Health needs assessment essay sample

Health & Medicine, Obesity

The aim of this assignment is to carry out a health needs assessment in my practice area, which will include a profile of the community with the intention to identify the main health needs. For the purpose of this assignment the borough B will be used as the authors borough of practice with the health visiting service and ward x as the authors practice area. The project will gather and analyse data to identify all the health needs of the area, then focus on one key health need. The rationale for using it will be discussed and will then be critically evaluated. The current statutory, private and voluntary service provision which have been put in place to meet the identified health need will be looked into, opportunities and limitations which affect this provision will also be examined. Finally a critical examination of the implications for professional practice will be discussed also local and government policies will be looked at and how changes are being made to reduce health inequalities.

The government have set up a new public health framework entitled the Public Health Outcomes Framework it sets the context which is structured from local to national level. It sets out the comprehensive scope to improve and protect health during a lifespan and to reduce inequalities in health that still persist (Department of Health 2012). One of the essential ideologies of health visiting is the search for health needs (Twinn and Cowley, 1992). Health visitors are at the forefront for carrying out public health and have a vast array of knowledge and skills which help in identifying any health and social problems, they offer a core evidenced based programme (Department of Health, 2009) therefore they are well equipped to carry out a health needs assessment. Through the implementation of the Healthy Child Programme

(Department of Heath, 2009) the government have made a resolve to improve the health and wellbeing of all children by ensuring they all receive essential immunisations, development checks and any additional child and family advice. Through this it will enable health visitors to access health needs, evaluate care and if necessary make referrals to the multi professional team.

A health needs assessment (HNA) examines and identifies the health issues in any given area (Cavanagh & Chadwick, 2005) in order to make an achievable change to improve health and reduce inequalities (Summers and McKeown, 1996). The rationale for undertaking a HNA is to recognise needs and highlight the problems in any given population, also to present proposals for clinical interventions in order to deliver a positive change in health outcomes.

In order to gather data for this assignment a community profile needs to be reviewed. Hawtin & Percy-Smith (2007) defines a community profile as a complete description of the needs of a community, for the purpose of developing an action plan of how to improve the quality of life of the community. This health need assessment is based in a PCT in the North West of London. The PCT which is based in Borough B is one of the most culturally diverse areas in England and has a population of approximately 240, 000 which makes it one of the largest populated areas in England. According to (Office for National Statistics (ONS) 2012) the borough has 119, 900 males and 122, 400 females. 20. 2% of the Borough’s residents are aged under 16 (48, 900). This proportion is roughly the same as for London overall which is

(20. 1%), 65. 5 % (158, 800) of the population fall within the new working age group (16 to 64), below the London level of 68. 7%.

There are 21 wards in this borough all of which are culturally diverse with a variety of ethnic groups, 82. 1% of school children are from black or minority ethnic (BME) group as stated in the (Child and Maternal Health Observatory(Chimat) (2013). In total 6. 7% of the Borough's residents are children aged four and under. 81. 6 % of all children aged 0 to 4 are from minority ethnic groups (all groups excluding White British). 44. 8 % of these young children are of Asian/Asian British ethnic origin, which is the largest ethnic grouping. Looking at the 18 ethnic groups, in numerical terms the highest numbers of young children in the Borough are of Indian origin. This Borough is also the most religiously diverse local authority in the UK; there's a 62% chance that two random residents would be from different religious groups (ONS 2011).

The Association of Public Health observatories (APHO) (2013) shows that on the whole the Borough has a good level of health, however, large health inequalities exist in the Borough. JSNA (2010) shows this from mortality rates and life expectancy with people living in the East of the Borough expected to live 7 years less than those in the North of the Borough.

The main causes of death according to (APHO 2013) is coronary heart disease, stroke and cancer. It is important to point out the common risk factors with these ailments which derive from bad lifestyle choices such as smoking, unhealthy diet and lack of exercise. If mortality rates from Coronary Heart Disease in the most deprived parts of Borough B were to

reduce to the rate seen in the most affluent, life expectancy would increase by over a year in males and over 9 months in females (JSNA 2010). Many Government policies such as the (Department of Health 1999) white paper Saving Lives: Our healthier Nation vowed to tackle health inequalities. The aim was to prevent illnesses such as cancer, coronary heart disease and stroke by better screening and treatment for everyone and also by reducing smoking. Many other government documents have been produced on this issue in recent years, such as (DOH 2009) Tackling Health Inequalities: 10 Years On. Nevertheless, a decade later this still seems to be an issue which may be ongoing for another decade if drastic strategies are not put in place.

Waldfogel (2010) defines child poverty as a share of children whose family income is below 60% or less than the national median family income for any particular year (Palmer 2011), whereas (JSNA 2010) defines child poverty as children living in a home that obtains a means-tested benefit. Poverty can have a major effect on the health of families which can impact on their mental wellbeing. Marmot et al. (2010) proposed strategies to “ give every child the best start in life” the aim was to reduce health inequalities. However, four years later many children are still living in poverty, which suggests further government interventions needs to be put in place in order to improve the situation.

The Institute of Race Relations (2014) identified that throughout the UK, people from BME groups are much more likely to be in poverty (with an income of less than 60 per cent of the median household income) than white British people. However, (CHIMAT 2014) highlights the fact that although 19.

7%% children are living in poverty in this BME borough, it still remains slightly lower than the England average of 20. 6% (APHO 2010, Chimat 2014). These figures have slightly fallen over the last year as (Chimat 2013) shows that there was 21. 2% children in the borough living in poverty. This could be due to the fact that the unemployment rate in the borough has recently dropped below the London average (Borough B Council 2014).

The UK has one of the highest amount of children living in unemployed households than virtually any other EU country (Department of health, 2009). Nevertheless, (Garnham 2012) states that income alone is not enough to guarantee a life free from poverty, as there are many employed residents assessing food banks. Although unemployment may be a factor for living in poverty there may be other reasons such as homelessness, lone parent families and overcrowding which can affect health in many ways. Overcrowding in a household poses the risk of air borne diseases such as tuberculosis which is highly contagious and there seems to be a rise of this in Borough A.

Tackling homelessness is a main priority for the Government but as many of the unemployed are in receipt of welfare benefits the recent welfare reforms will affect the deprived even more. Borough B (2013) state that the £500 benefit cap for non-working households is likely to impact around 700 households in Harrow, and the families with large numbers of children are predicted to be hit the hardest. For this reason many families have been rehoused outside of London, which can have a diverse effect on education and health.

According to the Boroughs Index of Multiple Deprivation (2010) Harrow ranked 184 most deprived local authority out of 326 but variations of deprivation are present within some areas in the south of the borough. Most deprivation is in the centre of the borough, with pockets of deprivation across the rest of the borough. The least deprived areas are in the northwest and the south of the borough. The borough on the whole has low levels of deprivation.

For the benefit of this assignment a windshield survey of Borough B was carried out. Hunt, (2009) describes this to be a motorized evaluation of a locality, by driving through a neighbourhood and using observation skills to conduct an assessment of the area. To get an objective overview of the community this survey was carried out by driving and walking. Based on observation, this survey showed the area to be a very diverse borough ranging from the very affluent to the very needy. This was revealed when driving through a private gated road comprising of very large houses and then driving out of this private road to find an area of social housing across the road. It was also observed that the community is heavily populated by black and ethnic minority groups, with a high density of the Sri Lankan Tamil residents in ward x. See Appendix 1 for full overview of windshield survey.

The (Chimat 2014) shows data which signifies the health and wellbeing of children in Borough B in comparison to the rest of England. (See Appendix 2). The chart indicates that on average most of the health issues in the Borough are on the whole better than the England average. Issue such as breastfeeding initiation and breastfeeding at 6 – 8 weeks are significantly

improved since the borough received full accreditation to the Unicef Babyfriendly award in 2012. Training has been provided for all multidisciplinary staff and a network of trained peer supporters was set up to work with mothers in hospitals and in the community, they also run breastfeeding support groups on every weekday. Borough B now has a breastfeeding helpline, website, Facebook page and Twitter site, all run by peer supporters. This initiative has gained great benefits in the borough because (Renfrew 2012), showed that 90% of mothers are initiating breastfeeding and 50% of mothers exclusively breastfeed since receiving the award.

According to the statistics pointed out in (Chimat 2014), health issues that are a larger concern in the Borough are low birth weight of babies and infant mortality which are closely associated with each other. These are both significantly higher than the England average in Borough B. Data shows low birth weight in this area which is 9. 0%, compared to the England average which is 7. 3% and Infant mortality 6. 1% and England average 4. 3% (Chimat 2014). Numbers appear to be lower in the south of the borough than in the north (JSNA 2010). A number of factors such as inappropriate antenatal care, maternal and child nutrition, premature births, drug and alcohol during pregnancy, multiple births and smoking during pregnancy could be the cause of this. Even though the concept of need may be greater in these areas, the health visitor will not be able to do much in the short term to put interventions in place to prevent them as they do not carry out antenatal visits at present. These preventative interventions need to be

undertaken by the midwifery services who will need to improve access to maternity services and focus on the most vulnerable mothers.

According to World Health Organisation (WHO) (2014) being overweight and obese are the fifth leading risk for global deaths. Improving obesity rates in childhood has been one of the Governments main public agenda issues and obesity prevention is a core part of the Healthy Child Programme (Rudolph 2009). For the last 2 years childhood obesity in 4-5 year olds in Borough B was not significantly different than the England average. According to (Chimat 2012) the England average was 9. 4% and Borough B was 7. 3%, however, (Chimat 2014) shows the England average is 9. 3% compared to Borough B which has risen to 10%. According to the latest data, the area is performing at 2% greater need than the England average (JSNA Refresh 2013/14). Even though the rate is similar to the England average, the contrast in rates over 2 years shows that it is a problem which is not improving and can lead to many health implications which can carry on into adulthood.

This Health Needs assessment aims to look into Childhood obesity rates in the Borough and will investigate ways to improve these rates. This topic was chosen because obesity considerably affects the most essential aspects of health, as well as being a local issue it is a national issue and it can be extremely detrimental to health to the point of causing death. In England the British 1990 growth reference (UK90) was recommended for monitoring the weight of the population and for clinical assessment in children aged four years and over. Obesity is classified as being ≥ 95th centile for population

monitoring ≤ 98th centile for clinical assessment. (National Obesity Observatory 2011).

The NHS Information Centre (2010), carried out The National Child Measurement Programme in the UK, this programme involved all children in Reception class and year 6 having their height and weight recorded. It found that 23. 1% of 4–5 year olds are overweight or obese. National Obesity Observatory (2010) felt that improvements were made in dealing with childhood obesity by producing data which showed that the rate of obesity has slightly slowed from 1998 to 2008, however (Rudolph 2009) found that more than 1 in 5 children were still overweight or obese by age 3.

Wijga (2010) found that overweight and obese children are more likely to become obese adults, therefore having a higher risk of morbidity with serious health issues such as coronary heart disease and stroke (Swanton 2008).

Reducing childhood obesity will benefit the many health implications such as diminishing the risk of diabetes, asthma, sleep apnoea, anxiety, bullying and it will also build self-esteem. Stettler (2002), identified that gaining rapid weight in infancy was the strongest risk factor for developing childhood obesity and therefore essential to the health visitors role. However, although (Department of Health 2009) Healthy Child Programme encourages health visitors to provide information and advice to pregnant women and parents of young children about nutrition and physical activity, and the Foresight Report in 2007 aim to reduce excess weight in children by the year 2020; no national guidance has being put in place to assist health visitors to manage

obesity in infancy. Redsell et al. (2011) found that GP's were more knowledgeable about the health risks of obesity, but not confident at giving overall advice and health visitors needed to increase their knowledge in order to identify and manage infants at risk of obesity.

More research needs to be undertaken to determine how practitioners should communicate obesity risk during infancy to parents (Redsell 2013). At present health visitors use clinical practice guided by the healthy child programme alongside the use of their professional judgement.

The borough has various service provisions in place to tackle this epidemic and many statutory and voluntary provisions have been looked into to meet this health needs. These are as follows:

Assessing overweight/obesity

Assessing risk of overweight and obesity at a New Birth Visit is very difficult for health visitors. Weng et al. (2012) established that maternal pre-pregnancy overweight/obesity, paternal overweight/obesity, high infant birth weight and smoking during pregnancy are non-modifiable risk factors. In addition, (Lumeng 2005) believes a child with one parent who is obese is 3 times as likely to become an obese adult. If a baby has a high birth weight then health visitors will use their professional judgement and the weight of those babies will be monitored regularly, the difficulty for health visitors will be to ascertain whether some parents are overweight/obese and how to relay to parents that this could be a risk factor for their infant gaining excess weight. This is a very sensitive issue and because of the fear of embarrassment and the stigma attached it may be overlooked.

Weng et al. (2013) devised a risk scoring algorithm to determine obesity risk in children called an Infant Risk of Obesity Checklist (IROC). (See appendix 3). It was piloted in Nottingham by a group of local health visitors and it was undertaken by health visitors carrying out a new birth visit, then again at 4 months and 12 months to assess for rapid weight gain. This tool entails a variety of questions with a scoring system, when added up at the end a score is given which determines whether the infant is at risk of being overweight/obese. This initiative was carried out on all babies therefore reducing the risk of singling out particular groups of people. It appears to be a very useful tool which will assist health visitors to assess weight without any embarrassment, however, development work is on-going as testing of its practicability is required prior to full implementation of this recommendation. At present the Health Visitors in Borough B will access a baby's weight at the new birth visit and document in their red book, this will enable a baseline weight to be recorded. The baby's weight is then recorded each time they are bought to the healthy child clinic. Breastfeeding

When mothers are seen at the New Birth Visit between 10 to 14 days after birth, they have usually established a feeding regime for their babies. In Borough B the local hospital and area has been accredited with the Unicef Baby friendly award therefore most of the mothers in the area are quite enthusiastic about breastfeeding. Gaining this award has helped the breastfeeding rate in the borough to rise and as (Unicef 2012) states increasing breastfeeding rates to a level compatible with reducing the rates of childhood obesity by as little as 5%, would result in reducing annual health-care expenses by more than £1. 6 million. All health visitors and

student health visitors have had Unicef breastfeeding training to enable them to assist mothers who wish to breastfeed, but may be struggling.

Borough B also has in place many peer counsellors who support mothers by providing drop in breastfeeding support centres which are run from Monday to Friday, two being held in breastfeeding cafés within the Borough. Various research articles have been undertaken and (Bogen et al. 2004, Weyermann et al. 2006 and Hunsberger et al. 2012) are three of many which has shown that breastfeeding reduces the risk of obesity, therefore, it is health visitor's duty to impart this information to the mothers. These research articles conducted various studies, the three studies gave differing results but on the whole suggests that exclusive breastfeeding for 6 months reduces the risk of obesity in children.

Healthy weaning

The World Health Organisation (2001) recommends that babies should be exclusively breastfed up until the age of 6 months before introducing solid food. This gives the babies digestive system a chance to develop and for the kidneys to be mature enough to handle waste from the solids. Sloan et al. (2008) found in his study that early weaning can lead to rapid weight gain in infancy which can have implications for childhood obesity. Health Visitors have a role in educating parents of the health risks involved with weaning too early and in Borough B weaning groups to teach parents how to feed their babies a healthy diet are run by health visitors and community nursery nurses. This service provision is co-ordinated in association with the Children

Centres. These groups are run on a monthly basis and parents of babies nearing the age of 6 months are invited to attend.

Having undertaken one of these sessions recently it was found that most of the mothers who attended the group were usually 1st time mothers who were new to the process and needed help and advice. It was therefore important to educate them on the correct way to introduce solid foods to their babies using evidence based information. The (Department of Health 2011) document Introducing Solid Foods booklet emphasises that parents are encouraged to make their own baby foods, to offer healthy meals such as fruit and vegetables, small portion sizes and family food. Also the importance of offering finger foods and allowing babies to feed themselves is recommended. This way babies are able to self-regulate their nutritional intake reducing the risk of them overeating. These groups are very successful because the feedback gained after was always positive.

Play activities for babies (Children Centre)

The borough has several Children Centres which provide activities such as music & movement and stay & play, it is important to advise parents about these centres and to encourage them to attend, the intention is for infants and toddlers to increase their active play.

The MEND programme (2008) is a healthy lifestyle non profitable organisation which focuses on obesity prevention. It is run usually by local children centres and caters for children, young people and their families from the age of 2 years to adulthood. It is a free service usually paid for by the local authorities. Parents attend with their children and it offers advice on

healthy eating and active play. There is a referral process for this programme which is usually from GP's, school nurse and teachers. Borough B no longer have this provision, the reason for this was not made clear. It is a very good intervention which would target at risk children who would otherwise be overlooked and the Borough would benefit from this if they aim to reduce childhood obesity levels further.

Regular clinic attendance for weighing

At present most infants and children who are recognised to be at risk of obesity are at present identified when they attend the healthy child clinic. The children are usually weighed and the weight is plotted on the centile chart; a crossing upward of 2 centiles on this chart can be interpreted as rapid weight gain (Redsell et al. 2013). It is important for these children to have their weight checked regularly at the clinic and that parents are given advice regarding infant nutrition, physical activity and the potential risks of their child gaining excess weight.

In Borough B at present all the healthy child clinics are walk in and are very busy, it is therefore very difficult to have adequate time for consultation. The Borough will soon be changing to an appointment system at the clinics, the advantage is that babies will be seen regularly after birth so that their development can be observed, the disadvantage arises when a child with weight issue needs to be monitored regularly and the health professional cannot book the child an appointment because all the time slots are filled. This issue will cause various problems, which may lead to overbooking or the

Health Visitor having to perform more home visits or clinic visits at impromptu times.

In conclusion, tackling childhood obesity should start in infancy and health visitors are at the forefront in delivering this initiative. In (Fair Society, Healthy Lives 2010) Marmot advocated a healthy weight should be consistent from ‘ cradle to grave’. The key is to identify infants who may be at risk of obesity and communicate this to parents. Redsell (2013) found that infant overweight/obesity was considered a sensitive issue that was difficult to raise with parents, but the IROC tool developed by (Weng et al. 2013) will assist health visitors to overcome this difficulty.

Most of the provisions above are in place in Borough B to meet the intended need, although the MEND programme which was once operational in the Borough would be beneficial if it was reintroduced. Nevertheless, the children centres have a vast array of healthy living initiatives which is helping to keep the childhood obesity levels in the Borough down. National Institute for Health and Clinical Excellence, N. I. C. E. (2006) advocates that working as part of a multidisciplinary teams is essential, to provide interventions to prevent and manage obesity, also to assist families who may need additional support. The Foresight report (2007) estimated that health care costs attributable to being obese were £4. 2 billion, possibly rising to £6. 3 billion in 2015. Early detection and intervention is more cost effective than treatment and other consequences of obesity in later life. In order for this to be achieved and to implement some of the interventions above, the government will need to fund training for all the health professionals

involved so that they are appropriately trained to deal with the rising epidemic of childhood obesity.

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