworth, 2002)
- Consider reaching individuals/groups who might be excluded from the main consultation methods (see Community engagement, page 50; Henderson et al., 2004, pages 70–81).

## WHAT ARE THE HEALTH CONDITIONS AND DETERMINANT FACTORS AFFECTING THE HEALTH FUNCTIONING OF THE TARGET POPULATION?

However you have gathered your data, a list of the health conditions and determinant factors affecting the population should be pulled together for final debate and agreement. These will form the main outcomes of the assessment, and are important in steps 3 and 4 when planning for change.

The determinant factors that might be affecting health conditions (see Section 2, page 13, Determinants of health) can be grouped under five general categories:

- Social
- Economic
- Environmental
- Biological
- Lifestyle.

## WHAT HEALTH CONDITIONS AND DETERMINANT FACTORS HAVE A SIGNIFICANT IMPACT ON HEALTH FUNCTIONING?

Use the health triangle (see Section 2, page 15) to assess what impact the health conditions and determinant factors have on the health functioning, in terms of size and severity, of the profiled population.

Then review the list for:

- Health conditions and determinant factors whose evidence of impact is unknown or contested – then delete them
- Health conditions and determinant factors that are relatively unimportant in size and severity – then delete them
- Check that all relevant national or local priorities have been included.

Share the list with all stakeholder groups involved to check for completeness, accuracy and understanding of the results of the assessment.

### EXAMPLE: TARGET POPULATION – CHILDREN UNDER FOUR AND THEIR FAMILIES

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#### Health conditions:

- Low birth weight
- Post-natal depression
- High levels of accidental injury in children.

#### Determinant factors:

##### Social –

- Experience of domestic violence
- Isolation/loneliness
- Isolation from family support
- Low English language proficiency.

##### Economic –

- Lack of access to training and employment
- Low income
- Low parental educational achievement.

##### Environmental –

- Unfit housing/hostels/temporary accommodation
- Lack of access to health services
- Lack of community and play facilities
- Poor transport links.

##### Biological –

(may be determinant factors, but unchangeable; see page 29, Changeability)

- Gender/sexuality/age/ethnicity
- Genetic factors
- Mental and physical disabilities.

##### Lifestyle –

- Substance and alcohol abuse
- Smoking
- Poor nutrition.

### CHOOSING PRIORITIES ACCORDING TO IMPACT ON THE HEALTH OF THE POPULATION

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The rest of this step can be done in one or a number of workshop(s) with all those who should be involved. Profiling involves using valid data from various sources and comparing this with different perspectives of participants may seem daunting. Remember the main function of data is to act as a check for the results of the preceding discussions about perceptions. Follow these principles when considering data:

- **Essentials** – information not directly relevant to the objectives of profiling should be ignored
- **Bias** – all information is subject to a bias, whether incomplete; untimely; varied definitions, etc – this is fine so long as any bias is identified and acknowledged

- **Triangulation** – assemble the data from a range of sources – if they emerge with similar results or themes, these will be reasonably robust; if not, consider whether their biases are different.

### WHICH HEALTH CONDITION/ DETERMINANT FACTORS HAVE A SIGNIFICANT IMPACT, IN TERMS OF SEVERITY, ON HEALTH FUNCTIONING?

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Put each of the identified health condition/determinant factors in a list of high, medium or low impact by assessing each for severity:

- Does the health condition/determinant factor significantly affect the most important aspects of health functioning?
- Does the health condition/determinant factor significantly affect other issues that affect health?

- Does the health condition/determinant factor significantly affect long-term health?
- Does the health condition/determinant factor cause death?

**WHICH HEALTH CONDITIONS/ DETERMINANT FACTORS AFFECT THE HEALTH FUNCTIONING OF MANY PEOPLE – SIZE IMPACT?**

Review known data or information on incidence or prevalence, either directly about your

population, or extrapolated from other, similar populations. Consider:

- **Absolute size**, eg number of cases of post-natal depression occurring within the population
- **Comparative size**, ie is the local size higher or lower than other local populations/national averages?

You may find using a table with these headings useful to draw out what the data are saying.

Choosing priorities according to size				
Data item	Data known? Yes/No	What do the data say?	Implications? So what?	Most important in size? Yes/No

**Table 1**  
*Recording impact – size*

Now enter both the severity and size impact ratings on Figure 4 (page 29).

Check that:

- Any health conditions and determinant factors where the evidence of impact is either unknown, extremely low, or contested are deleted from the list.
- Relevant national or local priorities are included in the list

- There is agreement on a final list of issues with significant impact in terms of size and severity on health functioning that can now be considered for changeability.

Finally, identify whose health is most likely to be at risk from the negative impact of these high priority health conditions/determinant factors – these will be the target population groups for action.

Health condition/ determinant factor	Impact			
	Severity (-ve/+ve)			Size Important
	High	Medium	Low	Yes / No

**Figure 4**  
Recording impact – severity and size

### CHOOSING PRIORITIES ACCORDING TO CHANGEABILITY

Which of the priority health conditions/ determinant factors can be effectively improved by those involved? Using the list of issues assessed for high impact of severity, assess them as:

- High – definitely changeable, with good evidence – keep in list
- Medium – some aspects significantly changeable, but not overall – possibly delete?
- Low – little, no or unknown changeability – delete from list.

Then check the list of priorities with both high impact and changeability for:

- Are all three levels of prevention assessed for action? (see Section 2, page 14)
- Are there relevant professional/ organisational policies that define recommended actions?
- Are these local and national priorities?
- Does this list of changeable priorities help to reduce health inequalities?

Ensure everyone is signed up to creating the final list of priorities and to taking these forward, and that the priorities are agreed by the most relevant senior planning groups.

It is important to be clear which organisations will need to be involved in taking the main priorities forward through step 3.

#### EXAMPLE: POST-NATAL DEPRESSION AND LEVELS OF PREVENTION

Provision of a safe babysitting service to isolated mothers, enabling them to have increased access to social and community activities, could be effective at all three levels: by preventing post-natal depression from occurring (primary); by preventing it from recurring or progressing (secondary); and by preventing or alleviating consequences of the problem (tertiary). (See Section 2, page 14).



Health condition/ determinant factor	Level of prevention Rank 0-10*			
	Occurring	Recurring	Consequences	Total

\*Rank 0=low; 10=high

**Figure 5**  
Changeability – levels of prevention

**COMPARE SCORES, COMMUNICATE THE FINDINGS AND SHORTLIST PRIORITIES FOR ACTION**

When you have assessed all the conditions and factors for impact and changeability, ensure you return to your population and stakeholder group with any preliminary findings.

Check that you have interpreted their input correctly, and that they understand the assessment results.

Aim for consensus between expert opinion, data and community perceptions when agreeing a shortlist of health priorities based on the findings. These can then be considered for selection in step 3.

**REVIEW – STEP 2**

At this point you should have identified a shortlist of health priorities for the profiled population, and assessed associated health conditions and determinant factors for each of these priorities for impact, in terms of size and severity and changeability.

This process will not have produced a totally objective assessment, but should ensure that issues are thoroughly debated and that a group consensus is reached about relative impact and priorities. If the project team’s assessment is regularly referred back to the stakeholder group and to the population for input, and adjustment if necessary, a democratic basis for further action will be established.

### ILLUSTRATIVE EXERCISE, GROUP ACTIVITY

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Aim: to assess the health conditions and determinant factors having an impact on children under four and their families in a deprived ward (number affected: 60 families).

As a team:

- 1 Identify the health conditions and determinant factors that might have a significant impact on the health functioning of children under four and their families
- 2 Select a health condition and enter this on the health triangle. Consider the relationship between the health conditions and each set of determinant factors (eg childhood injury with environmental factors; see example)
- 3 Reach a consensus about a final ranking for the effect of the health condition and its determinant factors on health functioning, by sharing individual rankings with the rest of the group and discussing differences
- 4 Consider how much the health condition and determinant factors:
  - affect health functioning
  - affect other health conditions
  - affect health, transiently or long term
  - cause death
- 5 Repeat this exercise for the same health condition and other determinant factors
- 6 Repeat the exercise with other health conditions and their determinant factors
- 7 Agree the severity ranking and size of the condition, and enter the findings on Figure 7
- 8 Consider each health condition/determinant factor for changeability across the three levels of prevention – occurring, recurring and consequences in the short to medium term. Enter findings on Figure 8
- 9 Compare scores for each factor on both impact and changeability, and prioritise issues for action.

## Illustrative case study – Step 2 Identifying health priorities

### Health Needs Assessment for a Sure Start Programme in West Newcastle upon Tyne

<p>How was a profile of the population developed?</p>	<p>The Public Health Nurse in conjunction with the Citywide Sure Start Health Coordinator collated quantitative data</p>
<p>What data were available on the health of the population?</p>	<p>Index of multiple deprivation scores (2000)</p> <p>Census information regarding numbers of families with under fours, levels of employment, lone parents, breakdown by ethnicity</p> <p>Going for growth consultation information and responses by local people; numbers of children on the child protection list, number of mothers experiencing post-natal depression; number with low birth weight babies; number of mothers with children under one; number of emergency admissions to hospital, SATs results, estimated literacy levels</p>
<p>How was information gathered about the population's and service providers' perceptions of needs?</p>	<p>Through multiple methods of consultation and ongoing involvement during the development of this Sure Start programme to include:</p> <ul style="list-style-type: none"> <li>• Meetings with existing parents' and grandparents' groups</li> <li>• Meetings with professionals in key organisations</li> <li>• The use of 'H' forms (a simple diagrammatic technique) to gather information about 'What was good about local services for families and young children, what was not so good, what would make things better, and what services people valued most?'</li> <li>• Kids' cocktail parties (consultation through fun activities for 3 to 14 year olds)</li> <li>• Passport to family support event</li> <li>• Under fives summer fun week and holiday activities</li> <li>• Newcastle Action for Parents and Toddlers Initiative Survey</li> </ul>
<p>What barriers were encountered?</p>	<p>Initially the parents in the two main communities were consulted separately, as they did not naturally meet, and eventually formed a whole representative group.</p> <p>In addition, one large area covered was undergoing consultation as a Going for Growth Regeneration Area, and there was much dissatisfaction with the local council at this time</p>

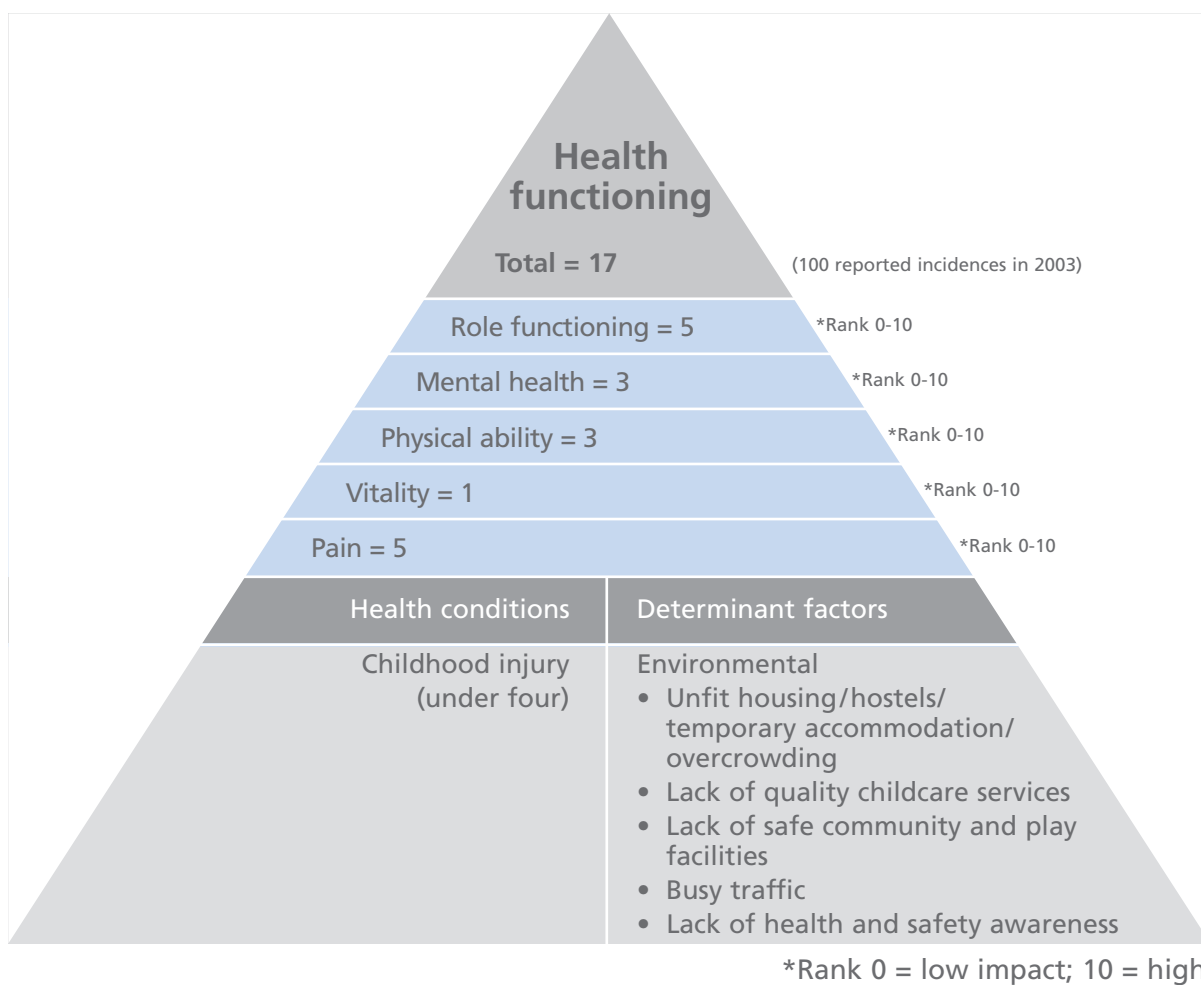
Cont...

*Illustrative case study - Step 2 Identifying health priorities cont.*

<p><b>How were these overcome?</b></p>	<p>The skilful work of the community development worker – lots of promotion of the HNA, and gradual and timely integration of two communities. The knowledge of local people that much of their wishes and needs could be realised in practice through Sure Start money</p>
<p><b>What were the key issues for the population?</b></p>	<p>From the qualitative data ,15 key points were raised where action could be taken across agencies, including:</p> <ul style="list-style-type: none"> <li>• More activities for children of all ages, and affordable leisure and sports facilities – specifically holidays and after school</li> <li>• An increase in the amount of affordable, good quality childcare</li> <li>• Health visitors must be more accessible within the community</li> <li>• Improved transport links to key services, specifically the need for lo-liner buses</li> <li>• Integrated services all on one site</li> <li>• Places for parents and children to meet and socialise</li> <li>• Improved family support, particularly for women suffering from post-natal depression</li> <li>• Home-based support and information about safety in the home, information and support to access safety equipment</li> </ul> <p>In terms of quantitative data, there was a need to increase access to training, education and employment, and to increase the educational attainment of the children in this area. There were many more areas for action</p>



Illustrative case study example of Figure 3 (page 15) health triangle used to assess the impact of accidental injury and determinant factors on the health functioning of children under four



Note: A high impact score for health functioning indicates a priority for action



Illustrative case study example of Figure 4: Impact size and severity rating

Health condition/ determinant factor	Impact			
	Severity (-ve/+ve)			Size (no. affected per year)
	High	Medium	Low	
Post-natal depression and environment	X			8
Low birth weight and environment			X	2
Accidental injury and environment		X		15

Illustrative case study example of Figure 5: Changeability – levels of prevention

Health condition/ determinant factor	Level of prevention Rank 0-10*			
	Occurring	Recurring	Consequences	Total
Post-natal depression and environment	5	0	8	13
Low birth weight and environment	0	0	4	4
Accidental injury and environment	7	7	5	19

\*Rank 0=low; 10=high

Note: In this example you might conclude that your team can do little or nothing to influence the effect of environmental factors in low birth weight in the short to medium term, but that it might be possible to intervene to reduce the incidence and consequences of post-natal depression and accidental injury. You might place these higher on the shortlist of priorities. But remember your stakeholders may disagree.

## Step 3

# Assessing a health priority for action

This step is the assessment of a specific health priority for action. The health priority may have been identified from either:

- The profile of the important aspects of health conditions/determinant factors for your target population and agreed list of health priorities – established by working through steps 1 and 2; **or**
- A national or local priority identified without population profiling or completing step 2 – eg a priority for many NHS planners is coronary heart disease, as both a national and local priority. If you are starting with a national or local priority it is crucial to ensure local ownership and involvement with that priority (see page 30).

By the end of this step you should have:

- Identified who should be involved in making the specific change happen, and included them in the process of choosing actions to tackle this health priority
- Gained a clear and shared understanding of the health priority through identifying the health conditions and determinant factors that have significant impacts on it
- Gained a clear understanding of the boundaries of the assessment
- Identified effective interventions to tackle this health priority
- Defined your target population
- Identified the changes required
- Confirmed that the proposed changes will help reduce health inequalities.

The task is to assess each specific health priority for change. The needs-led approach requires being clear about the 'what and why' before considering the 'how'. By completing this step you should be much clearer about:

- Why this specific health priority is important for the profiled population
- What changes you can make that will have a positive impact on the most significant issues affecting the priority.

This will ensure the detailed action planning in step 4 is based on sound information and clear assumptions.

This step starts with working through the same questions as for steps 1 and 2 for this specific priority, then applying the two final HNA selection criteria (see Section 2, page 14):

- **Acceptability** – what are the most acceptable changes required for the maximum positive impact?
- **Resource feasibility** – are the resource implications of these changes feasible?

### WHO IS BEING ASSESSED BY WHOM, AND WHY?

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It is important to be clear why the assessment of this specific priority is being carried out, and who cares enough to take any notice of the results.



Check:

- What is the aim of this assessment?
- Why are you doing this assessment?
- What are the boundaries of it?
- What are the fixed points?
- Who will be involved, when, and how?
- Are key partner agencies and groups involved or, if not, does this matter?

When you feel these are reasonably clear, gather together those involved to go through the following tasks. These may take some time, as you will probably need to collect information between the tasks.

### IDENTIFYING HEALTH CONDITIONS/DETERMINANT FACTORS THAT MIGHT HAVE A SIGNIFICANT IMPACT ON THIS HEALTH PRIORITY

Using the health triangle (see page 15):

- Identify the most important aspects of health functioning for people affected by this specific priority
- Ask each member of the group individually to rank the aspects of health functioning in terms of their importance to the health priority
- Reach a consensus about the final ranking by sharing their rankings with the rest of the group, and discussing any differences; write the aspects in the health triangle template
- Identify the health conditions and determinant factors that have a significant **impact** on the most important aspects of health functioning,

across the three levels of prevention (use the determinant factor groups and the levels of prevention as a check that important things have not been overlooked).

### CHOOSING THE HEALTH CONDITIONS/DETERMINANT FACTORS WITH THE MOST SIGNIFICANT IMPACT ON THIS HEALTH PRIORITY

Put each health condition/determinant factor identified into a list of high, medium or low impact, by assessing each for **severity** and then **size of impact** (see page 28).

#### Severity

- Does the health condition/determinant factor significantly affect the most important aspects of health functioning?
- Does the health condition/determinant factor significantly affect other issues that affect health?
- Does the health condition/determinant factor significantly affect long-term health?
- Does the health condition/determinant factor cause death?

Its impact could be at any of the three levels of prevention, and it could be either positive or negative.

Are there any issues whose strength of evidence about the **impact** is unknown (unclear, little, unknown, or no impact?)  
If so – delete them from the list.



## Size

Review any known data or information on incidence or prevalence directly for your population, or extrapolated from other, similar populations. Think about:

- **Absolute size**, eg number of cases of post-natal depression occurring within the population
- **Comparative size**, ie is the local size higher or lower than other local populations/national averages?

Look at the resulting flip chart for high, medium and low **severity**. Should any of the health

conditions or determinant factors move group when you consider:

- Their **size** in your population?
- Any national or local policies (corporate) or expressed needs.

If so, move them, and agree the final list of priorities as high, medium or low.

Finally, identify whose health is most likely to be at risk from the negative **impact** of these high-priority conditions/determinant factors – these will be the target groups for action.

**Example:** In one PCT that had 146 mothers with children under one year old, 27 were known to have post-natal depression, which equates to 18.5% of mothers in the area at that time. Following the processes outlined in step 3, the decision was reached to provide more home visiting support and a babysitting initiative.

## IDENTIFYING EFFECTIVE ACTION FOR THIS HEALTH PRIORITY – CHANGEABILITY

Taking the list of high-priority issues, check who else may need to be involved now, and how you might include them.

Create a list of potential actions by discussing:

- What are effective actions that could improve the significant health conditions/determinant factors across the three levels of prevention?

- What is the strength of their evidence of effectiveness?
- Are there professional or organisational policies that set out what should be done (eg National Service Frameworks, Social Services Inspectorate guidance etc)?

Include only those with positive evidence of effectiveness, or national 'must do's'.

Health Priority	Action	Action	Action	Action
Lower rates of accidental injury	Raise awareness through targeted health information literature	Provide safety awareness and first-aid courses for parents	Provide free smoke alarms and cupboard safety catches	Improve safety surfaces in playgrounds
Lower incidence of post-natal depression	Raise awareness of services available through targeted health information literature	Provide home-based family support, via safe babysitting, to isolated and vulnerable families	Increase access to post-natal health and fitness activities	Facilitate parent and baby support groups

**Figure 6**  
Identifying actions for the health priority to improve physical, intellectual and social development of under-fours in a disadvantaged area

## IDENTIFYING ACCEPTABLE CHANGES FOR THIS HEALTH PRIORITY – ACCEPTABILITY

For each of the effective actions agreed previously, check if similar activities for this priority are already happening. If yes, note:

- Who is involved in a similar activity locally?
- What is the target population for these actions, and how many recipients are there?
- Are these actions reaching the most disadvantaged?
- Are actions of the required quality?

Answering these questions should help to decide whether to improve existing action, or initiate new action.

Agree on a shortlist of potential effective interventions or actions, and consider these for public and professional acceptability. Remember that interventions or actions sometimes need to be grouped in order to be effective or to give a choice, and that single actions can have limited effect.

## WHAT ARE THE MOST ACCEPTABLE INTERVENTIONS/CHANGES?

Consider whether interventions or changes would be acceptable to:

- The target population and the wider community?
- Those delivering the activity?
- Organisations commissioning and managing the activity?

If any are totally unacceptable to one of these groups, should they be deleted from the list?

## WHAT ARE THE RESOURCE IMPLICATIONS OF THE PROPOSED INTERVENTIONS?

- What resources will be required to implement the proposed changes?
- Can existing resources be used differently to support the changes?
- Are other resources available that have not been accessed before?
- What resources might be released if existing ineffective interventions are stopped?
- Which actions will achieve the greatest impact on health for the resources used?

## ARE THE RESOURCE IMPLICATIONS OF THE PROPOSED CHANGES FEASIBLE?

It is important to clarify the resources that will be required to bring about the agreed changes. This will be influenced by who is involved, and how committed they are to this assessment. Health improvement is likely to be far greater if existing or mainstream resources are already directed at the health priority.

Key resources issues are:

- **People** – how long will it take to get the right people, in the right places, doing the right job?
- **Space** – is physical space available for the actions?
- **Equipment** – what equipment is required and is it available? If not, how and when can it be acquired?

Check:

- Can existing resources be used differently?
- Are possible funds recurrent or non-recurrent?
- When might savings from stopping ineffective actions become available?
- Which actions will achieve the greatest impact on health for the resources used?

Any acceptable changes that will have a significant impact on health, and require only low resource levels to implement, should be included in the action plan (step 4). Discussion needs to concentrate on those requiring medium or high resource levels to implement.

### Illustrative case study Step 3 – Assessing a priority for action

#### Health Needs Assessment for a Sure Start Programme in West Newcastle upon Tyne

What interventions were considered most effective and acceptable?

1. Employment of family safety workers to undertake home visits once they had undertaken a training programme. To promote safety by sharing information; enable parents to carry out safety checks in their own homes; assist parents in making use of safety equipment; facilitate groups in first-aid and child safety

2. Newcastle Family Support (previously the Baby Sitting Initiative) to provide babysitting and support to isolated and vulnerable families that:

- Is community based, takes place in the family home
- Provides counselling, advocacy and signposting facilities to families face-to-face and via telephone contact
- Operates seven days a week between 9 am and 11 pm
- Is free to families referred via the health visitor, a social worker, community psychiatric nurse, school or other voluntary agency

Main focus to provide support to those families where the mother has or is at risk of developing post-natal depression

How were resource needs met?

1. To help build local capacity the programme wanted to offer these posts to local people and to make sure training was offered to ensure a wider audience could apply. Family Safety Scheme – would be Sure Start funded. In addition to the cost of training and employing two local people, the experienced health visitor extended her hours to help coordinate this function across two programmes. The two new workers were housed with the existing Family Safety Scheme

2. Sure Start funds were transferred to Children North East to extend their existing 'family support' service into the new and neighbouring Sure Start area



### REVIEW – STEP 3

At this stage in the process you should:

- Be confident that the health conditions/determinant factors with the most significant impact on health functioning for the selected health priority are being tackled
- Be sure the action is focused on reducing health inequalities for that health priority
- Have identified acceptable and cost-efficient actions to improve the selected health priority.

You will now be ready for action planning.

# Step 4

## Action planning for change

Now you have worked out what changes you want to make in order to tackle your chosen health priority, and why, you should concentrate on how to implement change. This is the action planning for change stage of the project, and you will need to bring your team together to agree a plan.

By the end of this step you should have

- Agreed a clear set of aims, objectives, indicators and targets
- Set out the actions and tasks you need to undertake to achieve these
- Agreed how you will evaluate your programme
- Identified the key risks to the success of the programme and how they will be managed.

### AIMS

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- What, overall, are you trying to achieve?

It is important to remember what you agreed as the most significant aspects of health for the target population at the beginning of step 3, as this should be the basis of your overall aim.

### OBJECTIVES

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- What are you trying to achieve specifically, and how will this be measured?

Your objectives should reflect the health conditions/determinant factors that, as agreed in step 3, have the most significant impact and are changeable through acceptable and feasible actions.

To help focus on the differences you want to make, ask yourselves:

- What will the target population do differently?
- What will they say differently?
- What will you see in them that is different?
- How will you be able to demonstrate this?

This will help ensure the objectives you set are SMART (specific, measurable, agreed, results-orientated, time-bound).

Spending time ensuring you have robust objectives will help you define your:

- Indicators – against what measures should you monitor progress?
- Targets – what level of outcome do you want to achieve, for whom and by when?

This is also critical for effective outcome evaluation. (For more help with defining aims and objectives, and setting indicators and targets, see Hooper and Longworth, 2002, pages 80-85).

### ACTIONS

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To ensure you are successful, you will need to plan:

- Actions and tasks required to achieve the aims and objectives for the selected priority issue
- Responsibilities – who will do what?
- Delegation of key tasks to members of the project team and a programme of meetings to which they must report



- Timescales – milestones for each part of the project, eg
  - literature search completed
  - protocols agreed
  - baseline data for agreed indicators collected
- Skills and training requirements for each step

- Administrative and managerial systems to support the project
- Resources – finance, time, equipment, space.

It is always useful to keep checking back to ensure the actions will contribute to your agreed objectives, and will benefit the identified target population. Using a format as shown below can help keep you on track.

Figure 7

Aim		
Objectives		
Action	Objectives addressed by this action	Target population for this action

### MONITORING AND EVALUATION

As a project team you should:

- Be clear about what you want to evaluate, why, and how it will benefit those involved with the project
- Decide how you will collect data for the evaluation
- Ensure this includes a system for providing feedback to the population and policy makers/service providers.

You should appoint someone to take lead responsibility for monitoring and evaluation at the outset of the project.

You should put in place systems to measure how well the process you have chosen is progressing at various stages – **process evaluation**. You will also need to measure the impact or added value of your intervention on the health of the target population – **outcome evaluation**. This should be based on the aims, objectives, indicators and targets agreed earlier in this step.

#### Process evaluation

Agree a set of indicators that will enable interim progress on the project to be monitored (**operational indicators**), eg the number of people attending core team meetings indicating continued engagement with the project.

Some useful questions to enable the process to be reviewed, and amended if necessary, are:

- Are the original aims and objectives being followed, and are they still relevant?
- What is actually happening?
- Are all parts of the project proceeding as planned?
- What do those implementing the project think about it?
- Is the original target group receiving the interventions?
- What resources are being used, and are they adequate?

**Outcome evaluation**

A key part of the outcome evaluation is agreeing a set of indicators that will enable

measurement of the project’s achievements in altering the health of the population through improvement to services.

Some useful questions:

- Have the original aim and objectives been achieved?
- Have the indicators improved, and have the targets been achieved?
- Is the project still tackling priority issues?
- What should happen if the evaluation shows the programme has failed?

(For more help with defining aims and objectives, and setting indicators and targets, see Hooper and Longworth, 2002, pages 80-85).

*Illustrative case study example Figure 8: Action plan/progress report*

Health Priority	Action required	By whom	By when	Progress to date (review date, eg end of month 1)
Example: To recruit two family safety workers to provide home-based support and information about safety in the home; information and support to access safety equipment	<ul style="list-style-type: none"> <li>• Hold open event to present job/training opportunities to local people</li> <li>• Assemble recruitment pack</li> <li>• Plan interview schedule</li> <li>• Advertise post</li> <li>• Shortlist candidates</li> <li>• Interview</li> <li>• Induction</li> </ul>	Newcastle PCT in conjunction with Riverside Community Health Project	Autumn 2004	<ul style="list-style-type: none"> <li>• Job descriptions and person specifications drawn up</li> <li>• Advertisement schedule planned</li> </ul>

**RISK MANAGEMENT**

A risk-management strategy should be incorporated from the beginning of the project to evaluate and address the impact of risk to achieving the project’s aims and objectives. It should also be built into the planning of specific interventions. This might include:

- Identify potential risks to achieving project/intervention objectives
- Assess each risk according to both likelihood and impact as high, medium or low

- Inform the team and stakeholders about each high or medium risk, and enter onto a risk register (see illustrative example that follows)
- Review the risk register regularly at progress meetings
- Choose options for treating/minimising risks
- Allocate a person to manage risks
- Evaluate risks to ensure effectiveness of risk treatment
- Check for any new risks.

*Illustrative case study example Figure 9: Key strategic risks*

Project: to employ two family safety workers									
ID No.	Date added to register	Source	Risk identified	Consequences	Likelihood	Impact	Risk treatment	Management lead	Risk evaluation
A.1	31.01.04	Project team meeting 12.12.04	Failure to attract suitable applicants from local population	Project delayed	M	H	Consider secondment possibilities	Project coordinator	Application deadline

**REVIEW – STEP 4**

By the end of step 4 you should be ready to implement your plan for action, and have planned everything

thoroughly to maximise your chances of effecting change and making sustainable improvements to the health of your target population.

**Illustrative case study Step 4 – Assessing a priority for action**

**Health Needs Assessment for a Sure Start Programme in West Newcastle upon Tyne**

**Summary of the action planning process**

As both initiatives were already running in another programme, the two leads for each project took responsibility to employ and train local people. An open event was arranged for local people to come and learn about the jobs, and support was offered to people in completing applications and looking at how part-time employment would affect their benefits

Each lead set their own project timescales and targets in line with the national targets set for Sure Start, and demonstrated how they could help the overall programme meet its objectives



# Step 5

## Moving on/project review

This final stage of the HNA process involves the team in some reflective questions and the opportunity to take stock and learn, both for individual contributors and from a team perspective. This is a vital part of the process if HNA is to continue to be a relevant and effective tool in improving health and tackling health inequalities in the population.

Learn from the project:

- What went well, and why? Check achievements against the original aims and objectives of the project
- What did not go well, and why?

Is any further action required?

- Identify further action to be taken.

Perceived improvement in health/services following the interventions:

- How effective was it?
- How could it have been improved?
- What were the main challenges?
- What were the main barriers?

If appropriate, choose your next priority for assessment:

- Revisit the shortlist of priorities
- Take stock of any interim changes
- Is the priority still an issue? If so, return to step 3

*Celebrate having reached this stage in the five-step process.*

### Illustrative case study Step 5 – Moving on/project review

#### Health Needs Assessment for a Sure Start Programme in West Newcastle upon Tyne

How well was the action plan implemented?	There was good response to advertisements and individuals were quickly employed into posts and training undertaken
What was achieved by the project?	<p>1. Newcastle Family Support has been in great demand, with many families requiring a wide variety of support. Staff have been employed across both Sure Start programmes which has enhanced availability and choice for local people. We have also been able to target those most in need</p> <p>2. The family safety workers have worked actively with health visitors in local clinics, enhancing service provision. They have promoted the safety service and accessed individuals in clinics and community groups which has led to home-based safety assessments</p>
How did it contribute to reducing inequalities?	<p>There has been increased access to safety equipment and family support to those most in need</p> <p>Employment and training opportunities have been made available in an area of high unemployment</p>
What was learned through the project's successes and challenges?	The importance of joint working across agencies, and increased awareness of how one service can complement and support another. In both projects described, referrals in and out of statutory services have increased, as has signposting
What needs to happen next?	Formal evaluation of both is ongoing
What new priority was chosen for the population?	Action on a multitude of priorities is still being taken in this huge programme
What main message from the last HNA will you take forward to the next?	The importance of joint working. The strong partnership between the public health nurse and the community development worker was invaluable, with each bringing different knowledge and skills to this work



## 4 HNA skills required and tools available



# HNA skills required and tools available

Skills	Steps	Skill elements	Useful websites and sources of support	Useful texts (see pages 92-95)
<b>1 Project management</b> Responsibility for overall management of a project from initiation through to implementation and evaluation	All	Objective setting; Time management; People management; Stress management; Project leadership; Risk assessment	PRINCE (projects in controlled environments) is a project-management method covering the organisation, management and control of projects: <a href="http://www.ogc.gov.uk/prince">www.ogc.gov.uk/prince</a> (an alternative website is available at <a href="http://www.Prince2.com">www.Prince2.com</a> )	Office of Government Commerce (2002a,b)
	Step 4	Action planning coordination and scheduling of processes leading to taking action	The BOND network (British Overseas NGOs for Development) provides information on logical framework analysis – a log frame is a tool for planning and managing development projects: <a href="http://www.bond.org.uk/pubs/guidance/logical-fa.pdf">www.bond.org.uk/pubs/guidance/logical-fa.pdf</a>	Office of Government Commerce (2002a,b)
	All	Report writing	Plain English Campaign is an independent pressure group for public information to be written in plain English. It provides information and support in writing in plain English: <a href="http://www.plainenglish.co.uk">www.plainenglish.co.uk</a>	
<b>2 Team building</b> Identification of strengths, weaknesses, opportunities and barriers within teams and development of mechanisms to facilitate effective team working	All	Facilitation; Communication; Leadership; Negotiation; Capacity building; Skills development; Training	University of Warwick website – search for ‘team building’ and then Centre for Primary Health Care Studies – for information on effective team working/building <a href="http://www.warwick.ac.uk">www.warwick.ac.uk</a>	

Cont...



Skills	Steps	Skill elements	Useful websites and sources of support	Useful texts (see pages 92-95)
<p><b>3 Partnership working</b> Identification and engagement of key stakeholders and development of a common vision and shared responsibility for the work</p>	All	Networking; Building confidence and trust; Facilitation; Negotiation; Collaborative working; Problem solving	<p>Search for 'Making Partnerships Work' <a href="http://www.doh.gov.uk">www.doh.gov.uk</a> Neighbourhood Renewal Unit <a href="http://www.neighbourhood.gov.uk">www.neighbourhood.gov.uk</a> Sure Start <a href="http://www.surestart.gov.uk">www.surestart.gov.uk</a> Local Government Association <a href="http://www.lga.gov.uk">www.lga.gov.uk</a></p>	<p>Markwell (2003); Markwell et al. (2003); National Consumer Council (1994)</p>
<p><b>4 Community engagement</b> Developing links with community networks and ensuring active involvement of key members of the community</p>	Step 2	Identifying key people; Listening; Providing accessible information; Ensuring feedback; Understanding community boundaries; Negotiation; Reaching marginalised communities	<p>A method of accessing a range of organisations concerned with planning/implementing action: <a href="http://www.communitiesforhealth.net">www.communitiesforhealth.net</a> Search for 'Patients Advice Liaison Services' <a href="http://www.doh.gov.uk">www.doh.gov.uk</a> Local Compact Guidance: Getting Relationships Right Together, National Council of Voluntary Organisation and Local Government Association <a href="http://www.doh.gov.uk/compact.org.uk">www.doh.gov.uk/compact.org.uk</a> Community development Foundation <a href="http://www.cdf.org.uk">www.cdf.org.uk</a> Provides information on 'Contin You' aimed at building learning communities: <a href="http://www.cedc.org.uk">www.cedc.org.uk</a> Partnerships Ltd <a href="http://www.partnerships.org.uk/part/links.htm">www.partnerships.org.uk/part/links.htm</a></p>	<p>Henderson and Thomas (2002); Henderson et al. (2004); Maclennan (2000); Peckham and Spanton (1994); Webster (2001)</p>

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Skills	Steps	Skill elements	Useful websites and sources of support	Useful texts (see pages 92-95)
<b>5 Population profiling</b>	Step 2	Demographic knowledge Local history Environment/ housing/transport/ health and leisure amenities, etc Local voluntary and community organisations	Public Health Observatories <a href="http://www.pho.org.uk">www.pho.org.uk</a> National Statistics <a href="http://www.statistics.gov.uk">www.statistics.gov.uk</a> Neighbourhood Statistics <a href="http://www.statistics.gov.uk">www.statistics.gov.uk</a> Positively Diverse <a href="http://www.doh.uk/positively7diverse/">www.doh.uk/positively7diverse/</a> Minority Ethnic Communities and Health <a href="http://www.minorityhealth.gov.uk/index.htm">www.minorityhealth.gov.uk/ index.htm</a> Health Survey for England 1999 results <a href="http://www.dh.gov.uk/public/hs02">www.dh.gov.uk/public/hs02</a>	Hawtin et al. (1999)
<b>6 Data collection</b> Agreeing appropriate methodologies. Undertaking data collection to make sense of what is happening and assessing associations between various data items of relevance	Step 2	Rapid appraisal; Participatory appraisal; Surveys; Focus groups; Designing questionnaires; Analysis of routinely held data; Acquisition of information from local informed sources	National Co-ordinating Centre for Research Methodology promotes identification, development and use of appropriate research methods: <a href="http://www.publichealth.bham.ac.uk/nccrm/">www.publichealth.bham.ac.uk/ nccrm/</a> The epidemiological approach to healthcare needs assessment: <a href="http://hcna.radcliffe-oxford.com/introframe.htm">http://hcna.radcliffe- oxford.com/introframe.htm</a> Internet for Social Research Methods free teach-yourself tutorial to assist practice and development of Internet information skills: <a href="http://www.vts.rdn.ac.uk/tutorial/social-research-methods">www.vts.rdn.ac.uk/tutorial/social- research-methods</a> Project Gold, run by the Royal College of Nursing, provides a research methods glossary: <a href="http://www.bath.ac.uk/dacs/gold/glossary.html">www.bath.ac.uk/dacs/ gold/glossary.html</a>	Hawtin et al. (1999)

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Skills	Steps	Skill elements	Useful websites and sources of support	Useful texts (see pages 92-95)
<b>6 Data collection</b> Cont...			<p>Primary care trusts' information departments</p> <p>Strategic health authorities' hospital utilisation data</p> <p>General practices' disease registers, community contacts, prescribing data</p> <p>Local authorities' current resource allocation</p> <p>Census population statistics, numbers of people, births and deaths</p> <p>Car ownership, employment, age profiles, housing tenure, self reported limited illness</p>	
<b>7 Monitoring/ setting indicators</b> Setting milestones as interim points for project review and evaluation	Step 4	Indicator setting	<p>London Health Observatory provides information on health inequalities basket of indicators: <a href="http://www.lho.org.uk/HIL/Inequalities_In_Health/Basket_Of_Indicators/Basket.htm">www.lho.org.uk/HIL/Inequalities_In_Health/Basket_Of_Indicators/Basket.htm</a></p>	Burns and Taylor (2000)
Evaluation to measure effectiveness of activity and review progress and outcomes	All	Process evaluation; Outcome evaluation	HDA (2002); Peberdy, (1997); Pawson and Tilley (1997)	
Ensuring sustainable outcomes	Step 5	Exit strategies; Community capacity building	Information on sustainable development: <a href="http://www.sustainable-development.gov.uk">www.sustainable-development.gov.uk</a>	Chirico et al. (1998)



# 5

## Case studies

The following case studies were submitted by HNA practitioners and demonstrate how the core five-step process can be applied to different types of population.

- 1 Geographic populations – at different levels, eg regional, PCT/local authority catchment area or neighbourhood
  - 1.1 Deprived ward in Selby & York
  - 1.2 GP practice population – rural Mid-Hampshire
- 2 Settings populations – eg schools, workplaces, prisons, hospitals
  - 2.1 Secondary school population – Young people’s health survey
  - 2.2 Prison populations in three prisons in Durham
- 3 Shared social experience populations – eg homelessness, refugee, ethnicity, culture, age, sexuality
  - 3.1 Children under four and their families – Sure Start project
  - 3.2 Black and minority ethnic children – Leeds
- 4 Specific health experience populations – eg diseases, chronic illness, mental health, disabilities
  - 4.1 Cardiac service requirements of a black and minority ethnic population in Newcastle
  - 4.2 Suicide and self-harm – residents at risk in Greenwich and Bexley

Note: the case studies featured in this guide were submitted by experienced public health practitioners who have been invited by the authors to provide examples of HNAs conducted with different types of population. They are not intended to reflect a national geographical spread.

## 5 Case studies



# 1.1 Geographic populations

## Acomb health needs assessment, Selby and York PCT

### TITLE OF PROJECT

Acomb health needs assessment

### MAIN CONTACT DETAILS

Janet Flanagan, Senior Health Improvement Manager, Selby & York PCT, 37 Monkgate, York



Step 1 : Getting started	
What population, where located and why chosen?	The local population of one of the PCT's most deprived wards
What were the aims and objectives?	To improve the health and reduce inequalities in health of the local population
Who was included in the project team? Who was included in the stakeholder group?	A multi-agency steering group including local councillors and representatives from the PCT, primary care, mental health, social services, leisure services, youth service, residents' association
What resources were required?	Local workers in health, social care, education and many representatives from local non-statutory services, local parents, grandparents, carers and children
What resources were required?	Staff time to coordinate the process and funding of £5,000 made available by the PCT for venue costs, action plan implementation and to release a local health visitor for 12 days to be the local champion. Four two- to three-hour sessions arranged to follow the process
Any barriers encountered?	Time commitment

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How were these overcome?	<p>By having a local champion and PCT coordinator to facilitate the process and undertake work between meetings</p> <p>Obtaining prior senior-level support for the process. Creating an environment at meetings where participants felt they were able to contribute openly to the discussions and their opinions valued</p>
What was learned through the project's successes and challenges?	<p>The importance of joint working across agencies, and increased awareness of how one service can complement and support another. In both projects described, referrals in and out of statutory services have increased, as has signposting</p>

### Step 2 : Identifying health priorities

How was a profile of the population developed?	Through readily available data, eg deprivation data at ward level from the Department of the Environment, Transport and the Regions
What data were available on the health of the population?	GP practice data
How was information gathered about the population's and service providers' perceptions of needs?	A semi-structured interview questionnaire was used by the local champion, who visited approximately 12 major stakeholders. Steering group representatives collected information from their colleagues. All data were shared and reviewed by the steering group
What were the key issues for the population?	Family relationships, substance misuse, poverty, housing, social isolation, older people's issues
What priorities were chosen and why, in terms of impact and changeability?	The issue of older people and social isolation was chosen as it is a central issue for many organisations. Social isolation affects both the mental and physical health of older people
What evidence informed your decision?	Perceptions of key stakeholders, including Age Concern, and focus groups with older people

### Step 3 : Assessing a priority for action

What interventions were considered most effective and acceptable?

The focus groups' and Age Concern's feedback identified gaps in services. The Older People's NSF Standard 8: Information Strategy for Older People and other published papers underpinned the interventions the steering group identified to address unmet needs

What changes were required?

Membership of the steering group was reviewed to include organisations working with older people

How were resource needs met?

Additional funding to implement interventions was part of the action plan. Coordinator's time. A task group was established to explore the feasibility of developing a drop-in centre for older people

### Step 4 : Action planning

Summary of the action planning process

The revised steering group developed the action plan that was reviewed at two-monthly meetings. A progress report was presented to the Older People's Partnership Board. Progress reports were provided to the Older People's Forum

### Step 5 : Moving on/review

What was achieved by the project?

Ward Committee funding accessed to increase day centre capacity and for Age Concern to appoint a community development worker to support isolated older people

2000 copies of the Information Directory were circulated, local GP practices gave the Directory to patients attending for older people's health checks and referred socially isolated older people to the community development worker. The Directory is available on Age Concern's website ([www.ageconcern.org.uk](http://www.ageconcern.org.uk)) and is updated by a volunteer

The Older People's Forum meets every four months. The group is given information to disseminate to its members, eg benefits information, healthy lifestyles

A district nurse has been seconded for one day a week to establish a network of community-based chair-exercise sessions

Increased networking and referrals between statutory and voluntary organisations

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	<p>Age Concern funded a survey with older people to provide evidence for a drop-in centre. Over 500 questionnaires completed and analysed. The survey identified barriers to social engagement, and recommendations are being implemented by the steering group</p> <p>Lack of clean toilet facilities in the local shopping centre identified as a reason for not going out. The local council was notified, toilets have now been refurbished and their cleanliness is monitored at least three times a day</p> <p>An NHS community facility/café is underused, partly because of lack of marketing and access problems. The council has undertaken to make changes to the access road, and Age Concern will provide support and training for volunteers to develop the café. An information service will also be provided</p> <p>The Information Directory is being replicated in other areas of York by City of York Council, and other wards have made funding available to Age Concern to provide more community workers</p> <p>Membership of many of the social activities has increased</p>
How did it contribute to reducing inequalities?	The mental health needs of a vulnerable group of older people are being addressed by being more integrated into the local community
What was learned through the project's successes and challenges?	The <i>Health needs assessment workbook</i> (Hooper and Longworth, 2002) provided a systematic and logical framework, and the process strengthened multi-agency working. Senior-level support and commitment to the process is vital. Involving the local community and key local players contributes to action plan implementation. Facilitation and project management skills are an essential resource. Having the local councillor as chair of the steering group provided credibility to the project and enhanced action plan implementation
What needs to happen next?	The project is entering its third year, and an exit strategy will be developed
What new priority was chosen for the population?	None
What main message from the last HNA will you take forward to the next?	Support of key stakeholders and involvement of the local community are essential. Identify a local champion who has credibility in the community. Use a rapid appraisal approach to collect data. Involve the local strategic partnership to ensure commitment to the process at senior strategic level

## 1.2 Geographic populations

### GP practice population – rural Mid-Hampshire

#### TITLE OF PROJECT

GP practice-based health needs assessment

#### MAIN CONTACT DETAILS

Julia Pallant, Public Health Project Manager, Mid-Hampshire Primary Care Trust



#### Step 1 : Getting started

What population, where located and why chosen?	The population registered at a rural GP practice in Mid-Hampshire The HNA was undertaken to inform the Practice Professional Development Plan
What were the aims and objectives?	To identify the health needs and inequalities in the registered practice population  To assist the practice to identify priorities for service provision and staff development
Who was included in the project team?	The project was undertaken by the project manager in consultation with all staff employed and attached to the practice
Who was included in the stakeholder group?	The qualitative work involved consultation with local representatives from the parish council, schools, social services (care managers), police, voluntary organisations and patients
What resources were required?	The project manager was appointed for a period of six months. The role involved identifying the most effective way for a practice to undertake this work, and the most efficient use of staff to achieve it

Step 2 : Identifying health priorities	
How was a profile of the population developed?	Using quantitative and qualitative methods
What data were available on the health of the population?	Quantitative data were obtained from the practice and the health informatics service supporting the PCT
How was information gathered about the population's and service providers' perceptions of needs?	Qualitative information was obtained using semi-structured interviews and focus groups to explore findings further and to validate them
What barriers were encountered?	Data quality Lack of time, particularly for the qualitative work which was seen as valuable
How were these overcome?	Providing support of a Primary Care Information Services (PRIMIS) facilitator to assist the practice with data collection and templates for future use Exploring alternative ways of obtaining qualitative information
What were the key issues for the population?	Access (one ward on fourth percentile of index of multiple deprivation for access; local difficulties with transport) Information (lack of awareness and availability, eg benefits, support services, self-help groups) Older people – services to support in own homes and insufficient day centre provision, isolation, safety Mental health – issue for all age groups: for young, lack of service provision to support and length of time to access child guidance; stress and depression in middle-aged, middle class; isolation of elderly and depression Physical activity – lack of activity in all age groups
What priorities were chosen and why, in terms of impact and changeability?	Data quality – the practice produced an action plan to improve quantitative data to provide more robust information in future Physical activity – use of the exercise referral scheme and the introduction of a local walk scheme

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<p>... cont.</p>	<p>Access – volunteer driver scheme expanded and parish council approached Rural Transport Initiative</p> <p>Mental health – PCT provision of primary mental health worker for children and adolescents</p> <p>Older people – decision taken to action at later date</p>
<p><b>What evidence informed your decision</b></p>	<p>The practice recognised that the quantitative information was not accurate due to variables in use of code and lack of compliance. To ensure needs could be identified more accurately in future, this was seen as a priority to address</p> <p>The findings acted on were qualitative</p> <p>The physical activity issue was incorporated in coronary heart disease and diabetes work already in progress to provide a preventive measure. This was combined with a decision taken to target overweight/obese patients attending specialist clinics</p>

### Step 3 : Assessing a priority for action

<p><b>What interventions were considered most effective and acceptable for this priority and what evidence informed your decision?</b></p>	<p>Decisions were taken based on the following:</p> <ul style="list-style-type: none"> <li>• Size of population affected</li> <li>• Services and resources already available</li> <li>• Fit with national priorities, eg national service frameworks</li> <li>• Cost</li> </ul>
<p><b>How were resource needs met?</b></p>	<p>Some issues identified were not the practice's direct responsibility, which enabled more to be achieved – result of stakeholder involvement in process</p> <p>Mental health management was agreed as an area for the team to develop knowledge and skills; links were made with the Community Mental Health Team to support this development</p>

#### Step 4 : Action planning

##### Summary of the action planning process

The action plan was an identified weakness when progress was reviewed one year on

The need to produce an action plan with clearly defined roles and responsibilities, an agreed timescale and measurable outcomes was learnt

Enthusiastic individuals had achieved some valuable developments but they were not part of a central plan

This was a good learning experience for the practice

#### Step 5 : Moving on/review

##### How well was the action plan implemented?

Developments had occurred, but not as a result of conforming to an agreed plan

##### What was achieved by the project?

A toolkit for HNA was produced as a result of the project for other practices in the PCT to use

Raised awareness of the value of HNA and stronger links with the community. An understanding of committing time and resources where they would be most effective

##### How did it contribute to reducing inequalities?

Raised awareness of access problems, particularly for the young and elderly, and actions resulting

##### What was learned through the project's successes and challenges?

The need for a simple process, a champion to lead and a team to produce

The importance of not raising expectations, and of identifying small changes that could have considerable impact

##### What needed to happen as a follow up?

Review by the whole team of progress and deciding next steps

##### What new priority was chosen for the population?

Older people

##### What main message from the last HNA will you take forward to the next?

Keep it simple

The value of qualitative data and community involvement

Committing to actions to address identified needs

## 2.1 Settings populations

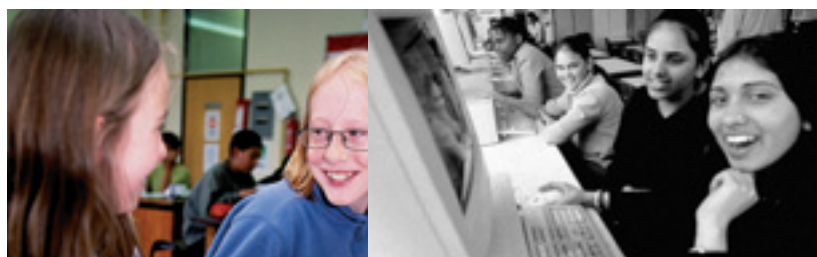
### Secondary school population – Young People’s Health Survey

**TITLE OF PROJECT**

Young People’s Health Survey

**MAIN CONTACT DETAILS**

Dawn Scott, Public Health and  
Gill Shapero, School Health, Newcastle PCT



Step 1 : Getting started	
What population, where located and why chosen?	Year 9 pupils from five senior schools across Newcastle upon Tyne. Initially three schools were chosen as a representative sample across three localities. However due to a lack of information in one locality a request was made to cover all three schools within this area
What were the aims and objectives?	To assist school health advisers across the city to target care better according to need, and specifically to assist them and others in implementing health promotion activities and interventions to meet the needs of the school population
Who was included in the project team?	Clinical Nurse Lead Public Health, Clinical Nurse Lead School Health, five school health advisers, a Senior Health Promotion Officer specialising in school health, Health and Drug Education Officer, a Child and Adolescence Mental Health Nurse Specialist and information and knowledge management staff
Who was included in the stakeholder group?	In addition to the above, community paediatricians, Director of Education, Chief Executive of PCT, school health advisers from a neighbouring trust, additional specialist health promotion staff, Teenage Pregnancy Coordinator, education staff
What resources were required?	A great deal of human resources – shared functions across project team

<b>Step 2 : Identifying health priorities</b>	
How was a profile of the population developed?	By looking at existing surveys across the country and adjusting them accordingly to meet our needs; specifically, changing some of the language to meet local need and increase pupils' understanding of the questions asked
What data were available on the health of the population?	Very limited data existed specifically for one area of the city. School health staff felt they had a good idea about the present problems, but needed formal evidence for this. The survey would act as one method of achieving this. Nationally the School Health Education Unit (SHEU) had produced information about young people's health, which was accessed as a comparator for this local work
How was information gathered about the population's and service providers' perceptions of needs?	Distribution of a structured questionnaire to year 9 pupils under examination conditions at school. Lifestyle (legal and illegal drugs, eating habits, exercise), size and shape, emotional health, sexual health and general physical health, environmental and safety information was collected. Questionnaires were scanned onto the FORMIC data-capture system
What barriers were encountered?	Local negotiation within specific schools regarding where and how to undertake survey was difficult, as this was near examination time
How were these overcome?	Through ownership of the project by the PCT Chief Executive and Directors, and a great deal of hard work and negotiation from frontline school health staff
What were the key issues for the population?	Some specific drug use across the city was higher than SHEU data. Bullying was a clear problem in one school; high numbers of pupils smoking was an issue in another. Lack of knowledge and understanding of sexually transmitted diseases and some issues relating to sexual health were also highlighted
What priorities were chosen and why, in terms of impact and changeability?	Each school had different areas of activity that were important to address, but citywide focus was required to address: <ul style="list-style-type: none"> <li>• Approaches to giving sexual health information and service provision both in and out of school</li> <li>• Smoking cessation for young people</li> </ul>
What evidence informed your decision?	Inconsistency across schools about the nature and type of sexual health information being offered, compared with pupils' understanding of sexually transmitted infections  No clear strategy to address smoking in young people

### Step 3 : Assessing a priority for action

What interventions were considered most effective and acceptable?

Increase in 'health drop-ins' on primary and secondary school premises, some of which also offer sexual health services (secondary schools only). Promotion of C-Card system\*

How were resource needs met?

Funding required to ensure family planning/sexual health specialist knowledge available via:

- Training existing school health advisers
- Some schools chose to fund a family planning nurse session

Availability and suitability of accommodation within school

Need to change school health work patterns to meet pupil needs

Availability of youth and play staff to support sessions

### Step 4 : Action planning

Summary of the action planning process

Agreement of governors and parents on nature of drop-in facility  
Local school survey to indicate need and desirability for health drop-in, to include best day, time and location within school for service

Responsibilities and timescale determined by each school, each at different stages of development of these services

Consistency across city regarding uniformity of standard of service, eg confidentiality statement, level of training and record keeping

Targets in accordance with local teenage pregnancy strategy and local strategic plans

Staff acknowledge differences in each service provision within schools in accordance with the faith, religion and ethos of the school

Step 5 : Moving on/review	
How well was the action plan implemented?	The action plan has been implemented effectively
What was achieved by the project?	Young people attending all secondary and high schools across the city now have access to health drop-ins
How did it contribute to reducing inequalities?	Increased access to health facilities (in some schools, sexual health facilities). Increased access to health information and signposting young people to relevant services as necessary
What was learned through the project's successes and challenges?	Importance of working closely with educational staff Language barriers, ambiguity and nature of questions asked on survey. On reflection, some needed to be changed to decipher clear information Lack of knowledge of sexually transmitted infections Need to strengthen the leadership role of school nurses
What needs to happen next?	Continue to work closely with education staff regarding health issues, although this function between school health advisers and teachers has been strengthened around curriculum development and delivery of information around sexually transmitted infections
What new priority was chosen for the population?	Development of smoking cessation work with young people. A working party has now been set up looking at ways to deliver 'stop smoking' services to secondary and high schools
What main message from the last HNA will you take forward to the next?	Importance of involvement of young people in developing services and appropriate methods of assessing their health needs

*\*C-Card is a condom distribution scheme for young people. After registering, the young person is issued with a C-Card which enables them to access free condoms and sexual health information and support from a range of young people-friendly settings across the city. It has been particularly successful in attracting young men into sexual health services.*

## 2.2 Settings populations

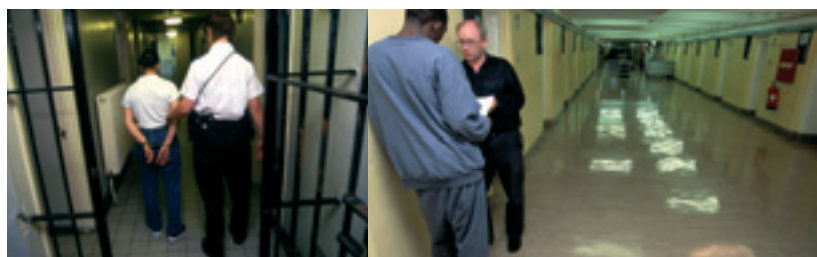
### Prison populations in three prisons in Durham

#### TITLE OF PROJECT

Health Needs Assessment within Durham Cluster of Prisons

#### MAIN CONTACT DETAILS

Dr Shahla Wright, 7 McLaren Way, West Herrington, Houghton le Spring, DH4 4NP  
Tel. 0191 5840717, mobile 07811 275249



Step 1 : Getting started	
<p>What population, where located and why chosen?</p>	<p>Three Durham prisons (HMP Frankland, HMP Durham and HMP Low Newton)</p> <p>Prison population reveals strong evidence of health inequalities and social exclusion</p> <p>Prisoners are largely from lower socio-economic groups</p> <p>Prisoners tend to have poorer physical and mental and social health than the general population</p>
<p>What were the aims and objectives?</p>	<p>To build a picture of the current health services; assess inmates' unmet needs; plan, negotiate and make necessary changes within Durham cluster of prisons. To identify ways prisoners could have access to the same quality and range of health services as the general public</p> <p>Designing and developing a framework to gather evidence-based information using available data and organising interviews and focus groups</p>
<p>Who was included in the project team? Who was included in the stakeholder group?</p>	<p>Involving various stakeholders such as prisoners, prison health service managers, prison governors, prison officers, board of governors, PCT chief executive, PCT lay member and NHS trust. Building on information from HNA to set up a plan of action designed to meet the needs and develop HIMP for prisoners</p>

Step 2 : Identifying health priorities	
How was a profile of the population developed?	Each prison had specific type of population: female, male, sentenced, remand. The prison profile of the population was developed according to age band and what category population they belonged to, and was compared with that of the whole of County Durham
What data were available on the health of the population?  How was information gathered about the population's and service providers' perceptions of needs?	Various information sources (epidemiological, corporate and comparative data) were used to collect health-related data for quality and accuracy control. To facilitate collection of appropriate information, chart templates were designed and sent to prison healthcare staff. Very limited health data information is collected in each prison, so health information data from inmates' medical records and prescribed medication for a three-month period was used
Any barriers encountered?	Lack of data information and IT system within prisons, incomplete information, lack of easy access to enter prisons, uncertainty of some staff regarding the change within the prison service
How were these overcome?	The necessary data were obtained by designing a template to collect specific data within a defined period of time, and staff were informed with necessary information and appropriate explanation
What were the key issues for the population?	The average daily population in prisons has increased. 51% of male prisoners in Durham prisons are on remand and 49% sentenced, the majority of male inmates are aged between 20 and 39, while the average age of female inmates is 25–44 years
What priorities were chosen and why, in terms of impact and changeability?	Workforce development, staff training, improved access to primary care services, health promotion and clinical governance; issues connected to substance misuse, mental health, management of suicide and self-harm; development of the computer system
What evidence informed your decision?	Baseline information, the high number of prisoners with mental health disorders, or who are drug misusers, or both. Weakness in healthcare management, skill mix duties, lack of health risk management, inappropriate use of staff skills



### Step 3 : Assessing a priority for action

What interventions were considered most effective and acceptable?

Appointment of a clinical nurse manager to ensure clinical and managerial staff use their skills appropriately. There was evidence that strong leadership would improve clinical health services

Training for workforce development, improvement in the appointment system within primary care

Clinical and audit performance management for the prison health system to provide the same quality of health service as received by the general public

How were resource needs met?

From April 2003, the Department of Health is responsible for funding prison health care. It has been made clear in the action plan the resource implications of every health issue improvement. The key issue was to ensure that the existing resources were used efficiently and effectively

### Step 4 : Action planning

Summary of the action planning process

The action plan and health improvement and modernisation programme for prisoners was signed by Durham and Chester le Street PCT chief executive and the prison governors

Key tasks were to: improve workforce development, staff training and continuing professional development; improving services such as primary care management, clinical governance, mental health, suicide and self-harm management; substance misuse; reception screening; health promotion; dental services; pharmacy services; infectious diseases; health information system; and improving facilities and services specific to women prisoners. All proposals for action were identified and designated to lead key individuals. The date for completion of tasks and performance measures was identified for every action plan

<b>Step 5 : Moving on/review</b>	
How well was the action plan implemented?	The priorities mentioned were identified for implementation by a newly appointed prison health development manager
What was achieved by the project?	Priorities were identified and some changes to improve and redesign services implemented to set the example that services could improve within a custodial environment and make resources more cost effective
How did it contribute to reducing inequalities?	A high proportion of prisoners come from socially excluded sections of the community
What was learned through the project's successes and challenges?	Involving stakeholders and key professionals in assessing prisoners' unmet needs and providing effective healthcare to them while in custody, even for a short period, can make a significant contribution to the health of individuals
What needs to happen next?	Very important to keep prison steering group meetings going to involve key stakeholders and professionals in improving prison healthcare services
What main message from the last HNA will you take forward to the next?	HNA within prison could be extensively improved, but the main message was the importance of close cooperation between prison healthcare and NHS (PCT) staff

# 3.1 Shared social experience populations

## Children under four and their families – Newcastle upon Tyne Sure Start project

### TITLE OF PROJECT

Health Needs Assessment for a Sure Start Programme in West Newcastle upon Tyne

### MAIN CONTACT DETAILS

Sure Start Armstrong, Riverside Community Health Project



Step 1 : Getting started	
What population, where located and why chosen?	Children under four, their families and carers living in a defined geographical area of West Newcastle upon Tyne. The area was chosen as the three wards made up the third, fourth and seventh most deprived in Newcastle and North Tyneside according to multiple deprivation scores
What were the aims and objectives?	The HNA was part of the Sure Start programme planning process. To work with parents-to-be, parents and children to promote the physical, intellectual and social development of babies and young children – breaking the cycle of disadvantage
Who was included in the project team?	The HNA was led by the Public Health Nurse for West Locality and an experienced community development worker employed by Riverside Community Health Project and established in offering family support in the area
Who was included in the stakeholder group?	Local workers in health, social care, education and many representatives from local non-statutory services, local parents, grandparents, carers and children
What resources were required?	The Public Health Nurse and Community Development Worker were allocated some time within their present jobs to undertake this work. A request for early funds was successfully made which helped pay for the community development workers' extra hours and some of the additional consultation

Step 2 : Identifying health priorities	
How was a profile of the population developed?	The Public Health Nurse in conjunction with the Citywide Sure Start Health Coordinator pulled together quantitative data
What data were available on the health of the population?	<p>Index of Multiple Deprivation scores 2000</p> <p>Census information regarding numbers of families with under fours, levels of employment, lone parents, breakdown by ethnicity</p> <p>Going for Growth consultation information and responses by local people; numbers of children on the child protection list, numbers of mothers experiencing post-natal depression, numbers with low birth-weight babies, number of mothers with children under one. Number of emergency admissions to hospital; SATs results; estimated literacy levels</p>
How was information gathered about the population's and service providers' perceptions of needs?	<p>Through multiple methods of consultation and ongoing involvement during the development of this Sure Start programme, to include:</p> <ul style="list-style-type: none"> <li>• Meetings with existing parent and grandparent groups</li> <li>• Meetings with professionals in key organisations</li> <li>• Use of 'H' forms (a simple diagrammatic technique) to gather information about 'What was good about local services for families and young children, what was not so good, what would make things better, and what services people valued most'.</li> <li>• Kids' cocktail parties (consultation through fun activities, 3-14 year olds)</li> <li>• Passport to family support event</li> <li>• Under fives summer fun week and holiday activities</li> <li>• Newcastle Action for Parents and Toddlers Initiative Survey</li> </ul>
What barriers were encountered?	<p>Initially the parents in the two main communities were consulted separately as they did not naturally meet, and eventually formed a whole representative group</p> <p>In addition, one large area covered was undergoing consultation as a Going for Growth Regeneration Area, and there was much dissatisfaction with the local council at this time</p>
How were these overcome?	<p>The skilful work of the community development worker – lots of promotion of the HNA, gradual and timely integration of two communities. The knowledge of local people that many of their wishes and needs could be realised in practice through Sure Start money</p> <p style="text-align: right;"><i>Cont...</i></p>

<p>... cont.</p> <p><b>What were the key issues for the population?</b></p>	<p>From the qualitative data, 15 key points were raised where actions could be taken across agencies, to include:</p> <ul style="list-style-type: none"> <li>• More activities for children of all ages, and affordable leisure and sports facilities – specifically holidays and after school</li> <li>• An increase in the amount of affordable, good quality childcare</li> <li>• Health visitors must be more accessible within the community</li> <li>• Improved transport links to key services, specifically the need for lo-liner buses</li> <li>• Integrated services all on one site</li> <li>• Places for parents and children to meet and socialise</li> <li>• Improved family support, particularly for women suffering from post-natal depression</li> <li>• Home-based support and information about safety in the home, information and support to access safety equipment</li> </ul> <p>In terms of quantitative data, there was a need to increase access to training, education and employment and to increase educational attainment of the children in this area. There were many more areas for action</p>
<p><b>What priorities were chosen and why, in terms of impact and changeability?</b></p>	<p>Sure Start funding meant many of the actions would be addressed by the employment of new staff on the project with specific roles and responsibilities. A number of priorities could be addressed at once. One priority that arose as a consequence of the consultation was the need for family support to:</p> <ul style="list-style-type: none"> <li>• Reduce accidents in the home</li> <li>• Help address post-natal depression</li> </ul>
<p><b>What evidence informed your decision?</b></p>	<p>National evidence and targets set around reducing child accidents. Local accident and emergency statistics</p> <p>Local statistics from health visiting records on post-natal depression; local needs highlighted by parents; increased demand on health service in this Sure Start geographical area</p> <p>Experience and evidence of successful local programmes</p> <p>An adjoining Sure Start programme coterminous with a New Deal for Communities Programme</p> <ul style="list-style-type: none"> <li>• Had already employed local people to train and act as safety scheme workers, and local people accessed information from the health visitor leading this scheme.</li> <li>• Babysitting initiative (subsequently renamed to demonstrate changing need) funded by Sure Start but provided by a local non-statutory organisation (Children North East)</li> </ul>

### Step 3 : Assessing a priority for action

<p>What interventions were considered most effective and acceptable?</p>	<p>Employment of family safety workers to undertake home visits once they had undertaken a training programme. To promote safety by sharing information; enable parents to carry out safety checks in their own homes; assist parents in making use of safety equipment; facilitate groups in first aid and child safety</p> <p>Newcastle Family Support (previously the Babysitting Initiative):</p> <ul style="list-style-type: none"> <li>• Provides babysitting to isolated and vulnerable families</li> <li>• Community-based and takes place in the family home</li> <li>• Provides counselling, advocacy and signposting facilities to families face-to-face and via telephone contact</li> <li>• Operates seven days a week between 9 am and 11 pm</li> <li>• Is free to families referred via health visitor, social worker, community psychiatric nurse, school or other voluntary agency</li> <li>• Main focus to provide support to those families where the mother has, or is at risk of developing, post-natal depression</li> </ul>
<p>How were resource needs met?</p>	<p>To help build local capacity, the programme wanted to offer these posts to local people and wanted to make sure training was offered to ensure a wider audience could apply</p> <p>Family Safety Scheme – this would be Sure Start funded. In addition to the cost of training and employing two local people, the experienced health visitor extended her hours to help coordinate this function across two programmes. The two new workers were housed with the existing Family Safety Scheme</p> <p>Sure Start funds were transferred to Children North East to extend their existing family support service into the new and neighbouring Sure Start area</p>

### Step 4 : Action planning

<p>Summary of the action planning process</p>	<p>As both initiatives were already running in another programme, the two leads for each project took responsibility to employ and train local people. An open event was arranged for local people to come and learn about the jobs, and support was offered to people in completing applications and looking at how part-time employment would affect their benefits</p> <p>Each lead set their own project timescales and targets in line with the national targets set for Sure Start, and demonstrated how they could help the overall programme meet its objectives</p>
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## Step 5 : Moving on/review

<p>How well was the action plan implemented?</p>	<p>Good response to advertisements, individuals were quickly employed into posts and training undertaken</p>
<p>What was achieved by the project?</p>	<p>Newcastle Family Support has been in great demand, with many families requiring a wide variety of support. Staff have been employed across both Sure Start programmes which has enhanced availability and choice for local people. Those most in need have been targeted</p>
<p>How did it contribute to reducing inequalities?</p>	<p>The family safety workers have actively worked with health visitors in local clinics, enhancing service provision. They have promoted the safety service and accessed individuals in clinics and community groups which has led to home-based safety assessments</p> <p>Increased access to safety equipment and family support to those most in need</p> <p>Employment and training opportunities have been made available in an area of high unemployment</p>
<p>What was learned through the project's successes and challenges?</p>	<p>The importance of joint working across agencies, and increased awareness of how one service can complement and support another. In both projects described, referrals in and out of statutory services has increased, as has signposting</p>
<p>What needs to happen next?</p>	<p>Formal evaluation of both is ongoing</p>
<p>What new priority was chosen for the population?</p>	<p>A multitude of priorities are still being actioned in this huge programme</p>
<p>What main message from the last HNA will you take forward to the next?</p>	<p>The importance of joint working. The strong partnership between the Public Health Nurse and the Community Development Worker was invaluable, with each bringing different knowledge and skills to this work</p>

## 3.2 Shared social experience populations

### Black and minority ethnic children – Leeds

#### TITLE OF PROJECT

A Health Needs Assessment of Black and Minority Ethnic Children's Needs (June 2002)

#### MAIN CONTACT DETAILS

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Step 1 : Getting started	
What population, where located and why chosen?	Children and young people (0–19 years) from ethnic minority communities in Leeds. Chosen because indicators for child health are worse in inner city areas where the majority of the ethnic minority population live
What were the aims and objectives?	To obtain a comprehensive baseline profile of the health needs of ethnic minority children in Leeds to ensure services planned for them in future are appropriate and culturally acceptable
Who was included in the project team?	Barnardos, University of Leeds Centre for Disability Studies, University of Leeds Centre for Primary Care Research
Who was included in the stakeholder group?	Children and Families Modernisation Team composed of NHS service commissioners and providers, representatives of Education, Social Services, the voluntary sector and service users, Assistant Director of Ethnicity and Health at former Health Authority and Health Action Zone (HAZ) Health and Ethnicity Manager
What resources were required?	HAZ provided £30,000 for a six-month study, printing and dissemination by June 2002



## Step 2 : Identifying health priorities

<p>How was a profile of the population developed?</p>	<p>National and local data were used; key sources 1991 census and Local Education Authority data. However no definitive pre-school data were available locally</p>
<p>What data were available on the health of the population?</p>	<p>Low birth weight, but not by ethnicity, available locally          No local data by ethnicity. National data from the Health Survey for England on smoking and substance use, physical exercise, blood pressure, accidents. National studies on disability, impairment and chronic illness. National studies on use of services. Local study on dental service use</p>
<p>How was information gathered about the population's and service providers' perceptions of needs?</p>	<p>Postal questionnaires of statutory and voluntary organisations, different professional groups including managers. Consultation event with professionals, plus face-to-face and telephone interviews          Views of parents through semi-structured interviews and group discussions. Views of young people through group discussions in a range of settings</p>
<p>What barriers were encountered?</p>	<p>Lack of local data by ethnicity. Difficulty accessing primary care data in timeframe          English not first language for some parents, but Asian researcher able to communicate in other languages, or interpretation could be accessed</p>
<p>How were these overcome?</p>	<p>Extrapolated local issues based on national data          Good access to aggregated LEA data</p>
<p>What were the key issues for the population?</p>	<p>Parents: language barrier difficulties while accessing child health services. Perceptions of cultural incompetence. Occasionally overt racism          Professionals: communication and access to services for users. Cultural competence of existing staff. Ethnic composition of staff grouping. Information-sharing. Public health issues, eg poverty and housing          Children and young people: access to health information and education. Communication barrier due to medical terminology. Access issues for young people generally. Did not see ethnicity as major factor in health or health services. However, would like more culturally sensitive services in areas of mental health and sickle cell anaemia</p> <p style="text-align: right;"><i>Cont...</i></p>

<p>... cont.</p> <p>What priorities were chosen and why, in terms of impact and changeability?</p>	<p>Need increased ethnic monitoring to improve local information</p> <p>Expanding translation and interpretation would improve communication. Cultural awareness training in existing services. More user involvement in planning and developing services. Mainstream funding for some short-term projects. Access to dental services and dental health promotion needs improvement</p>
<p>What evidence informed your decision</p>	<p>Results from extrapolated data and interviews</p>

### Step 3 : Assessing a priority for change

<p>What interventions were considered most effective and acceptable?</p>	<p>Monitoring to be taken forward through mainstream NHS informatics developments</p> <p>Translation and interpretation services developed under Ethnic Health HAZ workstream</p> <p>User involvement enhanced through Leeds Healthy Schools Scheme and its Youth on Health Forums, which are currently expanding. Fluoridated milk programme piloted with Children's Fund and HAZ funding through targeted schools</p>
<p>How were resource needs met?</p>	<p>Unable to secure separate funding for ethnic minority children's services outside the above-noted NHS initiatives. Mainstream funding for ongoing initiatives such as GP-led male circumcision service still to be secured</p>

### Step 4 : Action planning

<p>Summary of the action planning process</p>	<p>No separate action plan established. Priorities incorporated into annual work programme of Leeds NHS Children and Families Modernisation Team, across the five Leeds PCTs and service providers</p>
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### Step 5 : Moving on/review

How well was the action plan implemented?	Not applicable as there is no separate action plan. Ethnic minority health needs being addressed through main work programme
What was achieved by the project?	Project achieved a baseline assessment of local needs, gathered national and local data and a wide range of views. It indicated next steps for influencing and improving services
How did it contribute to reducing inequalities?	Contributes to reducing inequalities by raising level of knowledge of service commissioners and providers and confirming need for further developments in areas of communications and training, etc
What was learned through the project's successes and challenges?	Learned about the dearth of local information! Learned of general satisfaction of users, albeit for a small sample. Engaged providers and documented their concerns and hopes for future service development. Highlighted lack of new resources available to respond to the key issues
What needs to happen next?	Results were disseminated back to those who participated and other interested parties. Will be fed into the Local Preventative Strategy for Leeds
What new priority was chosen for the population?	Not applicable
What main message from the last HNA will you take forward to the next?	Need to progress cultural awareness training, communication and access to services for young people generally

## 4.1 Specific health experience populations

### Cardiac service requirements of a black and minority ethnic population in Newcastle

#### TITLE OF PROJECT

Evaluation of a locality-based Cardiac Rehabilitation Service leading to improvement of services for black and minority ethnic people

#### MAIN CONTACT DETAILS

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Step 1 : Getting started	
What population, where located and why chosen?	Patients who had experienced myocardial infarction (MI) and had been offered access to a community-based cardiac rehabilitation programme  West locality, Newcastle upon Tyne
What were the aims and objectives?	To determine whether the same approach could be developed across the city
Who was included in the project team?	The project was led by the Public Health Nurse; the core team involved the Community Cardiologist, a Community Cardiac Rehabilitation Nurse Lead and a locality manager
Who was included in the stakeholder group?	Included the community nursing staff, and patients who had both accessed, and not accessed, the programme
What resources were required?	Time was allocated to the Public Health Nurse to undertake the evaluation and needs assessment

## Step 2 : Identifying health priorities

How was a profile of the population developed?	All patients who had been diagnosed as having MI and who could have chosen to access this service
What data were available on the health of the population?	Newcastle MI data were available but had not been consistently collected by ethnicity. Ethnicity data had been collected in the cardiac rehabilitation programme
How was information gathered about the population's and service providers' perceptions of needs?	<p>Secondary data analysis of the existing database</p> <p>In-depth, qualitative interview and measurement of quality of life with a sample of patients – 50% had accessed the service, 50% had not</p> <p>Interviews with core group members and staff delivering the Heart manual</p>
<p>What barriers were encountered?</p> <p>How were these overcome?</p>	<p>Secondary data analysis of the cardiac rehabilitation database was one method employed to assess need. Analysing the data was extremely difficult as data had to be transferred to SPSS (Statistical Package for the Social Sciences) and there was a great deal of missing data, although paper evidence was available. This provided an opportunity to update the system, input data that was not already entered, and consider the future data collection needs of this programme</p>
What were the key issues for the population?	The needs of those most vulnerable, primarily the black and minority ethnic community, were not being met even with a focused effort by cardiac rehabilitation staff to engage with this community
What priorities were chosen and why, in terms of impact and changeability?	To focus on the needs of the black and minority ethnic population in the West end of Newcastle. Highest needs/lowest access
What evidence informed your decision?	National epidemiological data and local data on poor or no access to community cardiac rehabilitation

### Step 3 : Assessing a priority for change

<p>What interventions were considered most effective and acceptable?</p>	<p>A New Deal for Communities bid was designed aimed at developing services to meet the cardiac health needs of black and minority ethnic communities in West locality. It was designed to provide information, support and access to this community in both proactive and reactive ways. Additional evidence was obtained from working with local services providing support or with a special interest in working with people from black and minority ethnic communities. These key external stakeholders helped model the proposed service, which would eventually influence the service delivery across the city</p>
<p>How were resource needs met?</p>	<p>The New Deal for Communities bid was successful and ensured we could employ experienced bilingual health development workers and a project lead to work with black and minority ethnic communities. We also gained money for accommodation for this project</p>

### Step 4 : Action planning

<p>Summary of the action planning process</p>	<p>The Public Health Nurse continued to lead this priority by developing the bid and option appraisals. The Community Cardiologist was key in accessing additional evidence to support this vision, as was the Nurse Lead. The public health nurse, with locality manager support, wrote job descriptions and advertised posts.</p> <p>Once project staff were in place the team needed to identify people with coronary heart disease in the New Deal area</p> <p>Work with the wider community to improve the population’s understanding of coronary heart disease:</p> <ul style="list-style-type: none"> <li>• To aim to identify the presently unidentified population with heart problems by working with the community and raising awareness of symptomatic presentation, discussing lifestyle change and offering information and advice on present services</li> <li>• Help initiate self-help/support groups</li> <li>• Develop capacity by encouraging community education through experience and contact with other community groups</li> </ul>
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## Step 5 : Moving on/review

<p>How well was the action plan implemented?</p>	<p>Some difficulties were encountered in attempting to recruit to posts. Applicants needed to be bilingual in one of the main languages of this population. Equally important was the gender split of key workers – some of our Asian households were uncomfortable with males visiting female patients. Difficulties with placing people in posts resulted in an emphasis on cultural awareness rather than language skills, and more part-time posts on offer to meet diverse needs</p> <p>By working collaboratively with primary care staff and others developing cardiac registers, the community development workers were able to identify and improve identification of people with cardiac problems</p> <p>Self-help/support groups, as expected, developed separately from the already established one linked to the cardiac rehabilitation service. A men’s Asian group has developed separately from the women’s group within the project. Neither has integrated with the existing group as anticipated because of social and cultural differences</p> <p>Numerous methods to increase capacity through community education have been adopted from increased information to community events – including focused work in schools</p>
<p>What was achieved by the project?</p>	<ul style="list-style-type: none"> <li>• Increased access to cardiac rehabilitation</li> <li>• Greater understanding by service providers of the gender, spiritual and cultural needs/issues that might, if not understood, create barriers to access</li> <li>• Training of bilingual workers in and out of the project to act as heart manual facilitators, and local revascularisation training</li> <li>• Early visits to hospital to ensure people are seen through all stages of rehabilitation (improving delivery of secondary and community care)</li> <li>• Development of the Heart Start Scheme (locally named Heart Start Diversity) affiliated to the British Heart Foundation and partially funded by them – targeted training to local community to reduce mortality rate from coronary heart disease</li> </ul>
<p>How did it contribute to reducing inequalities?</p>	<p>Targeted those most in need with highest risk; provided a service in a different way; provided additional resources, enabling us to determine the changing population and service needs</p> <p style="text-align: right;"><i>Cont...</i></p>

<p>... cont.</p> <p><b>What was learned through the project's successes and challenges?</b></p>	<p>Practical issues relating to the provision of culturally and spiritually sensitive services, eg avoiding running sessions on a Friday</p> <p>Issues relating to gender (some groups of people wanted single-gender groups for exercise). Some women will not attend groups due to culture, so some one-to-one, home-based phase three work is essential if we are to provide equitable services</p> <p>Difficulties of having interpreters in a mixed group, where some not requiring interpreting facilities found concentration difficult. Inappropriate dietetics advice in relation to culture</p> <p>Sessions were run to meet the needs of different populations, health advice was modified and changed. It was recognised that, while some full integration was possible, some components of the service would need to remain separate</p>
<p><b>What needs to happen next?</b></p>	<p>Need to work with the broader family and children if change is to be sustainable</p>
<p><b>What new priority was chosen for the population?</b></p>	<p>To ensure a proactive approach and break the cycle of inequalities, the team started to work in three schools attended by a significant number of children from black and minority ethnic communities. This was funded by Newcastle's Children Fund. Fun-based art activities with children, teachers and some parents resulted in:</p> <ul style="list-style-type: none"> <li>• Production of health promotion information for all primary schoolchildren across the city – Cardio Kids Fortune Teller</li> <li>• Increased awareness of heart health among children in the city</li> <li>• A healthy lifestyle event</li> </ul>
<p><b>What main message from the last HNA will you take forward to the next?</b></p>	<p>The need for different approaches to provision of services and information. An inclusive approach to changing services to meet people's needs</p>



## 4.2 Specific health experience populations

### Suicide and self-harm – residents at risk in Greenwich and Bexley

#### TITLE OF PROJECT

Epidemiological Health Care Needs Assessment – Suicide and Self-Harm in Greenwich & Bexley

#### MAIN CONTACT DETAILS

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Step 1 : Getting started	
What population, where located and why chosen?	People in Greenwich & Bexley boroughs who feel distressed enough to be at risk of suicide or self-harm. Chosen because DH instructed all health authorities in England to reduce the suicide rate
What were the aims and objectives?	To examine the scope in the district for preventing suicides and self-harm
Who was included in the project team?	The researcher – a specialist in public health
Who was included in the stakeholder group?	The researcher; a senior manager and a psychiatrist from the local mental health provider trust; a GP; the commissioner of mental health services at the health authority; Metro Ltd (local lesbian, gay, bisexual and transgender agency); assistant head of social services; Chair of Accident & Emergency for one of the two local general hospitals; one of the local coroner's officers

<b>Step 2 : Identifying health priorities</b>	
How was a profile of the population developed?	Data on suicide were obtained from both public health mortality files and the local deaths' database. All suicides and unexplained death records were retrieved and entered in a database. The Coroner's Office provided data on deaths when they occurred
How was information gathered about the population's and service providers' perceptions of needs?	All the local agencies thought to be potential stakeholders were invited to participate. Many took part in the monthly suicide review group. The representative from one of the local provider agencies (the Chair of Accident & Emergency) chaired the meetings
What barriers were encountered?	(a) Lack of interest in suicide prevention by the health authority board – it appeared that so long as a local group was designated to discuss suicide, the board did not feel they needed to take further action  (b) Suicide is acknowledged in research as an unpleasant issue for anyone to contemplate – it is easy to marginalise it and avoid thinking about it
How were these overcome?	The stakeholder group actively promoted action in their agencies; in the end, little happened in the statutory agencies – eg a confidential 'no-blame' review and improvement system was set up for GPs, but although about 50 suicides occurred that year only two GPs used the review system to improve their care
What were the key issues for the population?	Generally, poor mental health among one in seven of the population; high self-harm rates and (apparently) higher suicide rates among younger men in the most deprived parts of the district; few systems for detecting and supporting self-harm attenders in A&E. Poor take-up of suicide risk-assessment systems among local GPs. Lack of evidence base for reducing suicide. Need for pan-London suicide review to give greater numbers for epidemiological study (health authority districts have populations that are too small to provide large enough study populations)
What priorities were chosen and why, in terms of impact and changeability?	To target people most at risk (younger unemployed men in Woolwich and Plumstead); to offer training in more effective life skills and coping behaviours, plus anti-poverty measures; to implement routine systems in A&E departments to identify attenders who self-harm and to offer support (as they are at increased risk of completing suicide in the next few years); to support and improve services for people identifying as lesbian, gay, bisexual or transgender (as they are at higher risk of self-harm and suicide); to implement Health of the Nation measures on suicide reduction

### Step 3 : Assessing a priority for action

What interventions were considered most effective and acceptable?

There are currently no available interventions supported by research evidence from good quality systematic reviews. We based our recommendations on good practice recommendations from DH 'Health of the Nation' initiatives. We recommended that the three local NHS trusts cooperate in a study of self-harm attenders and suicides, and that GPs take active part in 'non-blaming' reviews following a patient suicide to see if they can improve practice to prevent future suicides

How were resource needs met?

A few hours per month among provider agencies to implement training for staff on managing self-harm and on detecting suicide risk among patients; £2,000 to fund a year's support to GPs for confidential suicide reviews

### Step 4 : Action planning

Summary of the action planning process

As in Step 3 above. The trusts and voluntary agencies continued to meet regularly to review their systems for self-harm training for staff, and for the management of self-harm. The local lesbian, gay, bisexual and transgender agency secured SRB6 regeneration funding to support young people at risk of suicide. Because of the lack of a national evidence base, indicators could not be used

<b>Step 5 : Moving on/review</b>	
How well was the action plan implemented?	Patchily – it appeared to depend on the interest of individual agencies, managers and lead clinicians
What was achieved by the project?	The profile of self-harm and suicide and their associated bereavement and misery were raised among local agencies and staff
How did it contribute to reducing inequalities?	No such changes were achieved – the health authority did not implement changes to address action despite the huge disparity of self-harm among residents of the most deprived ward in the district; it was left to the mental health commissioner to take action instead of the health authority
What was learned through the project's successes and challenges?	That board-level agreement prior to needs assessment is vital if findings are to be implemented
What needs to happen next?	As above
What new priority was chosen for the population?	None. Suicide reduction remained marginal despite the needs of Woolwich and Plumstead residents and lesbian, gay, bisexual and transgender communities being clearly unmet
What main message from the last HNA will you take forward to the next?	That HNA may be a waste of time if the local board lacks the will to implement the findings, no matter how grave the needs or inequalities



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## 7 National and regional contacts



## 7. National and regional contacts

### National

**Department of Health** [www.dh.gov.uk](http://www.dh.gov.uk)  
Government health and social care policy, guidance and publications.

**National Institute for Health and Clinical Excellence (NICE)** [www.nice.org.uk](http://www.nice.org.uk)  
See publications section and regional web pages.

**NICE Evidence Base** [www.nice.org.uk/evidence](http://www.nice.org.uk/evidence)  
Best available information on what works to improve health and reduce health inequalities.

**Health Observatories** [www.pho.org.uk](http://www.pho.org.uk)  
The national home page for the UK Public Health Observatories.

**Public Health electronic Library (PHeL)** [www.phel.gov.uk](http://www.phel.gov.uk)  
Single port of call linking all public health web-based resources through one gateway.

### Regional

#### EAST OF ENGLAND

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**National Institute for Health and Clinical Excellence**

East of England Regional Office,  
c/o East of England Public Health Group,  
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**Eastern Public Health Observatory**  
[www.erpho.org.uk](http://www.erpho.org.uk)

**Government Office for the East of England**  
[www.go-east.gov.uk](http://www.go-east.gov.uk)

#### EAST MIDLANDS

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[www.empho.org.uk](http://www.empho.org.uk)

## Regional (cont)

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#### London Health Observatory

[www.lho.org.uk](http://www.lho.org.uk)

#### London Health Commission

[www.londonhealth.gov.uk](http://www.londonhealth.gov.uk)

#### Government Office for London

[www.go-london.gov.uk](http://www.go-london.gov.uk)

### NORTH EAST

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#### North East Public Health Observatory

[www.nepho.org.uk](http://www.nepho.org.uk)

### NORTH WEST

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#### North West Public Health Observatory

[www.nwphro.org.uk](http://www.nwphro.org.uk)

#### North West Public Health Team

Government Office North West  
[www.go-nw.gov.uk/health/healthteam](http://www.go-nw.gov.uk/health/healthteam)

### SOUTH WEST

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#### National Institute for Health and Clinical Excellence

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Bristol BS1 6ED  
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#### South West Public Health Observatory

[www.swphro.org.uk](http://www.swphro.org.uk)

#### South West Public Health Team

Government Office for the South and West  
[www.go-nw.gov.uk/health/healthteam](http://www.go-nw.gov.uk/health/healthteam)

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#### **South East England Public Health Observatory**

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### **WEST MIDLANDS**

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#### **West Midlands Public Health Observatory**

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### **YORKSHIRE AND THE HUMBER**

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#### **National Institute for Health and Clinical Excellence**

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