

A taxonomy of needs assessment, elicited from a multiple case study of community nursing education and practice

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The role and expectations of community nurses in carrying out needs assessments changed when an internal quasi-market was introduced to the British health service under the National Health Service (NHS) & Community Care Act 1990. This paper reports on a study commissioned by the English National Board for Nursing, Midwifery and Health Visiting (ENB) to investigate the changing educational needs of community nurses with regard to needs assessment in the context of this legislation. A multiple case study design was utilized and four cases identified, incorporating the geographical variation in England. Recently qualified practitioners (health visitors and district nurses) were observed during a regular shift ($n = 134$ visits), concentrating on their practice of assessing needs, and on liaison and collaboration within teams and across sectors. Participants were interviewed after the observation period ($n = 33$ practitioners), to determine the extent of formality they attached to each assessment, and to elicit information about aspects which may be embedded in everyday practice. Single and multiple case analyses across the four cases used an iterative process of pattern-matching, replication logic and explanation building. The preliminary analysis yielded a descriptive 'taxonomy' which could serve as a basis for classifying the variants of needs assessment and help to clarify the whole phenomenon. When applied further to the data, this revealed the complex interactions between the different ideals (relating to

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policy, nursing and ascribed worth), the various types (purpose, formality/specificity and complexity) and timing (in relation to client, service and practice issues) within needs assessment.

Keywords: health and social needs assessment, community nurses, multiple case study design, community health services, health and social care

BACKGROUND

This paper reports one part of a larger study commissioned by the English National Board for Nursing, Midwifery and Health Visiting (ENB), to investigate the educational needs of community nurses with regard to needs assessment and quality of care, in the context of the National Health Service (NHS) & Community Care Act 1990. Under that legislation, purchasing authorities were established that were responsible for assessing the health needs of the local population and purchasing services to meet those needs from separate provider units. At an individual level, care managers were to assess the needs of people with disabilities, the elderly and mentally ill, and then arrange suitable 'packages of care' as indicated by the assessments (Department of Health 1989a, b).

The Health Act 1999 introduced significant changes to this legislation, but the division between purchasing (known in future as 'commissioning') and providing authorities, and the emphasis on provision of services to meet assessed needs remains (Department of Health 1997). Although the legislative context has changed, this study remains relevant, as community nurses are among the disciplines represented on the boards of primary care groups (PCGs), which initially will advise health authorities about their commissioning decisions, and eventually assume these functions themselves.

Need and needs assessment

The idea that the concept of 'need' itself is personal, subjective, variable and constantly changing goes back at least as far as the 1970s in the literature of British community nursing (e.g. Council for the Education & Training of Health Visitors, CETHV 1977, Crouch 1977, Luker & Orr 1992, Twinn & Cowley 1992) and of research into needs assessment and classification (Bradshaw 1972, Alderson & Dowie 1979, Cartwright 1983, Bowling 1992). The concept is highly political and value-laden (Richardson 1994), and viewed differently by a range of interested disciplines, including economists, epidemiologists, policy makers and health care professions (Billings & Cowley 1995, Lightfoot 1995, Robinson & Elkan 1996).

It is widely acknowledged that 'need' is a socially constructed concept, which is closely bound up with identities, expectation and context (Willard 1982, Ong

1991, Lightfoot 1995); recognition of this variability may be integral to respecting client choice. The literature confirms the role of health care professionals in facilitating situations whereby consumers can learn to articulate their needs clearly (Chalmers 1993, Wainwright 1994). Community nurses have tried traditionally to take this personal-subjective dimension into account, through an individualized approach to assessment which is the initial stage of the nursing process (Clark 1986).

Once 'need' is linked to 'assessment', an instrumental outlook becomes common, and assumes an emphasis on clarity of purpose (Lightfoot 1995). McWalter *et al.* (1994) suggest that the term 'needs assessment' should not stand alone, but be followed by the phrase 'for what?' to make a link to service provision. To assist the process, they offer an example framework to guide needs assessment for people with dementia. Such guidance is available for many specified disorders, but it is an approach that does not help deal with hidden or unacknowledged needs. The literature suggests that unmet need continues to be an issue in the elderly population (Farquhar *et al.* 1993), and the importance of identifying children in need is well acknowledged within the Children Act 1989. Clients may like to be proactive in highlighting their own needs, but some prefer the professionals to set the parameters (Ong 1991, Chalmers 1993).

The traditional community nursing view of assessment has always encompassed the social context as well as the person's health status or medical condition (Council for the Education & Training of Health Visitors 1977, Orr 1992), but the NHS and Community Care Act introduced specific changes. The concepts of social need and health need are regarded as separate, and the responsibility of different agencies (Department of Health 1989a, b). Also, government guidelines urge practitioners to view assessment as a separate exercise from the service response (Social Services Inspectorate, SSI 1991). There is a statutory requirement in the legislation to co-ordinate arrangements for assessing community care needs on an interagency basis (Department of Health 1990, Department of Health 1989a, Social Services Inspectorate 1991).

Also, under the NHS & Community Care Act 1990, assessment of need within populations was viewed as a function of senior management, using epidemiological, statistical and research data. In the context of primary health care, difficulties arising from incompatible

boundaries for data-sets are well recognized (Chase & Davies 1991, Young & Haynes 1993, Billings 1996a). However, community nurses have long extended the idea of assessment to include a search for health needs in the population served (Council for the Education & Training of Health Visitors 1977, Mackenzie 1989, Orr 1992). This activity is intended to generate a profile which documents an assessment of need at the level of the community or caseload served.

These profiles have been flagged as essential in practice for prioritization, ensuring equity, evaluating the quality and effectiveness of approaches so practitioners could influence policy decisions (Hunt 1982, Twinn *et al.* 1990, Goodwin 1995, Billings 1996b). Despite the emphasis on profiling in the literature, its implementation into practice appears quite patchy. Young (1991) found little evidence of profiling activities at either a health authority or practitioner level, although more recently both Billings (1996b) and Robinson & Elkan (1996) have reported numerous examples drawn directly from practice.

To summarize, the terms 'need' and 'needs assessment' encompass a wide range of meanings, and hold different connotations according to the context in which they are found, the purpose for which they are being considered and the different occupational groups that are examining them. In view of this diversity, an introductory phase of the research was carried out to elicit views and clarify meanings attached to the notion of 'needs assessment' in the context of community nursing; details are reported elsewhere (Cowley *et al.* 1995, 1996). The second phase, part of which is reported here, aimed to describe educational provision and current practice in needs assessment, as a basis for identifying the changing educational needs of community nurses in the context of the NHS and Community Care Act.

THE STUDY

Method

The context-bound nature of need and needs assessment influenced the choice of case study as a research

approach. Case study is considered suitable for investigating contemporary phenomena, particularly where the boundaries between phenomenon and context are not clearly evident (Yin 1994). Four cases were identified, encompassing the geographical variation of north, south, east and west England; urban, rural and inner city locations were represented. Each case or 'unit of enquiry' comprised the educational programme provided by one college, and indications of its impact as demonstrated in needs assessment practices and perceptions in one region. Multiple case study design incorporates a 'replication logic' in which the results of one case study are compared or 'matched' with the results of subsequent ones, which adds to the robustness of the results.

Data collection

Recently qualified practitioners (health visitors and district nurses, see Table 1) were contacted with assistance from college lecturers; all qualified within 1 month of each other. The main obstacle to recruitment stemmed from the inability of practitioners to obtain employment as community nurses following qualification; moving from the area, loss of contact with the college, lack of confidence in the new role and maternity leave were also reasons for non-participation.

The practitioners were observed using a structured schedule during a regular shift 6–9 months after qualifying, concentrating on their practice of assessing needs, and on liaison and collaboration within teams and across sectors. They were asked to ensure that at least one visit was specifically about needs assessment. A semi-structured interview was carried out after the observation period, to determine the extent of formality they attached to each assessment, and to elicit information about aspects embedded in everyday practice as well as those recorded for explicit requirements. Practitioners were asked to identify which visit had been particularly about needs assessment, and to 'talk through' the rationale for the decisions and procedures they adopted. Following the requirements for multiple sources of data to converge upon the research question, assessment documentation

Table 1 Summary of practitioners accessed in the case study sites. (DN = district nurses, HV = health visitors)

Case	Cohort size		Number sought		Number contacted		Number agreeing		Final sample		Trusts accessed
	DN	HV	DN	HV	DN	HV	DN	HV	DN	HV	
L	11	23	5	5	11	20	5	6	4	5	7
M	9	27	5	5	3	26	3	10	2	6	8
N	21	16	5	5	21	16	4	5	4	4	4
P	10	11	5	5	5	7	5	7	4	4	4
Total	51	77	20	20	40	69	17	28	14	19	23

and curriculum documents were collected from each of the cases as well.

Data analysis

In case study research, analysis follows a pattern-matching and explanation-building strategy (Yin 1994). Patterns are sought in the data and repeatedly compared with other units of data, seeking recurring themes and replication across the different sources of information. Yin (1994) acknowledges that the procedures he describes have much in common with constant comparative analysis (Glaser & Strauss 1967) or the qualitative analysis techniques outlined by Miles & Huberman (1984). However, he stresses the importance of ensuring that the multiple sources of data are analysed following a strict cycle in order to build a reliable picture of the phenomenon in context. First, each separate data tranche is analysed independently within each case, then compared with other data in the same case. Once each case has been analysed separately ('within-case analysis') then the results from each case are compared with the results with the other cases (cross-case analysis).

This iterative and comparative procedure leads to the potential for theoretical replications, through which analytical generalizations (rather than statistical generalizations) can be made. Following these procedures revealed a wealth of information about practice and education for needs assessment, which is reported in full elsewhere (Bergen *et al.* 1996). One aspect that emerged from the analysis was a mechanism for classifying and describing the different aspects of the complex and disputed activity of needs assessment, which is reported here.

A TAXONOMY OF NEEDS ASSESSMENT

Bradshaw (1972) usefully indicates that 'social need' can be classified under four headings. Normative needs are those defined by professionals or experts according to their own standards, while felt needs are those that people perceive for themselves. If a felt need progresses to a demand, it is called an 'expressed need'. The final aspect is that of 'comparative need' in which one person's needs can be evaluated in relation to the position of others. Needs may, of course, fit under more than one heading, but understanding the principles by which the different components are classified helps to clarify the concept and provides a useful basis for teaching or researching the concept. This kind of classification system is known as a 'taxonomy'; it is most commonly used in biology to classify variations of plants and animals. The practitioners in this study almost all cited Bradshaw when asked if they had learned about need, but no similar classification system exists to help navigate the contested terrain of 'needs assessment'.

Table 2 Taxonomy of needs assessment

1 Ideals	2 Types	3 Timing
In policy	Purpose	Client issues
Discipline specific	Formality, specificity	Service issues
Ascribed worth	Complexity	Practice issues

The different ways of considering needs assessment that were represented in the data are summarized in Table 2; this offers a tentative means of classifying the variants and helps clarify the whole phenomenon. Each element contained under the broad headings appears independent of the others, so any combination may arise in the practice situation. The clarity and apparent simplicity which is achievable in theory is far more elusive in the reality of practice, but each aspect and group can be described separately in the abstract.

Ideals of needs assessment

The ideals of needs assessment were manifest in the data under three key areas. First, implications of the ideals relating to policy were demonstrated; in the data this mainly concerned the NHS & Community Care Act 1990 which was the focus of the study, although other policies — national legislation or locally established strategies — may be equally relevant. Second, the nursing ideals of holism in needs assessment emerged strongly across all cases. The purpose of the study was to examine needs assessment in the context of community nursing; this undoubtedly structured and limited the focus of the data. However, bearing in mind the vast literature across a range of occupations, the second area could encompass the 'discipline-specific ideals' of any interested groups. Such ideals may be translated into varying degrees of 'worth' or acknowledged value ascribed by assessors, by those being assessed, provider unit managers and purchasers, or by policy makers in general.

Policy ideals

The ideals of needs assessment in policy focus on specifying the position of both the assessors of need (e.g. the practitioners and purchasers), and those being assessed (the consumers); and the influence in both cases of their ascribed roles, responsibilities, rights and available resources. Specific legislation about health care obviously varies internationally and is also subject to constant change. However, the aspects listed in Table 3 feature in most policies, and it is clearly important for nurses to be aware of their own responsibilities and expected roles, as well as the rights of their clients.

Under the NHS & Community Care Act 1990, the concept of assessed needs in individuals was considered entirely separately from the requirement on purchasers to assess the

Table 3 Ideals of needs assessment in policy

Focus on specifying:

- *position of consumer*: as sole, joint, primary (lead) or secondary assessor, or recipient of services assessed by others
- *position of practitioner*: as sole, joint, primary (lead) or secondary assessor, or responsible for delegated duties assessed by others
- *roles* as assessors and referral agents: may be formally acknowledged — fully, partially or not at all; likewise respect for consumers and practitioners in this regard
- *responsibilities*: may be conferred (e.g. by national policy, such as health/social divide, or by local service planning strategies), may be claimed by service, practitioner or consumer (including family/carers) or may be accepted with varying degrees of willingness
- *rights*: may be explicit and overt, or obscured (intentionally or unintentionally, knowingly or not)
- *resource availability*: may influence needs assessment or not; influence may be explicit and overt, or obscured (intentionally or unintentionally); such influence may be permitted in policy or not

health needs within the populations they serve, and to purchase suitable services to meet those needs (Department of Health 1989b). No explicit definition of need was offered, and the concept seemed to be regarded as fairly static and simplistic. Monitoring of implementation (Department of Health 1994) showed that, while at a macroscopic level it may be possible to separate these two functions, at the level of individual care it is not so clear cut.

The idea of a concept separable into two distinct aspects known as 'health needs' and 'social needs' was implicit in the division of responsibility between the two different services (Department of Health 1989a, b). There was, nevertheless, a strong emphasis on collaborative working within the Act, as explained by this health visitor:

... things that strike me about the Community Care Act are the working together, issues of different professionals with social services and with health professionals and I suppose when you have children with special needs or child protection issues is when you work closely with other professionals particularly in the social sphere rather than just health. (HV 5 Case M)

Despite this example of understanding, teaching about specific aspects of the legislation seemed quite limited overall. The policy ideals are not necessarily opposed to the more traditional nursing approach, but they differ in emphasis and in certain key respects.

Table 4 Nursing ideals of needs assessment

- *levels*: may focus on individual; family; whole area; community; group or caseload
- *depths*: superficial or 'easily seen' needs; deep or deep-seated needs; hidden, submerged or unacknowledged needs
- *aspects*:
 - **physical**, e.g. health; illness; disability; dependence
 - **psychological**, e.g. emotional; affective; cognitive,
 - **social**, e.g. practical ('coping'); financial and housing; family and social network; community
 - **spiritual**, e.g. religion; culture; belief systems

Discipline specific ideals: nursing

Teaching generally favoured an emphasis on the holistic philosophy and the nursing ideal of 'wholeness'. This approach was seen to underpin the idea of needs assessment at different levels and depths; it may also help integrate different aspects of personhood (Table 4). The extent to which such ideals were translated into practice varied, but the holistic emphasis was ubiquitous in the data, featuring in interviews and observed practice in all the cases.

This meant that, even though one level or aspect might be uppermost at any one time, the assessment was generally more inclusive than implied in the reductionist and separate emphasis in the policy; for example:

...assessment of needs of the patient who in turn is a part of the community. (DN5 Case N)

...needs assessment is looking at the family's health, um, that's holistic; maybe using a model, but basically you can get the four basic codes that most models encompass, physical and social, psychological, environmental health. (HV2 Case M)

Awareness of the complex and variable nature of need emerged from descriptions of the different depths of need; for example, needs may be immediately obvious, or hidden and potentially overlooked by either client and

Table 5 Ascribed worth in needs assessment

Worth or value will be attached by:

- assessors
- those being assessed
- provider unit managers
- commissioners and purchasers
- policy makers

Worth or value attached will vary according to:

- perceptions of 'health' and its link with need
- service structures (e.g. health and social)
- contract specifications
- type of needs assessment; (e.g. approach and assessor)

practitioner. The importance of recognizing that the client's perceptions of need may not coincide with those of the professional was also widely acknowledged.

Ascribed worth

Different elements in needs assessment may be ascribed varying degrees of worth or acknowledged value (Table 5). The various actors in needs assessment will ascribe different values according to the different conditions pertaining at the time.

These differing values combine with the alternative ideals expressed in policy or in the nursing perspectives to demonstrate how changeable and potentially disputed is the baseline for examining 'needs assessment' in community nursing. The 'ascribed worth' is not necessarily static either; it may change according to circumstances. As an example, the power given to commissioning authorities under the NHS & Community Care Act 1990 suggested a higher worth is accorded to the needs assessed and prioritized by purchasers at a broad population level than to local and individual needs assessed and prioritized by community nurses. In practice, the needs may be identical; the varied extent of power is associated with different worth attached to community nurses or purchasers as assessors. Inclusion of community nurses on PCG boards under new legislation (Department of Health 1997) may shift this balance of power, but different views about the perceived role of the assessor, of the type of assessed need and opinions about which needs should be prioritized are likely to continue.

Types of needs assessment

To translate the ideals of needs assessment into reality requires planning, organization and a means of specifying how this should be achieved. This requires consideration of the huge diversity of different situations and types of assessment which are potentially possible. Apart from the acknowledged purpose — a starting point for protocols and specifications — each assessment may show different degrees of formality and complexity, as summarized in Table 6. There are no direct links between these separate elements; they may blend in unique and different ways at each assessment, and the various policy and nursing ideals may apply at any stage.

The purpose of needs assessment varies according to level. A major reason for assessing population needs is to plan service provision; this function will continue, largely under the control of PCGs, under new legislation (Department of Health 1997). At an individual level, assessments might be made in relation to transfer between services or members of the care team — when making, receiving or planning referrals (within and between agencies), or prior to delegating activities, perhaps in a skill-mix team. The role of care management was acknowledged as separate and distinct in this regard:

A care manager's needs assessment is different... it would be a more formal assessment; you're assessing the situation and the client as to what services you can put in. Once services are established — re-assessment, re-appraisal follows — it's more informal. (DN3 Case N)

At the most formal, the idea of 'needs assessment' has been closely associated with the specific assessments laid out in successive policies (such as the Disabled Person Act 1986, Children Act 1989, Carers' (Recognition and Services) Act 1995 and so on) in which certain procedures are to be followed in order to identify which services should be provided for the consumer as a right. To some extent, the phrase has, itself, become so closely linked with these specific, formal assessments, that alternative interpretations are considered inappropriate by some. However, assessments vary according to the degree of complexity: single or specific issue, multiple issues, interlinked or interdependent issues; this applies regardless of the level (individual person, family, whole population, etc.).

Quite often, the more formally defined assessments would be concerned with complex needs, perhaps involving a family (parents or carers, for instance) rather than one person, although a single issue may still lead to a formal assessment in some circumstances. In the data, being 'formally constituted' tended to refer to requirements, responsibilities, protocols and documentation; it does not necessarily designate the style of assessment or complexity. The Social Services Inspectorate (1991) suggests a framework of six levels of assessment ranging from 'simple' to 'comprehensive'.

However, other assessments appeared formal to the practitioners. The term signified a description of a

Table 6 Types of needs assessment

Degrees of complexity	Degrees of formality and specificity	
Single or specific issue	Features along a continuum:	
Multiple issues	from:	to:
Interlinked or interdependent issues	Very formal	(Purposefully) casual informality
Link with perceived severity or urgency	Specific, 'hard data' — measurable, objective	General, 'soft data' — subjective and 'intuitive'

specific, focused assessment, possibly using a particular assessment tool; it differed from the more usual, on-going assessment which occurred continuously. At the most informal end, the practitioners used far softer terms such as 'noticing', 'picking up on' and 'just listening'; even so, they were clear that this activity constituted a type of needs assessment:

... a lot of things come up when you're just chatting. You need to be a good communicator — to form a relationship — allow them to feel comfortable to disclose information, to adjust your conversation. You pick up whether they're uncomfortable about you asking questions. (DN2 Case P)

Indeed, in some situations a deliberately relaxed stance — almost bordering on the casual — would be adopted, perhaps as a means of allowing the client the opportunity to decide whether or not to raise an issue. The practitioners were clear that this still constituted a 'needs assessment', albeit one of a quite different order to the formally convened interagency assessments required for the NHS and Community Care Act. Within the observations, the assessments varied through a whole continuum from very formal to extreme informality, from the general to the very specific and the whole range of complexity from simple, single issues to multiple and interlinked issues.

A similar diversity of description was applied to the approaches used within community-wide assessments, such that the research team distinguished between the idea of 'intuitive profiles' which remained at an impressionistic level, unchecked against any harder data, and the more formally constituted ways of collating community or caseload-wide information:

Well I mean, you can do needs assessment on an area based on census material and that's broadly ward based, but the sort of information we carry on our records of clients and families is a

very much up to date detailed analysis of people's needs and I think that sort of information is the closest you will get to a snapshot picture of an area at any one time. (HV3 Case P)

That such ill-defined data would be regarded as unsuitable for planning or commissioning services was acknowledged, but a number of practitioners expressed frustration that they were not encouraged to collate information that they regarded as relevant into a more formal format:

I mean, really, when you think about it, how can you health visit in an area if you don't know what the really big needs are? ... and I'm still struggling to try and get together the information to do that community profile so that you know you can be quantitative as a whole, you know, and how can you help this community improve their health and well-being? Realistically, you come into the office and a pile of paperwork and a pile of visits and clinics to run. [...] unfortunately the community profile ended up being something I do in my own time. (HV3 Case M)

Such comments reflect the interrelated nature of the concept and, perhaps, a lack of worth ascribed by managers and commissioners to profiles compiled from needs assessments carried out by practitioners.

Timing of needs assessment

Arguably, the successful implementation of needs assessment depends on ensuring that an appropriate approach is used. The data highlighted the importance of various aspects related to 'timing' which emerged in different guises in the data (Table 7). Some of these issues are related solely to needs experienced by the client. However, most are intertwined, and indicate some of the sensitivity and skill required to elicit needs in the practice situation; they demonstrate the link (and potential for

Table 7 Timing of needs assessment

Client issues

- past — identifying history, culture, background of client, in personal/individual terms
- present — immediate or current actual need for service
- future — potential needs, planning ahead, in terms of health promotion and preventive care — both for individual clients, and for service
- timing-assessment to accord with clients perception of need, and their readiness to discuss
- urgency of response required

Service issues

- achieving service requirements, e.g. policy aims and annual targets
- facilitators and constraints — quality indicators, charter requirements, waiting lists, etc.
- planning ahead — at level of whole service, or local team (e.g. delegation and skillmix issues; prioritising within caseload)

Practice issues

- assessment as a single event, or a continuing process
- time as resource for client or service
- sensitivity and skill of the practitioner to mediate conflicting demands

conflict) between timing issues for services and for clients receiving them.

The matter of separation or integration of assessment concerns the contested issues of whether it is really possible to distinguish between health needs and social needs within the client context, and of the benefits or difficulties of separating assessment from the delivery of care. A related debate is whether assessment can realistically be considered a separate event at all, or if it is continuing process. There was little doubt in the minds of the practitioners, who described beginning the process of assessment as soon as they received information about new clients, and felt it continued throughout the time they were involved with them:

I think it's a continual assessment, whenever you go to see a client you are assessing and re-assessing the whole situation, it's continuous, it's not something you think about to do...Today the fourth one, it was thought about, it had to be done, it was more of a formal assessment. The other three, it was like a re-assessment, more informal, but it's something as district nurses you do continuously without even thinking about it, you don't put labels on it, you just, it is part of the job, you re-appraise the situation continuously. (DN3 Case N)

There was little difference of opinion about this; assessment was undoubtedly viewed as a continuing process. Indeed, practitioners conceived of assessment as the prelude to involvement in care rather than disengagement, and it was often conceptualized as part of that care. The perceptions expressed in the interviews were largely corroborated by the observation data, which demonstrated that only a minority of assessments were designated as 'complete' by the observers. In most instances, too, a follow-up of some kind was arranged, although this was sometimes an arrangement to meet up at a clinic or to make contact by telephone.

The second issue which recurred throughout the analysis relates to the availability of resources. Here, it is time as a resource which may be used to give attention and care to a client, or which may need to be conserved for other priorities within a pressured caseload. Indeed, shortage of time to offer clients the kind of service which seemed to be merited according to their assessed needs was, perhaps, one of the most enduring features in the data:

I always think that I could be doing more, that's what makes me think that I haven't done enough or there should be something else I could be doing... which doesn't always happen because you haven't got time to do that for each individual child when you've got a caseload this big. (HV1, Case L)

That took hours of time — we were whizzing around seeing other people because we were so busy. (DN4 Case P)

Important though it is, the challenge for community nurses who assess needs in practice is not merely one of

time management. The timing requirements arising from different levels of awareness in clients, of meeting the assessment agendas of purchasers, and those arising from needs on their whole caseload, while maintaining smooth working relationships with colleagues, require an ability to achieve both a clarity of purpose and a breadth of vision in practice.

CONCLUSION

This paper has reported one aspect of a wider study, which aimed to investigate the changing educational needs of community nurses with regard to needs assessment in the context of the NHS & Community Care Act 1990. Although that legislation has been superseded, a formal role for health visitors and district nurses in needs assessment will continue in the context of the 'New NHS' (Department of Health 1997). The different ways of classifying and exploring needs assessment offer an educational agenda which appears capable of modification and generalization beyond the immediate legislation, while still accounting for the context-bound nature of needs assessment.

The clarity and apparent simplicity which is achievable in the abstract was clearly far more elusive in the reality of practice, because the different elements cannot be readily separated when situated within individuals, families and communities. Certainly the messy, variable and multifaceted nature of needs assessment was reflected in data across all four cases. The assessment practices described as necessary to cope with these features emerged as variable, hugely diverse and intimately bound up with the whole of community nursing work. The practitioners generally recognized the complexity of assessing the needs they encountered, acknowledging that their own perceptions and levels of ability were some of the variables which helped to add to the confusing diversity.

The challenge for education is to prepare practitioners who, in the face of complex, value-laden and potentially sensitive situations, are able to identify the purpose and type of assessment required, who can draw on the skills required to elicit needs with regard to issues of timing, and demonstrate the implementation of appropriate ideals in practice. The tentative taxonomy of needs assessment described in this paper offers a basis to help guide programme planning in pursuit of this goal.

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