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# The effect of population-based health needs assessment on health visitor practice

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This paper reports on a study examining the effects of undertaking population-based health needs assessment (HNA) on the knowledge, views and working practices of health visitors. Data were generated through indepth interviews with health visitors who had all utilized a standard mechanism for needs assessment. This was analysed to assess the impact of this work on the research respondents' knowledge base, their attitudes and approaches to health visiting and their everyday practice. Findings suggest that undertaking health needs assessment increased understanding of public health concepts, enabled a profound reflection on current working practices and increased respondent's desire to practise differently. However, despite these forces for change, the practitioners in this study found it very difficult to refocus their work in the way they desired due to a combination of inhibiting factors, including custom and practice and the perceptions and demands of others. If health visitors are to expand the scope of their work to incorporate an increased amount of community based activity as the UK Government is proposing, this study would suggest that these inhibiting factors must be addressed not only by health visitors themselves, but also by their employers and other primary care professionals.

**Key words**: health needs assessment; health visitor; public health; targeting

## Introduction

Community health needs assessment (HNA) is the process of determining priorities and action plans for service delivery to meet identified health needs (Harris, 1997; Robinson and Elkan, 1996). The activity is commonly seen as made up of a number of stages. Firstly, the community under scrutiny is delineated and decisions are made regarding the nature of the information required to estimate health needs. Collection of relevant data follows, and this is then collated into a health profile. This is analysed and priorities for action determined through the use of specified criteria. Activities are then planned and undertaken to improve the health of the community in the area or population group targeted. This process can be carried out on a large scale across countries or health authority districts, or on a small scale with very local populations. The process can be undertaken either solely or collaboratively within primary health care teams, on a multiteam or multiagency basis or in conjunction with the community itself (Billings and Cowley, 1995).

Health needs assessment is identified by Hooper (1999) as an integral tool in adopting a public health approach to meeting the needs of the population. It can be a challenging process and one which almost inevitably confronts the health professional with a number of difficult ethical issues, such as models of health, defining need, issues of equity and the effectiveness of current practice (Lightfoot, 1995). For this reason it can be uncomfortable, yet important to engage any practitioner in debates around fundamental and profoundly held beliefs.

At a population level, HNA is seen as a fundamental part of public health work (Hensher and Fulop, 1999) and is increasingly being seen as essential in primary care (Department of Health, 2001). It is assumed to bring benefits in terms of

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prioritizing and planning health enhancing public health activities and as such it is particularly pertinent to health visiting practice. Health visitors have long been identified as key public health practitioners (Department of Health, 1999a; SNMAC, 1995) and in England are currently being encouraged to 'develop a family-centred public health role' (Department of Health, 1999b: 61) into address health inequalities.

## The study

Integral to this expanding role for health visitors is the skill of assessing population need in order to prioritize and deliver effective interventions to improve health. Despite being seen as a core health visiting competency (UKCC, 2001) HNA is seldom used as a tool in current practice (McIntosh, 2000; Pearson *et al.*, 2000). The data presented here are taken from a small study exploring the impact of a standardized approach to population level health needs assessment on the views, knowledge and practices of health visitors.

## Method

This study aimed to investigate practitioners' experiences of the HNA process. This necessitated the exploration of practitioners' perceptions of the experience and thus a qualitative methodology was used. Data were generated from semi-structured in-depth interviews and the sample was drawn from health visitors who had undertaken team based health needs assessment work using a specific resource pack (Rowe *et al*., 1997). This resource pack was developed by facilitators working with PHCTs. It identified the major stages of HNA and provided a series of activities designed to enable teams to work through the process. Specifically it addressed:

- the benefits of HNA
- exploring different models of health
- identifying health information
- collecting data (including community perspectives)
- sharing and interpreting the data
- creating an action plan
- changing practice.

The 16 study participants were purposefully recruited from three trusts in the West Midlands. Interviews were taped and transcribed and content analysis used to describe recurrent themes within the data. Data analysis began as the data were continuing to be generated. This allowed an iterative process of finding themes, verifying, expanding and testing them in the next stage of the data collection in repeated cycles continued throughout the data generation process (Silverman, 1993). On completion of data generation, a cross-sectional analysis was undertaken, including all the data. Content analysis was used, and data were categorized by themes, both those predetermined by the research questions and those arising from the data itself.

## Findings

The study explored a wide range of areas including respondents' perceptions of their current working practices, their experiences of the health needs assessment process and the impact of this process on their knowledge and working practices. The full range of findings is reported elsewhere (Rowe and Carey, 2000). This paper concentrates on the impact on practitioners and practice.

## The process of health needs assessment

Most respondents had found the HNA work enjoyable and stimulating. It increased knowledge, both of the community under study and of the roles, experiences and working practices of other team members. The process was, however, found to be time consuming and sometimes frustrating. The most stimulating aspect of the process was the opportunity it presented for examining current practice and priorities.

### Stepping outside everyday practice

The respondents reported that the process of HNA provided a means of stepping outside their everyday practice in an examination of their role. This examination and debates around such fundamental issues as models of care, skills and health determinants was identified as an important part of the process:

> It gave us a forum for debate (HV 10), allowed us to debate issues, shows that we


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> have different models of health (HV 13), beneficial to go [and examine issues] on a wider scale (HV 2).

For some, it also provided an important opportunity to reflect upon their present working practice in a safe environment, facilitating debates on the developing role of the health visitor:

> It helped people look at practice (HV 4), it gave us space to ask what is pertinent to your practice? (HV 2), it made me aware of disproportionate amount of time spent on things that are ineffective . . . made me try and change (HV 1), we are now discussing it [our work] more, evaluating effectiveness, comparing our work, reflecting (HV 9).

### Changes in the conceptualisation of health visiting practice

The data revealed changes, both in how participants practised after completing health needs assessment and in the way they perceived their role as health visitors:

> There was a general sort of change in the whole attitude towards the service (HV 5), We had to move away from the traditional styles of health visiting, which is easy to become entrenched in and comfortable as well (HV 4).

This change in attitude resulted in the respondents examining their beliefs surrounding practice:

> It made people go away and challenge practice (HV 13), a lot of issues have continued, like a roller coaster . . . people are now interested in working with health in the community (HV 11).

The re-examination of perspectives on practice led to the health visitors reporting a broader approach to their work, including an increasingly community-focused service which specifically targeted needs:

> This is actually what the data showing us, so why are we not addressing it, or why are we addressing it on our own? (HV 10), to offer a uniform service is sometimes not always appropriate (HV 2).

### Changes made to practice

In conjunction with changes in the perceptions and beliefs surrounding practice the data highlighted changes in the participants' activities. The process of health needs assessment was identified as instrumental in identifying a new, shared focus and altered priorities for practice:

> [HNA] helped us to start to focus more, given us some forethought as to what we want to achieve, maybe where we are going, and why we are going that way (HV 3).

> [HNA] helped to identify what is important, what is a priority . . . before [I] was less focused (HV 9).

The process of HNA was reported by a number of participants as directly impacting upon day-to-day health visiting practice. The reported changes in practice varied from modifications to the way in which participants delivered existing services through to increased networking and collaborative work. Sometimes this had led them to explore areas that they had previously not considered as their area of practice.

### Potential hazards of change

The process of changing working practices and priorities was both initiated and reinforced by the work on HNA, which encouraged reflection on practice in the light of evidence of the needs of a specific population. However, there was a strong perception that deciding to work differently was hazardous, either because of the perceptions of others or because the health visitor would at some future date put herself in a vulnerable position:

> The child protection advisor that we have, and I understand exactly where they are coming from you know, they are all specialists in child law and other law, but I think they put a lot of pressure on people to feel they must do x number of visits, rather than talk in terms of your accountability and can you justify your actions (HV 13).

For some it was not the public health work itself that seemed risky, but moving away from custom and practice:

> Public health work can feel like you're not doing anything. With developments [developmental assessments] you feel busy, the



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> demand is more instant, you know you've got that pile to get through (HV 1).
>
> Those 'have to do' things take up a lot of time. Its difficult to stand back and be seen to be doing something different (HV 7).
>
> . . . I don't think the work is risky, its not the public health work, its letting go of the caseload . . . (HV 13).

## Constraints on practice

Whilst the practitioners in the study felt that health needs assessment had raised their understanding of the communities' health needs and had convinced health visitors that change of their practice was necessary, making and sustaining change was still seen as difficult.

*Custom and practice and the 'must do's'*

Custom and practice, and the difficulty of addressing this issue was a recurring theme in the data. It was described variously as:

> . . . the day-to-day kind of stuff that's always been routine, which has been passed on to us through time (HV 10).
>
> There is a certain amount of routine stuff that we have to do . . . (HV 16).
>
> There are certain things that you have to do and its difficult not to (HV 7).

The health visitors in this study made reference to a number of tasks and functions that they felt either constituted the things that 'had to be done' or that were expected to be the work of health visitors. Most of this work involved home visiting to the family unit, for example routine universal child health promotion assessments, new baby visits, families transferring into the area, and for some 'weaning' visits and 'home safety' review visits. In addition, they reported the importance of child health and immunization clinic sessions. Only after this routine work had been attended to could other work be considered.

For a number of health visitors the tension between what had to be done for families and the community-oriented public health work was causing real dilemmas:

> . . . can you be a mums and babies nurse, can you deal with the child protection (and we've got tons) and take a serious approach to public health? I do think that there is a strong case for more dedicated public health posts . . . [however] a down side of that is its your everyday work with the families, in particular the needy ones, that gives you the knowledge to take forward. But it would be nice if we could move in and out of some protected public health work . . . (HV 13).

*Perceptions and demands of others*

As an additional obstacle to change, the perceptions and demands of others appeared to have a large amount of influence on the work of health visitors. This created difficulties for the practitioners who felt unable to determine their own priorities or working practices:

> Other peoples expectations of you make it difficult sometimes to organize your workload in the way you might want to (HV 8).

A number of different peoples expectations were said to influence health visiting:

> I think there are assumptions, not just in the client population, but even within our own discipline or multidisciplinary, there is a misapprehension that it [the health visitor role] is just to deal with babies and families and does not go any further . . . (HV 2).
>
> The community now has expectations, for example developmental assessments, people expect 'checks' (HV 4).

Not only expectations, but also demands from others constrained health visiting practice. GPs, managers, the Department of Health and even the child health department's computer were all mentioned as demanding and influencing health visitor practice. Where demands were seen as low priority a health visitor would sometimes decide herself to sidestep them, but often negotiation was needed to address them. This seemed particularly to be the case where a decision to stop undertaking a particular piece of work was being considered.

Although the expectations of others had a significant effect on the work of health visitors in the study, many of the research participants felt


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that health visitor colleagues were themselves resisting change.

> . . . There was still [after health needs assessment] a reluctance to change, despite what everybody said. Its much easier to stick with what has been routine and what has been historical than it is to say 'right then are we actually making progress here?' (HV 10).

> There is fear of change. It [public health] is a new role and that's daunting, there is a lack of knowledge, a lack of confidence (HV 4).

None of the respondents suggested a radical alteration of the health visiting role as a potential solution to these dilemmas of practice, discussing instead the need to restrict demand, complete the 'must dos' as efficiently as possible, give each other more time by combining their efforts and gain the support of others to stop those activities seen as giving little benefit.

The expectations and demands of others, combined with the weight of history and custom combined to create a powerful force resisting change. The health visitors in this study, as described earlier, had often made small changes to practice and service delivery. However, any larger changes they felt necessary were made difficult by the expectations of them and peer pressure. Any attempt to radically alter the nature of their work was felt to expose practitioners to personal risk.

## Discussion

The data analysis demonstrated a number of recurring themes relating to the impact of HNA on the health visitors' perspectives and practice.

### The impact of health needs assessment

HNA has been identified as a key public health tool, enabling practitioners to identify, prioritize and plan for the health needs of a given population (Hooper, 1999). Very few of the research respondents had previously used health needs assessment as part of their everyday practice, despite it long being an explicit part of health visitor education (Orr, 1992; Pearson *et al*., 2000). This infrequency of reported health needs assessment or profiling, prior to the team approach used by the study respondents would appear to suggest that health visitors routinely depend on individual client reports and personal observation to assess need and determine priorities (Cowley *et al*., 1996; McIntosh, 2000). However, for many of the research participants the data collected during HNA was a major challenge to this practice, as it highlighted health issues and concerns that they had previously not considered. In addition, at times, health issues previously identified as a priority did not prove in fact to be a serious concern.

The discovery of evidence of population health needs was viewed as a positive benefit for the practitioners in this study. It enabled them to identify and debate the health issues most relevant to their practice population. This was identified as fundamental to practice, supporting the health visitors to gain valuable information and knowledge of the community and thereby focus the emphasis of their work. In addition many respondents reported that health needs assessment had helped them make the connection between day-to-day practice and the population needs as a whole, and gave them an increased sensitivity to the cultural and social needs of the community. This provided motivation to change practice and was evidenced through the examples given of changes designed to meet the specific needs of the population. The resultant move away from a task-orientated approach towards a needs-led model of care provision was, for some, a return to the origins of health visiting practice (Doolan and Kitson, 1997). This shift in perspective was sufficiently strong for participants to identify that in future health needs assessment would be an integral and continuous component of their health visiting practice.

The health needs assessment work undertaken by the study participants was reported to have encouraged an examination of health needs on a population rather than solely on an individual level. This led to an increased community-based focus in practice and a raised awareness and demonstration of collaborative work. This collaboration involved not only other health professionals but also other agencies and at times the communities themselves. The examination of evidence concerning a whole population enabled the health visitors in this study to identify and differentiate between different population groups, be they linked by geography, access to social provision, age or gender. This raised an awareness of the issues surrounding uniformity of service provision



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and enabled discussion and attempts to resolve the difficult issue of targeting health care. This evidence of collaboration and assessing the comparative needs of different groups is an indication of the adoption of a public health approach to health visiting practice (Twinn and Cowley, 1992).

## Issues for health visiting practice

The process of health needs assessment appears to highlight and expose the dilemmas inherent in current health visiting practice. Health visitors in the study clearly demonstrated an increased commitment to delivering a flexible, adaptive service based on identified health needs. However, this desire was constrained by the competing agendas directing health visiting practice and the perceived lack of sufficient power to override these.

The degree to which any health professional can truly claim to be an autonomous practitioner is questionable, as such things as custom and practice, protocols, the expectations of others and organizational structures and rules constrain an individual's ability to adapt and change (Holden, 1991). Organizational structures have previously been shown to be a significant constraint to the public health practice of nurses (Billingham *et al*., 1997). However, in reality some professionals have more freedom to exercise clinical or professional judgement than others, both in terms of the priorities and nature of their work and during the course of their work with clients or patients. For the health visitors in this study the former type of autonomy was constrained, as their freedom to define their overall priorities appeared to them to be restricted. One could argue however, that as professionals these health visitors have a responsibility to question this state of affairs. The health visitors in this study felt that HNA had given them the motivation and means to examine their practice and determine priorities. However, they passively accepted the right of others to deny them the means to achieve this ambition. By not accepting the responsibility to challenge the status quo and question the 'givens' the health visitors in this study denied themselves the opportunity to make real change on behalf of local people.

Nevertheless, a number of the participants detailed change in their working practices as a result of the health needs assessment work. In describing how they instigated the changes, they highlighted the support of other members of the team as a counterbalance to the perceived risk associated with nontraditional approaches to work. The adoption of new approaches in health visiting has been seen as difficult given the lack of good evidence to support different ways of working (Hutchinson *et al*., 1995, cited in Appleton and Cowley, 1997). When also seen as flowing against the tide of current norms, with the present wide range of expectations and unsupported by colleagues, a significant change of focus for practice such as taking an increasingly population-based focus, would appear extremely difficult. This difficulty and the frustration this caused were clearly demonstrated by the research participants.

Even though recent UK policy (Department of Health, 2000a) has highlighted the importance of fieldworker level knowledge and decision making, this study reveals the complexity and interrelatedness of a number of issues in determining professional practice, in particular the potentially competing agendas of primary care trusts (PCTs), primary health care teams and individual health visitors. Unless PCTs as providers of services are prepared to work with their staff to deconstruct the pressures and assumptions that determine everyday practice as a prelude to change, then it seems unlikely that significant exploration and changes to working practices will occur. In order to achieve this, fieldworkers and managers will need to be willing to question, listen and debate the fundamental concepts underpinning health visitor practice.

## Impacting on the public health agenda of PCTs

PCTs are required to determine and meet the health needs of their local population. In order to achieve this there is an explicit requirement that local population are engaged in the determination of health priorities (Department of Health, 2000b). This can be achieved through a number of activities, one of which is HNA. Health visitors' education has always addressed the issue of HNA and its application to practice. This, along with their daily contact with the local community, would suggest that this group of practitioners are well placed to undertake this work within a PCT. This is reinforced by the Department of Health's guide to good practice, the 'Health Visitor Development Resource Pack' (Department of Health, 2001). However, the findings of this study suggest that


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few health visitors are currently seeing this as an integral part of their work. Without consistent use of HNA skills, health visitors' ability and confidence to undertake this activity will be limited and without action from the PCT to reduce the number of obstacles to changing practice, health visitor action to address the health issues uncovered by HNA will be limited. The challenge therefore is for health visitors to rediscover and apply their HNA capabilities and for PCTs to facilitate and enable changes to the practice environment.

## Limitations of the study

The small-scale retrospective nature of the study prohibited the collation of before and after measures of knowledge or practice. As such the findings are not generalizable. In addition, the authors acknowledge a number of issues in relation to the internal validity of the study. Within the limitations of this study, it was not possible to undertake triangulation of data sources, or attempt inter-rater reliability. The credibility of the research relies on the explicitness of the research decision trail (Guba and Lincoln, 1981) and the honest account of the research process. Both these were documented by the researchers. An additional pressure on the internal validity of this study comes from the researchers' position as both authors of the open learning pack used in the study and researchers of its effect. Motivation for the study came from a real desire to know and understand the outcomes of work on health needs assessment, and, as can be seen from the analysis, the project expanded far beyond its original boundaries. The researchers, however, were very conscious of the potential for bias arising from their position, and questioned themselves and each other rigorously during both collection and analysis of the data.

## Conclusion

It would appear that undertaking a health needs assessment was a strong contributory factor in a reported increased desire to change professional practice. However, an individual commitment to changing practice is rarely sufficient to sustain change, even if the practitioner feels they are in a powerful enough position to determine their practice priorities (Tarplett and McMahon, 1999). The health visitors in this study reported making some changes to their professional practice, but felt that radical alterations would subject them to unacceptable exposure and personal risk. Managing and supporting change in the behaviour of professionals is a complex process involving a multitude of influential factors (Iles and Sutherland, 2001; NHS Centre for Reviews and Dissemination, 1999). Practitioners' attempts to refocus their working practices need to be supported by modifications to the large number of determinants that influence and constrain them. Addressing these wider restrictions will require professional commitment and managerial support.

Thus, although HNA was reported by research participants to increase their knowledge of, and commitment to, a needs-led and community-based service, attaining and sustaining change in practice to meet this agenda would appear to also need additional input and support from health visitors' employing organizations, other agencies and other primary care and community professionals.

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