

HEALTH NEEDS ASSESSMENT - AN ESSENTIAL TOOL FOR HEALTH SERVICE PLANNING & COMMISSIONING

Introduction

Providers and commissioners of health care need comprehensive information on the health needs of the populations they serve. Without this, there is little chance of needs being met. Health needs assessment (HNA) provides a useful framework for collecting and interpreting this information.

HNA explained

For any population (borough, locality, practice or case list) and health issue (particular client or disease group), HNA can generate a description of the service requirements. HNA recognises that patients, professional and the public all make a valuable contribution to identifying service requirements but that their perspectives will vary according to their knowledge, assumptions or experiences.

HNA recognises four key perspectives:

- Patient / public– what they want (***felt and expressed needs***)
- Experts - what they think would help their patients / clients (***normative needs***)
- Making comparisons - the health care that people / patients in other areas get to help them (***comparative needs***)
- Epidemiology – what the research evidence shows in terms of clinical effectiveness, health status and demographic trends (***epidemiological needs***)

Advantages and drawbacks of HNA

The overriding benefit of comprehensive HNA is its ability to take into account all of the perspectives and generate balanced recommendations which are not skewed in favour of any specific dimension of need.

HNA proponents champion the case for comprehensively researching each of these four perspectives. But this comprehensive approach is often impractical because it tends to be time consuming and requires considerable technical expertise. In general, the NHS cannot systematically afford the time and expense of comprehensive HNA for every service development or commissioning contract.

In practice, some organisations address these problems by limiting HNA to one or two of the perspectives. There are increasing pressures on NHS organisations to incorporate public, patient and carer involvement. As a result, felt and expressed needs are perhaps the most likely to be considered.

Restricting HNA in to one or two perspectives only is a dangerous practice. It will inevitably produce unbalanced and inefficient decision-making that produces solutions are services that do not meet population needs. For example, at an individual level, people with high blood pressure will not always be fully aware of the treatment options available to them. Similarly, health professionals can fully identify treatment options, but they may be less likely than patients to identify key inter personal issues and in choices for different treatment alternatives.

At a population level, choices informed only individual preference, and not by constraints of costs or effectiveness lead to inefficient services, and will be less likely to address the health needs of the least articulate. Equally, services designed by professionals in isolation from communities beliefs and health behaviours are unlikely to be used by target populations.

HNA in Gateshead PCT

So, if biased HNAs are unhelpful and comprehensive HNAs are impractical, what can NHS organisations do?

Gateshead PCT has responded to this challenge by incorporating a HNA framework into its planning processes. This framework – the Gateshead Health Needs Grid – is attached along with three illustrative examples.

As the examples show, the advantage of the Gateshead Health Needs Grid is that it facilitates informed and balanced decision making. The grid summarises key evidence regarding each of the four perspectives and serves as a reminder of the relative importance of each perspective. It can be used for any type of HNA regardless of the target population or health / health care issue

The tabular presentation allows, at a glance, decision makers to identify whether there is an appropriate balance of the different views of need to inform the decision.

Armed with information presented in the Gateshead Health Needs Grid, any decision maker will be able judge how complete and balanced their recommendations can be.

Conclusions

The Gateshead Health Needs Grid is an appropriate and practical tool to inform decisions about commissioning and providing services that meet the needs of populations.

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July 2006.

THE GATESHEAD HNA GRID

TARGET POPULATION AND HEALTH ISSUE:	
<i>Wants of patients</i>	<i>Comparative needs</i>
<i>Epidemiological / evidence-based needs</i>	<i>Normative – professional needs</i>
<i>Conclusions</i>	
<i>Recommendations</i>	

EXAMPLE 1:

Background – this piece of work was undertaken in response to an atypical request for the PCT to fund IVIG treatment for a patient

Case summary: *deleted for confidentiality*

Health Needs Assessment of IVIG for neonatal haemochromatosis

<p><i>Wants of patient</i> <i>Deleted for confidentiality</i></p>	<p><i>Comparative needs</i> The Trust DTP panel prepared to fund this treatment if PCT doesn't Chicago team providing IVIG</p>
<p><i>Epidemiological / evidence-based needs</i> Limited specific evidence - 1 study only with some methodological limitations (historical controls,) but demonstrable disease in 12 babies and yet good clinical outcome which is unusual</p> <ol style="list-style-type: none"> 1. Gissen P, Kelly D. New hope for treatment of neonatal haemochromatosis. The Lancet 2004, Nov 6-12; 364(9446): 1644-5 2. Whittington PF, Hibbard JU. High dose immunoglobulin during pregnancy for recurrent neonatal haemochromatosis. The Lancet 2004, Nov 6-12; 364(9446):1690-7 <p>Incidence – a rare condition unlikely to present a regular or growing trend in treatment needs</p>	<p><i>Normative – professional needs</i> Trust Expert clinical team says yes – paed, genetics, and pathology Birmingham experts say yes</p>
<p><i>Conclusions</i> This limited yet balanced HNA provides evidence to support funding for this treatment in this patient. The lancet article is more relevant than the Cochrane review– the reason for previous loss is thought to be neonatal haemochromatosis, there is risk of recurrence, the study shows powerful evidence of benefits of IVIG for the fetus</p>	
<p><i>Recommendations</i> Public health perspective is that there is sufficient evidence of health need to justify funding IVIG in this instance but more work is required to identify with the prescribing adviser the appropriate drug budget for this.</p>	

Example 2: Secondary prevention of osteoporotic fractures

Background: This assessment was produced following on from a business case considered by the PCT's Professional Executive Committee, where a clinical policy was approved, but not implemented on the grounds of affordability.

Community Profile

There are between 4,699 and 7,831 women with osteoporosis in Gateshead. The real figure is likely to be towards the upper end of these estimates, as the population of Gateshead is older than the national populations on which these estimates are based. There are an estimated 694 osteoporotic fractures each year in this population, costing an estimated £ 5,700,000. Again, this is likely to be an under-estimate, given the local population profile.

Wants (felt or expressed need)

Individuals have approached GPs, hospital services, and the PCT directly for scanning.
No systematic work has been undertaken to assess views of local people.

Comparative need

Most populations in England have made progress towards implementation of this guidance. But in Gateshead progress has been limited, largely because of the availability of DEXA scanning. Recent analysis by the Regional Drugs and Therapeutics Centre shows that counter to the expected picture, Gateshead GPs are prescribing bisphosphonates at the highest rate in the North East- well above the England mean, and costs are increasing well above the national norms (*Appendix deleted for brevity*). This suggests increasing the availability of scanning is very unlikely to increase prescribing costs, and rather it may help us constrain cost growth in this field.

<p>Epidemiological or evidence-based need (value for money)</p> <p>Osteoporosis is a common condition that increases with age. It is also a common cause of bony fracture, which in turn is a significant effect on both quality and length of life.</p> <p>NICE guidance gives us confidence that NICE has reviewed use of bisphosphonates in secondary prevention of osteoporosis (preventive treatments after a first osteoporotic fracture)</p> <p>Attempts have been made to quantify the likely effects of implementation on use of scanning, prescribing costs and costs of fractures avoided. These concluded that whilst there were significant uncertainties in the medium term the costs were close to balance. But in the short term there were some scanning costs and potentially very large calls on the prescribing budget.</p>	<p>Expert opinion (normative need)</p> <p>A local expert group has been meeting for some time to explore options for implementing NICE guidance. It has dealt with conflicting views about best methods for managing this population, but presented the Professional Executive Committee at its February 2006 meeting with a single option, which was agreed in outline:</p> <p><i>For people with an established fracture: among those aged 75 and over: continue case finding in secondary care, where risk assessment will not normally require scanning</i></p> <p><i>among women aged 65-74: continue case-finding in secondary care, using peripheral DEXA scanning as the usual investigation, with referral to Newcastle for axial DEXA scanning where required</i></p> <p>Neither of these is a material change to local activity, but</p> <p><i>among post-menopausal women aged under 65, and where the fracture is 'low impact': (1) GHNHSFT should ensure there is specific information in A&E and orthopaedic discharge letters alerting the GP to the presence of a low impact fracture AND (2) GPCT should ensure there is direct access for GPs to axial DEXA scanning</i></p>
<p>Appraisal of alternative actions</p> <p>(1) Do nothing: Without the appropriate risk scoring (which may include the need for scanning) many people will either not be receiving the medicines they need or that they will be unnecessarily receiving potent drugs (principally bisphosphonates).</p> <p>(2) Commission a new service for axial DEXA scanning for under 65s with low impact fracture (costs identified within LDP) i.e. implement the PEC proposal. This option, if implemented effectively, will ensure that everyone sustaining an osteoporotic fracture should be risk assessed, and receive effective drugs. It should also effectively eliminate the need for new cases receiving unnecessary medicines.</p>	
<p>Recommendation</p> <p>The PCT should support the letting of a new contract for DEXA scanning (as envisaged in the LDP), to secure the PEC's agreed approach to secondary prevention of osteoporotic fractures.</p>	

Example 3: Health Trainers

Background: public health workforce development is a strong theme of work in Gateshead, the Health Trainers initiative is a national mandated programme. This was used to inform the business case to reassure the PCT that investment in health trainers is an important investment

Community Profile	
<p>The borough is made up of 22 wards, using the Index of Multiple Deprivation (IMD) 2004, 12 of these wards are ranked in the worst 25% nationally for health deprivation and 8 are in the second most deprived 25%. Locally 41 priority neighbourhoods at sub-ward level have been identified as part of Gateshead's Neighbourhood Renewal Programme. There is nearly a 6 year difference between life expectancy in the lowest fifth of wards at 73.3 years compared to 79.6 years in the highest fifth.</p>	
<p>Wants (felt or expressed needs) During the national Choosing Health Consultation local people have indicated the need for more consistent health messages delivered at community /local level</p>	<p>Comparative need Health Trainers is a new initiative. Gateshead is a Spearhead PCT i.e. it has been identified as having a population with poor health outcomes, and plans to be among the first PCTs to implement the programme. Thus, a similar service is not provided for most other populations, locally or nationally. Health professionals will signpost clients to health improvement services as part of their public health role in all geographical areas, but they cannot provide the extended support and motivation which will be offered by Health Trainers.</p>
<p>Epidemiological / evidence-based need The "Gateshead Community Health Profile" (APHO, 2006) shows that both health outcomes and lifestyle behaviours are poorer in Gateshead than the comparative indicators for England. Specifically:</p> <ul style="list-style-type: none"> • Male life expectancy 2 years lower than average for England, female life expectancy 1.5 years lower. • Under 75 mortality rate due to circulatory disease (CHD and stroke) 26% higher than rate for England. Under 75 mortality rate due to all cancers 15% higher. • Locally, levels of chronic disease are high. Over 10,000 people in Gateshead are diagnosed with CHD. 	<p>Normative need (expert opinion) Choosing Health identifies key priority areas for action on improving the health of communities</p> <ul style="list-style-type: none"> • Gateshead is designated a Spearhead PCT allocated more resources with an expectation to focus more closely on the reduction of inequalities • Established theoretical framework for behaviour change evaluated in relation to smoking cessation • Employment of Health Trainers a priority identified by Department of Health

<p>Prevalence is 5.0% in Gateshead compared to 3.6% across England.</p> <ul style="list-style-type: none"> • In Gateshead 23% of males and 25% of females smoke (2004 Gateshead Lifestyle Survey) compared to 24% and 23% respectively for England (Health Survey for England 2004). ONS synthetic estimates and lung cancer SMR for Gateshead (153) suggest true prevalence is higher. • Consumption of five-a-day is low for both Gateshead (26% of adults) and England (25%). • Teenage conception rate in Gateshead is falling, but is 7% higher than average rate for England. PCT wants to reduce the local rate by 50% between 1998 and 2010. By 2004 a 22% reduction has been achieved. <p>While there are a range of health improvement services locally people in need may not readily access these.</p>	
<p style="text-align: center;">Summary</p> <p>The aim of the Health Trainer service is to build on current service provision and partnership working and identify and engage with local people and target groups as identified locally in line with the IMD and localities with lowest life expectancy. The project's aim is to bring individuals into contact with mainstream health improvement services and support individuals to change lifestyle behaviours by signposting to services</p> <p>The Health Trainer model, supported by the Department of Health meets with local needs assessment.</p>	
<p style="text-align: center;">Option Appraisal</p> <p>1) Do nothing. At best health outcomes in Gateshead continue to improve steadily but the health inequalities gap between Gateshead and England remains constant. At worst, health inequalities between Gateshead and England, and between those communities within Gateshead with the best and poorest health, grow larger.</p> <p>2) Implement the Health Trainers programme, signposting those who wish to adopt healthier lifestyles to existing health improvement programmes. Support those people to maximise their chances of success in making enduring behaviour change. In the medium to long term the health status of the population of Gateshead will improve and the cost burden of acute health services will be reduced, as per the "fully engaged" scenario outlined in the Wanless Report, "Securing Good Health for the Whole Population" (2004).</p>	
<p style="text-align: center;">Recommendations</p> <p>The PCT should support investment in Health Trainers in Gateshead</p>	