PEOPLE LIVING IN FINGLAS AND THEIR HEALTH

The health needs of people living in Finglas area

February 2003

northern area health board
bord sláinte an limistéir thuaidh

REPORT PREPARED FOR THE NORTHERN AREA HEALTH BOARD BY THE DEPARTMENT OF COMMUNITY HEALTH AND GENERAL PRACTICE, TRINITY COLLEGE, DUBLIN

PEOPLE LIVING IN FINGLAS AND THEIR HEALTH

The health needs of people living in Finglas area

February 2003

PART 1 A COMMUNITY BASED SURVEY

Jillian Deady
Jean Long
Tom O' Dowd

PART 2 THE HEALTH SERVICE PROVIDERS' PERSPECTIVE

Jillian Deady
Frances O'Keeffe
Jean Long
Tom O' Dowd

Report prepared for the Northern Area Health Board
by the Department of Community Health and General Practice, Trinity College, Dublin

TABLE OF CONTENTS

Page

TABLE OF CONTENTS

Page

ACKNOWLEDGEMENTS

The authors wish to thank the Northern Area Health Board for commissioning and funding this study.

Thank you to the Chief Executive Officer and staff of the Northern Area Health Board for their support. In particular thank you to Mr. Noel Mulvihill, General Manager, Community Care Area 6.

A special thank you to Nicola Sweeney who assisted in the training and co-ordination of the data collectors and did tremendous work on the household survey.

Special thanks to the people who assisted with the fieldwork, in particular the data collectors from the local community.

Thanks to all the individuals in the community and the representatives of the different community groups who shared their knowledge of the community and its needs.

A special thank you to all the service providers who shared their knowledge of and insights into the community.

Thanks to Tommy O'Leary and the staff of Wellmount Health Centre for the use of the premises during the survey.

Thanks to James Williams, Head of the Survey Unit at the Economic and Social Research Institute , for selecting the sample, and to Mediscribe Ireland for transcribing the service providers' interviews.

Thanks to Paul Rogers of the Finglas Cabra Partnership and Stephen O' Brien (comissioned by the Northern Area Health Board) for the photographs.

We also thank our colleagues Deirdre Handy, for administrative support and editing the report and Conor Teljeur, for providing population numbers and maps.

And finally a special thank you to all the people who agreed to participate in the survey.

FOREWORD

In November 2001, the Northern Area Health Board commissioned a study to investigate the health needs of people living in Finglas from the perspective of people living in the area and also service providers working in the area. The Health Strategy – 'Quality and Fairness for You' recognises that the health system must respond to people's needs and that services must be organised, located and accessed in a way that takes greater account of the needs and preferences of the community they serve.

The work contained in this report was undertaken by the Department of Community Health and General Practice, Trinity College. The findings will greatly assist the future planning, development and delivery of health services in the Finglas area and may also be used as a model for the development of services in other areas. The Board will continue to work closely with local communities and other health care providers to ensure that properly integrated health services will lead to better outcomes, better health and better cost-effectiveness.

I wish to congratulate and express my appreciation to each person, and to the local community at large, for their participation and co-operation with the survey. I also extend my thanks to all of those involved in collecting and compiling the data.

We are indebted to all those involved in producing this report, in particular, Professor Tom O'Dowd, Ms. Jillian Deady, Dr. Jean Long and Ms. Frances O'Keeffe.

Maureen Windle
Chief Executive
Northern Area Health Board

February 2003

LIST OF TABLES

Page

LIST OF TABLES

Page

LIST OF FIGURES

Page

LIST OF APPENDICES

LIST OF ABBREVIATIONS

CI	Confidence interval
DED	District Electoral Division
ENT	Ear, Nose and Throat
GP	General Practitioner
GU	Genitourinary surgery
n	Total number who answered the question
OR	Odds ratio
RAPID	Revitalising Areas by Planning, Investment and Development

PEOPLE LIVING IN FINGLAS AND THEIR HEALTH

The health needs of people living in Finglas area

PART 1 A COMMUNITY BASED SURVEY

Jillian Deady
Jean Long
Tom O' Dowd

Summary

We have presented the main survey findings in this summary. More detailed findings are available in the results section for use by health planners employed by the area boards. The information contained in this document is also pertinent to those working in primary care or with a special interest in health care.

What we set out to do

We set out to assess the health needs of households and their individual members residing in Finglas.

How we conducted the assessment

Initially, we contacted key individuals in the community to inform them of the proposed study and to ascertain the key health and social issues in the area. We included these issues in the questionnaire. We then conducted a cross sectional study in the twelve district electoral divisions of the study area. We interviewed primary or principal carers (defined as the person in the household who manages the welfare and health of the family/household) in 325 of the selected 420 households. We selected the households employing a cluster sampling methodology. We chose 30 clusters from both the four less deprived district electoral divisions and the eight more deprived district electoral divisions. Each of the 60 clusters consisted of seven adjacent households. We interviewed the primary carers in their homes, using an interviewer administered questionnaire.

What we found in the survey

Of the 420 households selected to participate in the survey, over 77% participated, indicating a keen interest in health related issues. Data were also collected on 963 individuals residing in these houses.

The people of the area

This is generally an older population with one third over the age of 50 years and almost half of these aged 65 years or over. Eighty-three of the primary carers were aged between 65 and 85 years old, of whom, 30 (36%) were living on their own. Of those who stated that they were the primary carers, one third were men.
Primary or principal carers reported that:

- 44% of all household members were outright owners of their homes, 12% of householders were residing in government supported accommodation,
- 31% of households did not own a car,
- just 2% of households were occupied by non-nationals,
- 35% of households had medical card cover,
- 26% of households had neither medical card nor private health insurance,
- 13% described themselves as lone parents,
- 40% of primary carers had primary school education or less.

Lifestyle and family issues

Primary or principal carers reported that:

- 63% had experienced stress in the year prior to the survey,
  of these,
  - 41% consulted their general practitioner because of their stress,
  - 25% had received prescribed medication,
  - 8% had visited a counsellor.
- 12% experienced violence or intimidation in the previous year,
  of these,
  - 26% had experienced the incident in their own homes,
  - 55% had reported the violent incident to the police,
  - 37% had sought medical assistance.
- 54% worried about their teenagers' socialising,
- 46% found their teenagers' attitudes or behaviours upsetting,
- 28% of household members, 18 years or over, smoked,
- 1% of household individuals, aged 18 years and older, had a problem with either alcohol or drugs.

Chronic illness and disability

Primary carers reported that:

- 29% (adjusted) of the 963 household members had a chronic illness,
  - the most common chronic illnesses were cardiovascular disease (33%), respiratory (25%) and arthritis (12%).
- Overall, 4% (adjusted) of household members had a disability (either mental or physical),
  of these,
  - 30% had their disability since birth,
  - 80% reported a physical disability.

Hospital services

Primary or principal carers reported that:

- 33% (adjusted) of household members used a hospital service in the 12 months prior to the survey, of these;
  - the main reasons for attending were injury or an acute emergency (19%), cardiovascular disease (15%), and ear, nose, throat and eye problems (11%),

  of those who used hospital services:
  - 62% were elective or planned attendances at the hospital,
  - 43% attended outpatients, 24% were seen in accident and emergency, 11% were day patients and
  - 23% were admitted to hospital,
  - 79% were satisfied with outpatient services,
  - 72% were satisfied with inpatient services,
  - 92% were satisfied with the day care service,
  - 66% were satisfied with the accident and emergency service.
  - The main reasons for satisfaction and dissatisfaction were common to all hospital services,
    - the main reasons for satisfaction were that staff were friendly and the individuals had received good treatment and care,
    - the main reason for dissatisfaction was the long waiting periods encountered.
- Hospital services were more likely to be used by those with chronic illness, those attending the general practitioner and those waiting for health care.

Health services for women

Female primary or principal carers (of child bearing age) reported that:

- 50% (56/113) were using a method of family planning,
- 52% of women aged 18 to 65 had a smear in the last five years,
- 50% of women aged 18 to 65 had a breast examination in the last five years,
- 41% of women aged 52 to 66 years (eligible for the BreastCheck programme) had a mammogram in the last five years.

Primary or principal carers reported that:

- 52% of the women's most recent pregnancies were planned,
- 38% opted for general practitioner and hospital shared care,
- 24% of the women smoked during their last pregnancy,
- 85% delivered their last child in the Rotunda Hospital.

SUMMARY - PART 1

Community health services

Primary or principal carers reported that:

- 58% (adjusted) of the household members had attended their general practitioner in the last year,
  of these
  - the main diagnoses or treatments that resulted in the individuals attending were; respiratory conditions (22%), cardiovascular disease (16%) and ear, nose and throat problems (8%).
  - the main purpose of the individuals most recent visit to the general practitioner was a sudden illness (42%) or a repeat prescription (25%),
  - 83% were satisfied with services provided by their general practitioners;
    - the main reasons for satisfaction were, the doctor provided good treatment or care (65%), the doctor listened to their problem(s) (46%) and the doctor was friendly (38%),
    - the main cause of dissatisfaction was that the doctor did not listen to their problem(s) (7%).
  - 16% of respondents were unhappy with the current 'out of hours' general practitioner service,
- 3% of the individuals had consulted a community nurse in the last year,
  of these,
  - 96% were satisfied with the service provided.
- 84% of children aged between two and five years residing in their households had completed the routine childhood vaccines,
- 82% of children aged between two and five years had received the meningitis C vaccine,
- the most common sources of health information were the staff at their general practice (67%),
- just 12% of the population had visited a dentist in the 12 months prior to the survey and 91% were satisfied with the service.

Waiting for health care

- 7% (adjusted) of the household members were on a waiting list,
  of these,
  - 71% were waiting for hospital services,
  - 29% were waiting for dental services and other community services.

Additional health services identified by the people in the area

- 71% of the primary carers identified additional health needs in the area,
  of these,
  - 36% requested improved services for the elderly,
  - 35% suggested that the 'out of hours' general practitioner services should be reorganised,
  - 31% suggested clinics to promote 'a healthy lifestyle',
  - 21% specifically suggested services dedicated to adolescents including the provision of psychological services and contraceptive advice,
  - other services suggested included free primary care and expansion of the dental service to all members of the community.

Conclusion

The people living in Finglas were keen to participate in the study and made valuable suggestions about the services needed in the area. We hope that the information will be an important resource for health planners and service providers in the area.

INTRODUCTION AND METHODS

PART 1

Introduction

The overall purpose of health needs assessments is to gather information required to bring about change that benefits the health status of the target population. Data collected during a health needs assessment incorporate the wider social and environmental determinants of health such as, demographics, housing, education and employment as well as health status. During such an assessment the data collection process normally includes a combination of quantitative and qualitative techniques. It is also sensible to seek the views of health service providers and community organisations as well as individuals living in the community.

According to the primary care strategy document,[1] each community care area is required to complete a community based health needs assessment prior to developing a plan for primary care in its area. In November 2001, the Northern Area Health Board commissioned a study to investigate the health needs of the community living in the Finglas area.

The Department of Community Health and General Practice, based at the Trinity College Centre for Health Sciences, Adelaide and Meath Hospital, Dublin, incorporating The National Children's Hospital, was requested to undertake the community based survey in the Finglas area. The survey was approved by the Irish College of General Practitioners' Research Ethics Committee.

The research team wished to assess the health status of, health service uptake by, level of satisfaction with and health needs for persons living in Finglas. Another view of the needs of the community was obtained through in-depth interviews with twenty health service providers working in Finglas. They represented a broad spectrum of health and social service providers in the community, both health board staff and independent practitioners. This comprises Part 2 of this document.

Study objectives

The objectives of the cross sectional survey were to:

- Describe the socio-economic status and demographic details of the community.
- Estimate proportions with chronic illness and disability in the community.
- Measure current health service utilisation.
- Measure satisfaction with current health service provision.
- Establish areas of unmet needs.

Methods

This chapter describes the method employed to conduct and analyse this cross sectional survey and is presented in six sections:

2.0 Introduction
2.1 Study area
2.2 Sampling
2.3 Fieldwork
2.4 Data collection instrument
2.5 Statistical methods

2.0 INTRODUCTION

In November 2001, the Northern Area Health Board commissioned a study to investigate the health needs of the people living in the Finglas area. The Department of Community Health and General Practice, based at the Trinity College Centre for Health Sciences, Adelaide and Meath Hospital, Dublin, incorporating The National Children's Hospital, conducted this study. The study was approved by the Irish College of General Practitioners' Research Ethics Committee.

2.1 STUDY AREA

The study area comprised the 12 district electoral divisions of the Finglas area.

Health status and service uptake has been linked to deprivation[2] and therefore it was necessary to take account of this factor when selecting the sample. The Small Area Health Research Unit[2] provided a deprivation score, based on parameters from the 1996 census, for each district electoral division in the country, including the 12 district electoral divisions in the study area. The deprivation scores range from one to five, where one is least deprived and five is most deprived. In order to select the study population, the deprivation scores were collapsed into two groups where district electoral divisions with scores of one and two were classified as less deprived and district electoral divisions with scores of four and five were classified as more deprived; none of the district electoral divisions in the Finglas area were assigned the deprivation score 'three'. Table 2.1 presents the twelve district electoral divisions of Finglas (with population numbers) by level of deprivation. At the time of the survey there were approximately 11,250 households in Finglas with approximately 65% of the households situated in the more deprived areas.

Table 2.1 Distribution of sample and population in both high and low deprivation district electoral divisions in Finglas

District electoral division	Sample households		Population households	
	Total	Percent	Total	Percent
Low Deprivation (1 and 2)				
Ballygall B (2)	36	17.1	731	18.5
Ballygall C (1)	73	34.8	1323	33.5
Ballymun F (1)	52	24.8	884	22.4
Finglas North C (2)	49	23.3	1010	25.6
Total	210	100.0	3948	100.0
High Deprivation (4 and 5)				
Ballygall A (4)	14	6.7	925	12.7
Ballygall D (4)	21	10.0	850	11.7
Finglas North A (5)	21	10.0	1092	15.0
Finglas North B (4)	35	16.7	1048	14.4
Finglas South A (5)	35	16.7	942	12.7
Finglas South B (5)	49	23.2	931	12.8
Finglas South C (5)	14	6.7	864	11.8
Finglas South D (4)	21	10.0	643	8.9
Total	210	100.0	7295	100.0

2.2 SAMPLING

The estimated sample size was 420 households based on the proportion of individuals reporting chronic illness (22%) in a survey carried out in Tallaght in June 2001.[3] The sample was selected using a sampling methodology validated by the World Health Organization[4] and adapted by the Primary Health Care Management Advancement Programme for assessing community health needs and health service coverage.[5] In this methodology cluster sampling rather than random sampling was employed, and for the Finglas survey 30 clusters of seven households were selected from each of the low and high deprivation areas, giving the required number of 420 houses.

Mr James Williams, Head of the Survey Unit at the Economic and Social Research Institute, supplied the sample. Williams (personal communication) reported that according to the electoral register there were a total of 7,208 houses in the high deprivation group of district electoral divisions and 4,063 in the low deprivation group of district electoral divisions. The 12 district electoral divisions in the survey area were then partitioned into 1,610 clusters, each of seven households. A systematic sample of clusters, proportional to the number of households in each contributing district electoral division, was then selected; 30 clusters from the high deprivation group of district electoral divisions and 30 clusters from the low deprivation group of district electoral divisions. Each cluster consisted of seven adjacent houses (Appendix 1). This led to an intentional over representation of the population living in less deprived areas and the proportions for each of the key outcomes have been adjusted to take account of this sampling bias.

Variation in the number of households listed in each district electoral division (Table 2.1) versus numbers of households reported in the census arises due to under-registration of households (James Williams, personal communication 2002). The Department of the Environment has reported that 10% of households on the electoral register are not listed or else not occupied by the person named on the electoral register as a result of death or migration.

The researcher adjusted each cluster of seven adjacent houses and inserted those houses missing from the numerical sequence (in order to include those not on the electoral register). The researcher then removed from the end of the sequence the number of households in excess of seven. This was done in order to ensure a representative sample of the population actually living in Finglas rather than the population living in Finglas according to the electoral register. Of the 420 houses in the Economic and Social Research Institute sample, 12 (2.8%) households were missing from the electoral register and were therefore placed in their numerical sequence in their respective clusters as described above.

2.3 FIELDWORK

Prior to the fieldwork local health care providers in the Northern Area Health Board and the general practitioners in the Finglas area were informed of the survey. Posters were designed for display at the two health centres and five general practices in Finglas (Appendix 2a). An article was placed in the local newspaper to inform the community about the survey. In March 2002, each of the 420 selected households was sent a letter signed by the General Manager of Community Care Area 6, in the Northern Area Health Board and the Professor of General Practice at the Department of Community Health and General Practice (Appendix 2b).

People living in the area were invited to participate as data collectors for the household survey. Those people who expressed an interest attended a training programme prior to the survey. Each interviewer was given a survey pack which included; formal identification, a map of the survey area (incorporating selected clusters), a list of the sample households, additional copies of the household letters, call back slips for no access visits and an information sheet for the data collectors (Appendices 2 and 3).

The data collection commenced in mid March and data were collected each evening between 6 and 9 pm unless otherwise requested by the respondents (Appendices 2 and 4). The questionnaire used for the survey was similar to that used in two previous health needs assessments.[3 6] The questionnaire was administered by the interviewers to the primary carer (defined as the person in the household who manages the welfare and health of the family/household) in each of the participating households. Flashcards were used to assist respondents identify the scale of an experience, identify the name of chronic illness and as a prompt for health services s/he may have used.

When a household was not accessed, a note was left with a date for a return visit and a contact telephone number. Households were then revisited in the afternoons or evenings, until access was gained or up to a maximum of four return visits. Data collection was completed on 26th April 2002.

2.4 DATA COLLECTION INSTRUMENT

Prior to data collection during the months of January and February 2002 the researcher met with key individuals within the Finglas community and informed them about the survey and elicited their perceived needs. Several health and social service needs were identified, many of which refer to specific groups within the population, such as, the elderly, adults and teenagers.

The needs for the elderly were:

- Increased personal security both within and outside their home including personal alarms,
- A re-institution of meals on wheels on a daily basis,
- Assistance with both house and garden maintenance,
- Improved public transport linking specific areas.

The needs for adults were:
- Interventions to deal with domestic violence including the re-opening of the women's refuge,
- Additional educational and social support for parents of young children,
- Childcare facilities for parents with young children.

The needs for teenagers were:
- Strategies to address their health issues, in particular, the high number of suicides among young men in the area and substance misuse by young people.

Overall, issues pertaining to health were found to be similar to the issues that had been included in the questionnaire, which was used in the health needs assessment carried out in the other two areas.[36] Some minor revisions were made to the questionnaire following consultation with community organisations.

The different sections of the questionnaire were designed to ascertain:
- Demographic and socio-economic characteristics for each household and its individual members.
- Experience of chronic illness and disability for households and individual household members.
- Behaviours in relation to cigarette smoking and/or alcohol or drug misuse for households and individual household members.
- Primary carers' experience of teenage children, violence and stress.
- Uptake of cervical screening, breast examination, antenatal services and family planning by women.
- Children's (aged 24-59 months) uptake of vaccinations and developmental assessment.
- Utilisation of and satisfaction with health services and experience of waiting for health care.
- Primary carers' perceived gaps in the service.

2.5 STATISTICAL METHODS

A team of medical and graduate students entered the data into two Excel spread sheets (one for the household and the other for household members). The data was cleaned and checked for accuracy by the principal researcher. Frequency distributions were performed for all variables to identify discordant values and ensure data followed logical checks. Statistical analysis was carried out using JMP IN,[7] and STATA.[8]

The frequency distribution for each variable was described in both the household and individual household members datasets. Pearson $\chi 2$ test was used to compare proportions in independent groups of categorical data. The $\chi 2$ test for trend was used to identify linear trends in categorical data. Multiple logistic regression models were developed to determine which variables best predicted key outcomes (chronic disease, disability, service utilisation and waiting for health care results) for the household members. Exact 95% confidence intervals were calculated for proportions of binomial variables and for regression adjusted odds ratios.

RESULTS
PART 1

Results

3.0 INTRODUCTION

The results of the survey are presented in twelve sections:

3.1 Response rate.

3.2 Demographic and socio-economic characteristics of the:
- participating households,
- primary carers (respondents),
- individual members in each of the participating households.

3.3 Health care issues
- stress and violence and health related behaviours (including cigarette smoking and substance misuse).

3.4 Chronic disease.

3.5 Disability.

3.6 Deaths.

3.7 Acute hospital services.

3.8 Health services for women.

3.9 Community health services
- including general practice, community nursing, pharmacy services and dental services.

3.10 Waiting for health care.

3.11 Primary carers' sources of health information.

3.12 Primary carers' suggested additional health needs.

All findings are as reported by the primary carer (the person in the household who manages the welfare and health of the family/household) in each household.

3.1 RESPONSE RATE

Of the 420 households invited to participate in the survey, 325 (77%) agreed to be interviewed. Seventy-seven households (18.3%) did not wish to be interviewed while 18 (4.3%) households were not accessed (despite a minimum of four return visits). The response rates were similar in geographical areas that were classified as more deprived compared with the areas classified as less deprived (160/210, 76% versus 165/210, 78%; p=0.6).

The age profile for the individual household members was significantly different from that reported in the 1996 census, p=0.005 (Figure 3.1). There was a lower proportion of household members in the 10 to 19 year age group and a higher proportion in the 65 years or more age group compared to the census population. The gender profile was similar, p=0.2 (Figure 3.2).

Figure 3.1 Age profile of the population in 1996 census versus household members in 2002 survey

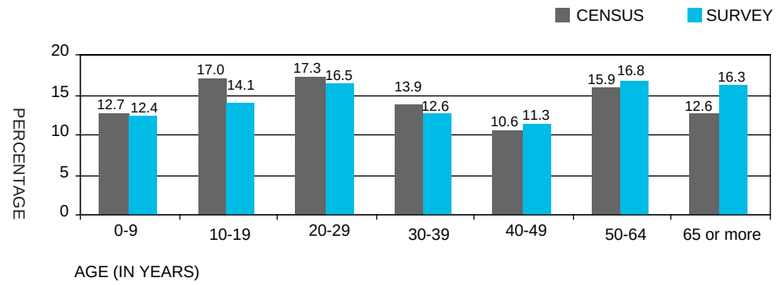
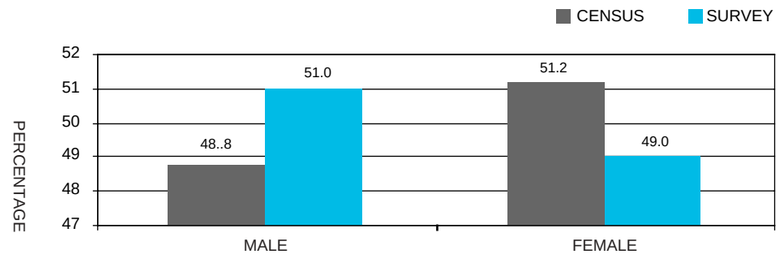


Figure 3.2 Gender profile of the population in 1996 census versus household members in 2002 survey



Analysis pertaining to the households and primary carers refers to information ascertained from the 325 primary carers who took part in the survey. The 325 primary carers also provided information on the 963 individuals (including themselves) who resided in the participating households. Denominators vary because not all the respondents answered all the questions.

3.2 DEMOGRAPHIC AND SOCIO-ECONOMIC CHARACTERISTICS

Demographic and socio-economic characteristics at the household level

Table 3.1 presents the household characteristics as reported by the primary carers. On average, three individuals lived in each house. Over one quarter of the households were living in the area for less than ten years and the majority of these (51/86, 59%) had moved into the area within the last five years. Over two fifths of the households were outright owners and three out of every ten households were repaying a mortgage while almost twelve percent of the households resided in government supported accommodation. Irish nationals occupied almost all the households (98%) (Figure 3.3).

Table 3.1 Primary carers' reported characteristics of their households

	No.	%
Number of people living in each house		
1 to 2	155	47.7
3 to 4	115	35.4
5 to 11	55	16.9
n	325	
Average	2.9	
Median	3	
Range	1 to 8	
Living alone		
Yes	53	16.3
No	272	83.7
Year moved into house (grouped)		
1937 to 1962	87	26.9
1963 to 1982	112	34.6
1983 to 1992	39	12.0
1993 to 2002	86	26.5
n	324	
DED deprivation score for area of residence		
(where 1 is least deprived and 5 is most deprived)		
1	96	29.5
2	69	21.2
3	0	00.0
4	64	19.7
5	96	29.5
n	325	
Resides in an area classified as deprived (scores 4 and 5 combined)		
Yes	160	49.2
No	165	50.8
n	325	
House occupancy status		
Mortgage	100	30.9
Outright owner	142	43.8
Tenant purchasing plan	30	9.3
Rent paid by health board or renting from local authority/housing association	38	11.7
Rent privately	14	4.3
n	324	

According to the primary carers, almost all (98%) of the households had access to a telephone (Table 3.2) while approximately 70% of the households owned a car (Figure 3.3). Almost 97% of the households had central heating, of which 73% used gas heating. Just over one third of the households had full health care cover through the General Medical Services, while 30% of households had private health insurance. Eight primary carers (of whom six respondents were aged 70 years or over) had both a medical card and private health insurance. Those with both may have received their medical card as a result of the new over 70's Medical Card Scheme. One quarter of the respondents had no health cover (Table 3.2). Overall, almost 60% of the households are dependent on the public health services.

Table 3.2 Primary carers reported access to communication, heating and health cover

24 hour access to telephone by household member		
Yes	319	98.2
No	6	1.8
n	325	
Emergency communications for those households		
without 24 hour phone access		
Neighbour's phone	5	83.3
Panic button	1	16.7
n	6	
Central heating in the house		
Yes	315	96.9
No	10	3.1
n	325	
Method of central heating		
Gas	232	73.6
Oil	61	19.4
Solid Fuel	10	3.2
Electricity	12	3.8
n	325	
Health cover for household occupants		
Medical card	115	35.4
BUPA†	18	5.5
VHI†	96	29.5
Other private†	13	4.0
None	83	25.6
n	325	
†Private health insurance 127 (39%)		

Demographic and socio-economic characteristics for the primary carers

The primary carer is the person in the household who manages the welfare and health of the family/household. Table 3.3 presents the self-reported demographic and socio-economic characteristics of the primary carers. Of those who said that they were primary carers, 32% were men; this included men who were single (36/103, 35%), separated (8/103, 8%), widowed (13/103, 12%) or those who shared the caring role with their partner (46/103, 45%). On average the primary carers were 52 years old and over a quarter were aged 65 years or older. Fifty three percent of the primary carers did not work outside the home. Just over 60% of the primary carers had completed a state examination (group certificate or more) (Figure 3.3) and almost nine percent of those who had completed their state examination did so with assistance from an adult education scheme. Almost 13% of primary carers described themselves as lone parents (Figure 3.3).

Figure 3.3 Key characteristics of the household and primary carers (n=325)

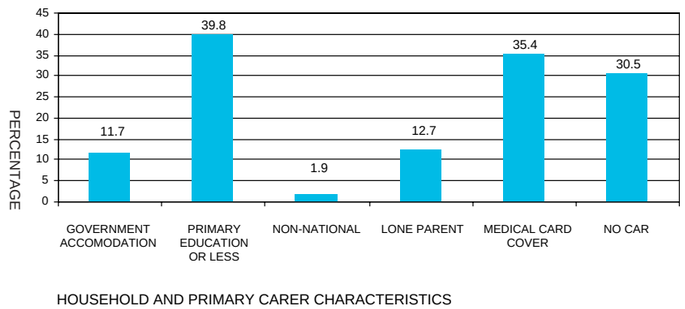


Table 3.3 Demographic and socio-economic characteristics of the primary carer

	No.	%
Gender		
Male	103	31.7
Female	222	68.3
n	325	
Age in years		
18 to 34	59	18.5
35 to 49	84	26.3
50 to 64	93	29.2
65 to 85	83	26.0
n	319	
Average	51.7	
Median	52	
Range	18 to 84	
Current employment status		
Working full time	113	34.9
Working part time	39	12.0
Always in the home	172	53.1
n	324	
Occupation		
Employers/managers, higher/lower professionals, self employed	39	12.1
Non manual or manual skilled workers	80	24.8
Semi skilled or unskilled workers	24	7.5
Work in home, retired, ill-unable to work or unemployed	172	53.4
Currently in education	7	2.2
n	322	
Educational attainment		
Primary education or none	129	39.8
Junior group or intermediate certificate, technical or vocational training	85	26.2
Leaving certificate, A levels and technical training	55	17.0
Non degree qualification	31	10.0
Degree, professional qualification or both, or post-graduate qualification	24	7.0
n	324	
Attained highest qualification through an adult education scheme		
Yes	17	8.7
No	178	91.3
n	195	
Marital status		
Single	89	27.4
Married	158	48.8
Separated, divorced or widowed	77	23.8
n	324	

Demographic and socio-economic characteristics for individuals living in the participating households

Table 3.4 presents the primary carers' reported demographic, family and socio-economic information for individuals residing in the participating households. The household residents' ages ranged from zero to 95 years and one third were aged 50 years or more. Over one third of those living in the households were primary carers while just over half of the individuals were the primary carers' children. Sixty five percent of household members, aged 15 to 65 years, were employed.

Table 3.4 Primary carers' reported demographic, family and socio-economic information for individuals residing in the households

	No.	%
Gender		
Male	491	51.0
Female	471	49.0
n	962	
Age in years		
0 to 4	65	06.8
5 to 12	89	09.3
13 to 19	99	10.4
20 to 29	157	16.5
30 to 39	120	12.6
40 to 49	108	11.3
50 to 65	160	16.8
65 or more	156	16.3
n	954	
Average	37.2	
Median	35	
Range	0 to 95	
Primary carers	325	33.8
Other household members relationship with primary carer		
Son or daughter	340	54.4
Partner or spouse	180	28.8
Parent	30	04.8
Sibling	20	03.2
Grandchild	14	02.2
Other	41	06.6
n	625	
Members of the household in education, employment or at home		
Employed -full or part time	412	43.1
Always in home	347	36.3
School	167	17.5
College or university	18	01.9
Community employment or training scheme	11	01.2
n		
Members aged 16 to 65 years in education, employment or at home		
Employed –full or part time	391	65.2
School	29	04.8
College or university	18	03.0
Community employment or training scheme	11	01.8
Always in home	151	25.2
n	955	
DED deprivation score for area of residence		
(where 1 is least deprived and 5 is most deprived)		
1	268	27.8
2	176	18.3
3	0	0.0
4	210	21.8
5	309	32.1
n	963	

3.3 HEALTH CARE ISSUES AND BEHAVIOURS

Smoking and substance misuse

According to the primary carers, at least one person in 49% of households smoked cigarettes while almost 3% of households had a person with a drug or alcohol problem (Table 3.5).

Table 3.5 Primary carers' reported tobacco use and (alcohol or illicit) drug dependency in the households

	No.	%
Number of households with one or more smokers		
Yes	160	49.2
No	165	50.8
n	325	
Numbers of households with a person with alcohol or drug dependency		
Yes	10	3.0
No	315	97.0
n	325	

According to the primary carers, no one aged less than 18 years old smoked. Among those 18 years and over, over one quarter of the household members smoked, and of these, the majority of them (70%) smoked ten or more cigarettes per day (Table 3.6).

Table 3.6 Primary carers' reported number (%) of individuals (18 years or older) in the household who smoke and quantity smoked each day by these individuals

	No	%
Smoke (18 years or older)		
Yes	219	28.4
No	553	71.6
n	772	
For individuals who smoke, quantity smoked per day		
1 to 10	66	30.1
10 to 20	152	69.4
More than 20	1	00.5
n	219	

The primary carers reported that 10 (1%) of the 963 individuals residing in the households had a problem with either alcohol or drugs at the time of the survey, of whom six persons had a serious problem (Table 3.7). They were aged between 19 and 70 years. According to the primary carers, six had a problem with alcohol while four had a problem with illicit drugs. Of the four household members with a drug problem, one misused heroin. The primary carers also reported that less than half of those with a substance misuse problem had sought help.

Table 3.7 Primary carers' reported number (%) of individuals in their household with a drug/alcohol problem and also their health service uptake

	No.	%
Scale of problem (1 not serious to 5 very serious)		
1	0	00.0
2	0	00.0
3	3	30.0
4	1	10.0
5	6	60.0
n	10	
Main drug used		
Alcohol	6	60.0
Benzodiazepam tablets	1	10.0
Cannabis	1	10.0
Heroin	1	10.0
Prozac	1	10.0
n	10	
Services used by all		
Visit general practitioner in relation to use		
Yes	4	40.0
No	6	60.0
n	10	
Attend counselling		
Yes	3	30.0
No	7	70.0
n	10	
Attend a support group		
Yes	2	20.0
No	8	80.0
n	10	
Taking sedatives		
Yes	5	50.0
No	5	50.0
n	10	
Services accessed by heroin users		
Visiting a needle exchange programme		
Yes	0	000.0
No	1	100.0
n	1	
On methadone maintenance		
Yes	0	000.0
No	1	100.0
n	1	
Had methadone detoxification		
Yes	1	100.0
No	0	000.0
n	1	

Primary carers' experience of stress

Over three fifths of the primary carers reported that they had experienced stress in the year prior to the survey (Table 3.8). Family issues (28%) was the most commonly cited cause of stress. Other common causes of stress were illness (20%) and pressure at work (14%).

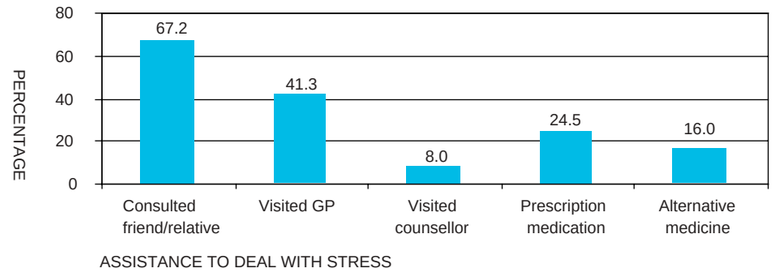
Over one third of the primary carers said that they had experienced severe stress (Table 3.8). Over four fifths reported negative effects of stress. The most commonly reported negative effects of stress were anxiety (47%), insomnia (40%) and depression (35%).

Table 3.8 Primary carers' reported experience of stress

	No.	%
Stress in the last 12 months		
Yes	204	62.8
No	121	37.2
n	325	
Reason for stress		
Family	58	28.4
Illness	41	20.1
Pressure at work	29	14.3
Everyday living	23	11.3
Bereavement	18	8.8
Financial	10	4.9
Study	5	2.4
Moving house	5	2.4
Unemployment	4	2.0
Post injury or trauma	4	2.0
Loneliness	3	1.5
Marital	2	1.0
Related to alcohol or drug addiction	1	0.5
Bullying	1	0.5
Scale of stress 1(not serious)-to 5 (very serious)		
1	29	14.2
2	40	19.6
3	63	30.9
4	31	15.2
5	41	20.1
n	204	
Experienced negative effects		
Yes	170	83.3
No	34	16.7
n	204	
Negative effects (n = 170)		
Anxious	79	46.5
Sleeplessness	68	40.0
Depressed	59	34.7
Easily annoyed	39	22.9
Smoke more	27	15.9
Eating too much or too little	26	15.3
Illness	18	10.6
Aggressive	15	8.8
Take more drugs / alcohol	10	5.7
Communication problems	4	2.3

The primary carers were asked what they did to seek help to deal with their stress (Figure 3.4). Over two thirds sought help from close friends or family while over two fifths attended their general practitioner. Almost one quarter said that they had taken prescribed medication to help them deal with stress.

Figure 3.4 Primary carers' reported sources of help to deal with stress (n=201)



Primary carers' experience of violence and intimidation

Thirty-eight (12%) primary carers reported that they had experienced violence or intimidation in the year prior to the survey, and of these, thirteen said that the scale of the violence or intimidation was very severe (Table 3.9).

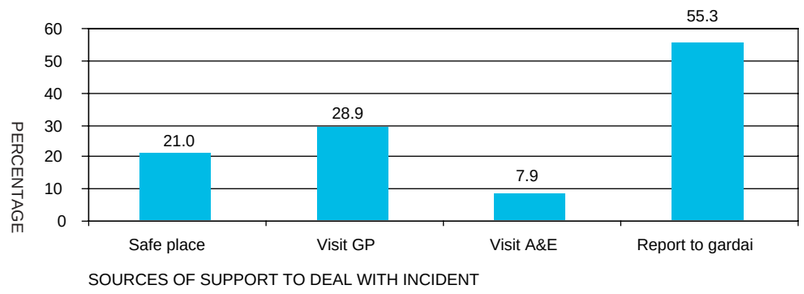
Of the 38 primary carers who experienced violence, 21 (55%) respondents said that it had occurred several times; 10 (26%) respondents said that the incident had occurred in their home; and 20 (53%) of them said that the incident was perpetrated by someone they knew (Table 3.9). One quarter of the episodes of violence or intimidation were as a result of a previous disagreement.

Table 3.9 Primary carers' reported experience of intimidation and/or violence in the last 12 months

	No.	%
Experienced intimidation and/or violence in last 12 months		
Yes	38	11.7
No	286	88.3
n	324	
Scale of intimidation and/or violence; 1(not serious) to 5(very serious)		
1	3	7.9
2	6	15.8
3	8	21.1
4	8	21.0
5	13	34.2
n	38	
Frequency of intimidation and/or violence		
Once	13	34.2
Few times	4	10.5
Several times	21	55.3
n	38	
Place where intimidation and/or violence occurred		
In the home	10	26.3
Outside the home	28	73.7
n	38	
Perpetrators of intimidation and/or violence		
Someone they know	20	52.6
Stranger	18	47.4
n	38	
Reason for attack		
Random attack	28	75.7
Result of previous disagreement	9	24.3
n	37	

The primary carers who had experienced violence or intimidation were asked where they had gone for help (Figure 3.5). Eight primary carers said that they had moved to a safe place while 14 said they had sought medical assistance. Twenty-one respondents said they had reported the incident to the police.

Figure 3.5 Primary carers' reported sources of support to deal with the last incident of intimidation or violence (n=38)



Primary carers' experience of dealing with teenagers

According to the primary carers with teenage children, over half (54%) worried about their teenagers' socialising (Table 3.10). Almost half (49%) of the primary carers said that the incident that would cause most concern was that their teenager would be sexually assaulted, robbed or attacked while socialising. Another notable cause of concern for over one third (37%) of respondents was that their teenagers would develop a problem with, or as a result of, drugs or alcohol use.

Table 3.10 Primary carers' reported experience of coping with teenage children and type of assistance sought

	No.	%
Worried about teenagers' socialising		
Yes	53	53.5
No	39	39.4
Sometimes	7	07.1
n	99	
Incident primary carer would worry about most		
Sexually assaulted, robbed or attacked	28	49.1
Drug and drink related	21	36.8
Car related	3	05.3
Pregnancy	3	05.3
Mix with wrong company	2	03.5
n	57	
Happy with his/her friends		
Yes	88	88.9
No	3	03.0
Some of them	7	07.1
Don't know	1	01.0
n	99	
Found teenagers' attitudes or behaviours upsetting		
Yes	45	45.5
No	54	54.5
n	99	
Attitude, behaviour or action that is most upsetting		
Mood swings	21	46.7
Does not listen to advice	9	20.0
Does not observe boundaries or rules	8	17.8
Always wants to be out with friends	3	06.7
Leaves house without informing parents	2	04.4
Refuses to go to school or work	2	04.4
n	45	
Assistance or advice sought from others outside primary carer's family		
Yes	13	28.9
No	32	71.1
n	45	
Where primary carer has gone for advice		
Teacher	5	38.4
Priest	3	23.1
GP	3	23.1
Counsellor	1	07.7
Social worker	1	07.7
n	13	

Just 11% of primary carers said that they were not happy with some or all of their teenagers' friends (Table 3.10). The primary carers were asked if they found their teenagers' behaviours upsetting and 45% said yes. Of the primary carers who found their teenagers' behaviours upsetting, almost half of them reported that the most upsetting behaviour was their teenager's mood swings. Over one third of respondents reported that their teenager's unmanageability was upsetting (does not listen to advice or does not observe boundaries). Twenty nine percent of primary carers said that they had sought help to deal with their teenagers' behaviour. According to the primary carers, the most common sources of advice were teachers, priest or general practitioner.

3.4 CHRONIC DISEASE

Proportion of households with one or more members having a chronic disease

According to the primary carers, 62% of households had at least one person who had a chronic illness while 24% of all households had more than one person with a chronic illness (Table 3.11)

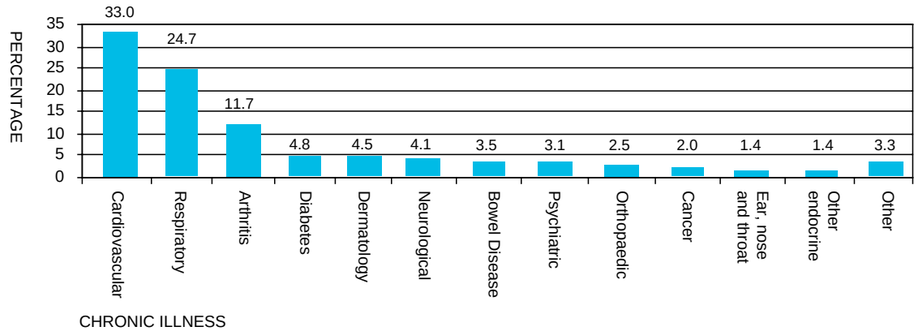
Table 3.11 Primary carers' reported numbers (%) with a chronic illness

	No.	%
Suffer from chronic illness		
Yes	201	61.8
No	124	38.2
n	325	
Number suffering from chronic illness in each household		
No one	124	38.2
One person	124	38.2
More than one person	77	23.6
n	325	

Proportion of individuals with one or more members having a chronic disease

The primary carers reported that 291 (30.2%) of the 963 individuals residing in the survey households had a chronic illness. This figure was adjusted to take account of the over representation of the population in the sample who lived in low deprivation district electoral divisions compared to the proportion living in high deprived district electoral divisions, and following adjustment, 29.2% of household members had a chronic illness. The most commonly reported chronic illnesses were cardiovascular diseases (34%), respiratory diseases (25%) and arthritis (12%) (Figure 3.6).

Figure 3.6 Types of chronic illness reported by primary carers for the household members (n=291)



Of those with a chronic illness, the primary carers reported that 10% required some degree of help at home (Table 3.12). Of those with a chronic illness, twelve (4%) had a home help while a public health nurse visited 21 (7%) individuals in the three months prior to the survey. Over three fifths (64%) had visited their general practitioner in the three months prior to the survey, of whom, 112 (60%) attended for a repeat prescription. Over one third (35%) of the individuals reported that their general practitioner surgery was not within walking distance. Almost 30% of individuals with a chronic illness visited a hospital in the same time period.

A higher proportion of household members (151/444, 34%) living in a less deprived area had a chronic disease compared to the proportion (140/519, 27%) living in a more deprived area (p=0.02).

Table 3.12 Primary carers' reported types of chronic illness, level of care required and health services used by individuals residing in their households

	No.	%
Degree of care required		
No assistance	262	89.7
Housekeeping including medication	23	08.9
Help to sit out in chair	1	00.3
Help to sit out in chair and attend to personal hygiene	2	00.7
Total nursing care as confined to bed	1	00.3
n	289	
Have organised home-help		
Yes	12	04.1
No	278	95.9
n	290	
Visited by public health nurse in past 3 months		
Yes	21	07.2
No	270	92.8
n	291	
Attended GP in past 3 months		
Yes	186	64.0
No	105	36.0
n	291	
Reason for GP visit (n=186)		
Sudden illness	25	13.4
Repeat prescription	112	60.2
Advice	5	02.7
Medical check up	44	23.7
GP's surgery within walking distance		
Yes	184	64.8
No	100	35.2
n	284	
Hospital visits due to this illness in last 3 months		
Yes	85	29.7
No	201	70.3
n	286	

Characteristics and practices associated with those who have a chronic illness

Bi-variate analysis using six groups of variables (demographic characteristics, socio-economic characteristics, disability, health related behaviours, health service utilisation and waiting for health care) indicated that several factors were significantly associated with having a chronic illness.

Logistic regression models were constructed to clarify the independent associations between the significant variables and the likelihood of having a chronic illness (Table 3.13). The relationships presented are those that remained statistically significant or were deemed clinically important after taking account of confounding. The associations are expressed as odds ratios (OR) adjusted for confounding.

Table 3.13 Logistic regression model to identify factors associated with having a chronic disease in the Finglas population (291/963)

	Total	Reported chronic illness	Prevalence %	Adjusted Odds ratio (95% CI)	p-value
Gender					
Male	491	123	25.0	1	
Female	471	168	35.7	1.5 (1.1 to 2.0)	0.02
Missing	0				
Age (in years)					
0 to 49	638	105	16.5	1	
50 or over	316	183	57.9	5.1(3.6 to 7.1)	<0.0001
Missing	9				
Medical card					
No	660	167	25.3	1	
Yes	303	124	40.9	1.6 (1.1 to 2.2)	0.01
Missing	0				
Attended GP and/or hospital in the year prior to the survey					
None	348	39	11.2	1	
Either	358	106	29.6	2.7 (1.8 to 4.2)	<0.0001
Both	257	146	56.8	6.6 (4.3 to 10.4)	<0.0001
Missing	0				
Disability					
No	922	268	29.1	1	
Yes	40	23	57.5	2.3 (1.1 to 5.1)	0.03
Missing	1				
Whole model $\chi 2=272$, $p<0.0001$					

The initial model included variables significant at the 0.05 level and these were: age, gender, time spent in the home, living alone, medical card status, disability status, history of drug or alcohol dependency, used hospital or attended GP in the last year and waiting for health care at the time of the survey. Significant factors were retained in the final model.

Female household members were 50% (adjusted OR 1.5, CI 1.1 to 2.0) more likely to have a chronic illness than male. Also household members aged 50 years or more were over five times (adjusted OR 5.1, CI 3.6 to 7.1) more likely to have a chronic illness than those less than 50 years old. Those who had a medical card were more likely to have a chronic illness than those who had no medical card (adjusted OR 1.6, CI 1.2 to 2.2). Household members attending both a general practice and the hospital in the year prior to the survey were almost seven times (adjusted OR 6.6, CI 4.3 to 10.4) more likely to have a chronic illness than those who did not attend either service in the same time period. Household members reported to have a disability were more than twice (adjusted OR 2.3, CI 1.1 to 5.1) as likely to have a chronic illness than those who had no disability.

3.5 DISABILITY

Proportion of households with one or more members having a disability

According to the primary carers, eleven percent of households had at least one person who had a disability while one percent of all households had more than one person with a disability (Table 3.14).

Table 3.14 Primary carers' reported numbers (%) with disability

	No.	%
Suffer from disability		
Yes	36	11.0
No	289	89.0
n	325	
Number with disability per household		
No one	289	89.0
One person	32	10.0
Two persons	4	1.0
n	325	

Proportion of individuals with one or more members having a disability

The primary carers reported that 40 (4.2%) of the 963 individuals residing in the survey households had a disability. This figure was adjusted to take account of the over representation of the population in the sample who lived in low deprivation district electoral divisions compared to the proportion living in high deprived district electoral divisions, and following adjustment, 3.9% of household members had a disability. Twelve individuals were born with a disability while 20 individuals acquired their disability during adulthood.

The most frequently reported type of disability was physical (Table 3.15). Of those with a disability, the primary carers reported nine (23%) individuals required some degree of help at home and 19 (48%) used special aids to assist them in their daily lives. According to the primary carer, a public health nurse had visited five of the individuals in the three months prior to the survey. Four of these individuals had a home help assisting them on a regular basis. The primary carers said that 13 (33%) of those with a disability had visited their general practitioner in the three months prior to the survey while 10 (25%) visited a hospital or special service in the same period.

A similar proportion of household members who had a disability were living in the less deprived areas and the more deprived areas (22/444, 5% versus 18/519, 3.5%, p=0.2).

Table 3.15 Primary carers' reported types of disability, level of care required and health services used by individuals residing in their households

	No.	%
Types of disability		
Physical	32	80.0
Learning	6	15.0
Combination of physical and learning	2	05.0
n	40	
Time occurred		
Born with or occurred at the time of birth	12	30.0
Childhood	7	17.5
Adolescence	1	02.5
Adult	20	50.0
n	40	
Degree of care required		
No assistance	31	77.5
Housekeeping including medication	7	17.5
Housekeeping including medication, help to sit out in chair, attend to personal hygiene and feeding	2	05.0
n	40	
Special aids required		
Yes	19	47.5
No	21	52.5
n		
Type of aids (n=19)		
Hearing aids	8	42.1
Mobility aids	7	36.9
Household aids	4	21.0
Have home help		
Yes	5	12.5
No	35	87.5
n	40	
Visited by nurse in past 3 months		
Yes	5	12.5
No	35	87.5
n	40	
Attended GP in past 3 months		
Yes	13	32.5
No	27	67.5
n	40	
Attended hospital or specialist services in past 3 months		
Yes	10	25.0
No	30	75.0
n	40	
Proportion of individuals with a disability 40/963 (4.1%)		

Characteristics and practices associated with those who have a disability

Bi-variate analysis using six groups of variables (demographic characteristics, socio-economic characteristics, chronic illness, health related behaviours, health service utilisation and waiting for health care) indicated that several factors were significantly associated with having a disability.

Logistic regression models were constructed to clarify the independent associations between the significant variables and the likelihood of having a disability (Table 3.16). The relationships presented are those that remained statistically significant or were deemed clinically important after taking account of confounding. The associations are expressed as odds ratios adjusted for confounding.

Table 3.16 Logistic regression model to identify factors associated with having a disability in the Finglas population (40/963)

	Total	Reported chronic illness	Prevalence %	Adjusted Odds ratio (95% CI)	p-value
Living alone					
No	907	32	3.5	1	
Yes	56	8	14.3	2.7 (1.1 to 6.3)	0.02
Missing	0				
Chronic disease					
No	671	17	2.5	1	
Yes	291	23	7.9	2.8 (1.4 to 5.8)	0.003
Missing	1				
Engaged in a training scheme					
No	944	37	3.9	1	
Yes	11	3	27.2	17.5 (2.3 to 92.8)	0.001
Missing	8				
Medical card					
No	660	19	2.9	1	
Yes	303	21	6.9	2.1 (1.1 to 4.2)	0.03
Missing	1				
Whole model $\chi 2=30$, $p<0.0001$					

The initial model included variables significant at the 0.05 level and these were: age, medical card status, living alone, time spent on a training scheme, chronic disease status and used hospital in the last year.

Household members who were living alone were almost three times more likely to have a disability than those who were not living alone (adjusted OR 2.7, CI 1.1 to 6.3). Household members who reported having a chronic illness were almost three times more likely to have a disability than those who did not report having a chronic illness (adjusted OR 2.8, CI 1.4 to 5.8). Household members reported to be engaged in a training programme were over seventeen times more likely to have a disability than those not on a training scheme (adjusted OR 17.5, CI 2.3 to 92.8). Household members with a medical card were twice as likely to have a disability than those without a medical card (adjusted OR 2.1, CI 1.1 to 4.2).

3.6 DEATHS

Of the 266 households who were living in the area before 1997, 25 primary carers reported at least one death of a household member between January 1997 and May 2002 (25/266, 9.4%).

There were 771 household members living in the 266 households. According to the primary carer, 27 (3.4%) of the 798 individuals, residing in the surveyed households before 1997 had died. The majority (20/27, 74%) of the individuals were aged 65 years or older.

The primary carers reported a cause of death for 26 of the 27 household members. According to the primary carers all of the 26 deaths were illness related. They gave specific details of the cause of death for twelve of the individuals; seven people died as a result of cancer, two as a result of cardiovascular disease, two deaths were drug or alcohol related and one person died as a result of a respiratory illness.

3.7 ACUTE HOSPITAL SERVICES

Proportion of households with one or more members who used hospital services

According to the primary carers, at least one person in two thirds of the households used one or more of the hospital services in the year prior to the survey. Thirty one percent (102/325) of households had one or more persons admitted to a hospital during the same period (Table 3.17).

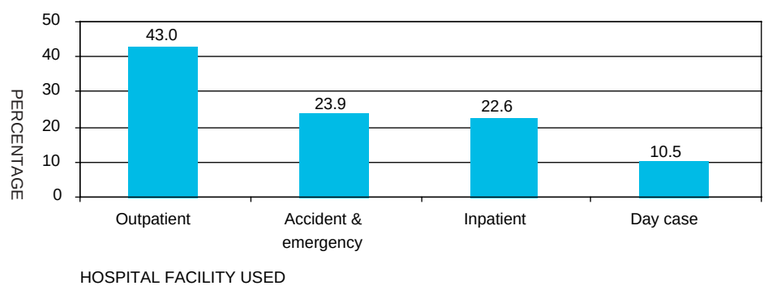
Table 3.17 Primary carers' reported numbers (%) who attended the hospital

	No.	%
Used hospital in last 12 months		
Yes	215	66.2
No	110	33.8
n	325	
Number admitted to hospital		
No one	223	68.6
One person	80	24.6
More than one person	22	6.8
n	325	

Proportion of individuals who used hospital services in participating households

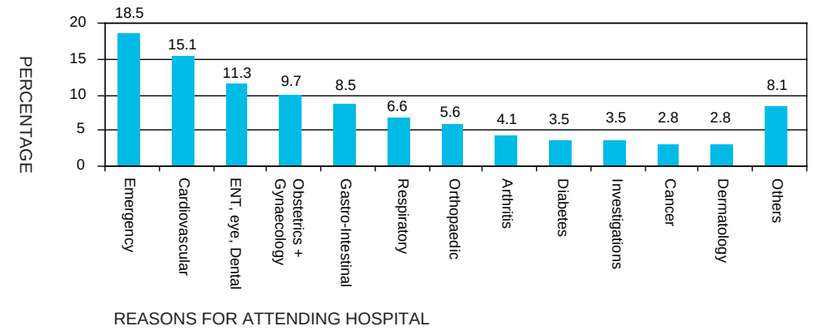
The primary carers reported that 324 (33.6%) of the 963 individuals residing in the survey households used a hospital service in the year prior to the survey. This figure was adjusted to take account of the over representation of the population in the sample who lived in low deprivation district electoral divisions compared to the proportion living in high deprivation district electoral divisions, and following adjustment, 33.4% of household members used a hospital service in the year prior to the survey. Seventy-three (7.6%) of all household members were admitted to hospital in the year prior to the survey. Of those who used the hospital, 43% attended outpatients, 24% attended accident and emergency, 23% were admitted into the hospital and 11% used the day hospital facilities (Figure 3.7).

Figure 3.7 Hospital facilities used by household members as reported by primary carers (n=323)



According to the primary carers, of those who attended the hospital, 18% attended as a result of an acute emergency and 15% had a cardiovascular disease (Figure 3.8).

Figure 3.8 Household members' reasons for attending hospital as reported by primary carers (n=319)



The primary carers reported just over three fifths had a planned appointment at the time they attended the hospital (Table 3.18). According to the primary carers, 35% of those who used a hospital service referred themselves. The respondents reported that 33 of the 324 household members who used the hospital service were transported by ambulance, of these, 29 were emergency cases.

Similar proportions of household members who reported using a hospital service in the year prior to the survey were living in the less deprived areas and the more deprived areas (143/444 32% versus 176/519, 34%, p=0.6).

Table 3.18 Primary carers' reported type of appointment for, channel of referral to and means of transport used by individuals in their households to attend a hospital service in the 12 months prior to the survey

Utilisation planned or emergency	No.	%
Planned	200	62.1
Emergency	122	37.9
n	322	
Referral to hospital by:		
Self	114	35.3
GP	143	44.3
Hospital doctor	62	19.2
Other health professional	4	01.2
n	323	
Hospital facility used		
Out patient	139	43.0
Accident and emergency	77	23.9
In patient	73	22.6
Day	34	10.5
n	323	
Transport used to travel to hospital		
Private	189	59.8
Public	94	29.8
Ambulance	33	10.4
n	316	

Characteristics and factors associated with those using a hospital service in the last year

Bi-variate analysis using seven groups of variables (demographic characteristics, socio-economic characteristics, chronic illness, disability, health related behaviours, other health services utilised and waiting for health care) indicated that several factors were significantly associated with using a hospital service in the year prior to the survey.

Logistic regression models were constructed to clarify the independent associations between the significant variables and the likelihood of using a hospital service in the year prior to the survey (Table 3.19). The relationships presented are those that remained statistically significant or were deemed clinically important after taking account of confounding. The associations are expressed as odds ratios adjusted for confounding.

Table 3.19 Logistic regression model to identify the factors that influenced use of a hospital service in the year prior to the study among the Finglas population (324/963)

	Total	Attended hospital	Proportion %	Adjusted Odds ratio (95% CI)	p-value
Age (in years)					
0 to 49 yrs	638	133	20.8	1	
50 or more	316	153	48.4	1.8 (1.3to 2.5)	0.0006
Missing	9				
Chronic disease					
No	671	163	24.3	1	
Yes	291	156	53.6	2.0 (1.4 to 2.7)	0.0001
Missing	1				
Attended GP in the year prior to the survey					
No	384	62	16.1	1	
Yes	553	257	46.5	3.5 (2.5 to 5.0)	<0.0001
Missing	26				
Waiting for health care at the time of the survey					
No	899	26	2.9	1	
Yes	63	37	58.7	2.6 (1.5 to 4.6)	0.0009
Missing	1				
Whole model $\chi 2=165$, $p<0.0001$					

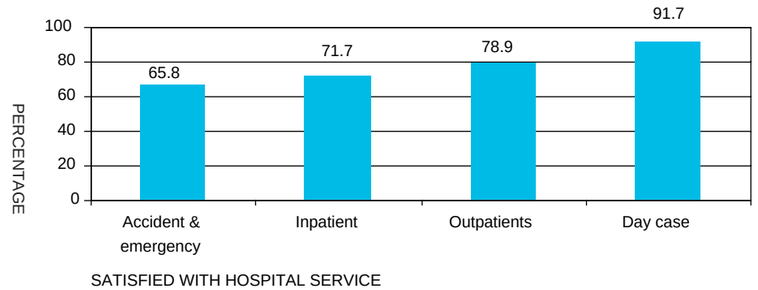
The initial model included variables significant at the 0.05 level and these were: age, house occupancy status, time spent in the home, chronic illness status, disability status, medical card status, attended GP in the last year and waiting for health care at the time of the survey. Significant factors were retained in the final model.

Household members aged 50 years or more were almost twice (adjusted OR 1.8, CI 1.3 to 2.5) as likely to have used a hospital service in the past year than the individuals less than 50 years old. Those household members reporting a chronic illness were twice (adjusted OR 2.0, CI 1.4 to 2.7) as likely to have used a hospital service than those not reporting a chronic illness. Individuals attending a general practitioner in the year prior to the survey were over three times (adjusted OR 3.5, CI 2.5 to 5.0) more likely to have also used a hospital service than those not attending their general practitioner during the period. Household members reporting waiting for health care were over two and a half times (adjusted OR 2.6, CI 1.5 to 4.6) more likely to use a hospital service than those individuals not reporting to be waiting for health care.

Satisfaction with and utilisation of specific hospital services

Primary carers were asked to recall the last three hospital services used by themselves and by the other household members in the year prior to the survey. If they had used a service or accompanied the household member, they were also asked to recall their level of satisfaction with the service, and reasons for satisfaction or dissatisfaction. Appendix 5 presents detailed tables on satisfaction with hospital services and Figure 3.9 presents the proportion satisfied with each hospital service.

Figure 3.9 Household members' satisfaction with hospital services as reported by primary carers



Accident and emergency

According to the primary carers, 87 (9%) household members had attended an accident and emergency service in the year prior to the survey (Appendix 5), of whom, 63 individuals stated the location of the accident and emergency department attended; 22 (35%) went to the Mater Misericordiae Hospital (Mater), 18 (29%) went to the Children's Hospital, Temple Street (Temple Street Hospital), 10 (16%) went to Beaumont Hospital, eight (13%) went to James Connolly Memorial Hospital and one person (2%) went to St. James's Hospital.

The primary carers reported that almost two thirds of the individuals were satisfied with the service. Among those who were satisfied, the main reasons given were that the staff were friendly (42%) and staff explained the patient's medical condition clearly (38%). Among those dissatisfied with the service the main reason given was the long waiting periods encountered (63%).

Of those who attended accident and emergency departments in the last year, the vast majority (59/85, 70%) attended once only, 14 (16%) attended twice, 12 (14%) attended between three and nine times and one person (1%) attended ten times.

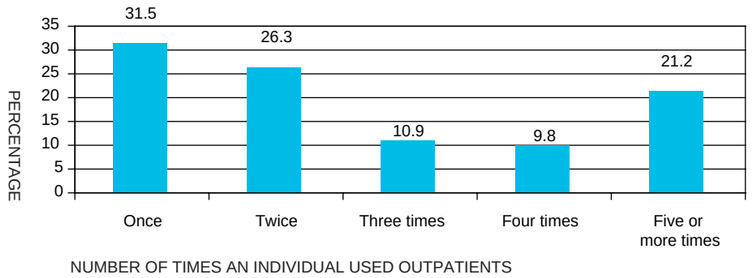
Outpatients

According to the primary carers 191 (20%) household members had attended an outpatient service in the year prior to the survey, of these 117 individuals stated the location of the outpatient department; 65 (56%) went to the Mater, 19 (16%) went to Beaumont, 12 (10%) went to Temple Street, 8 (3%) went to James Connolly Memorial (Appendix 5).

The primary carers reported that the majority (79%) were satisfied with the service. Among those who were satisfied, the main reasons given were that they had received good treatment or care (54%) and the staff were friendly (46%). Among those dissatisfied the main reason given was the long waiting periods (65%).

Of those who attended the outpatient department in the last year, just under three fifths (145/184, 79%) attended between one and four times while one fifth (39, 21%) attended between five and 24 times (Figure 3.10).

Figure 3.10 The number of times an individual used the outpatient service in the 12 months prior to the survey (n=184)



Inpatients

According to the primary carers, 53 (6%) individuals using hospital services were admitted to the hospital, of whom 48 individuals stated the location; 16 (33%) went to the Mater, seven (15%) went to Beaumont, seven (15%) went to the Rotunda Maternity Hospital, five (10%) went to James Connolly Memorial (Appendix 5).

The majority (72%) were satisfied with the care they received. Among those who were satisfied, the main reasons given were that they received good treatment and care (73%) and the staff were friendly (51%). The main reasons given for being dissatisfied were that the staff were unfriendly (38%), they received incorrect treatment or care (38%) and the environment was unpleasant (38%).

Of those who admitted to hospital in the last year, the vast majority (42/50, 84%) were admitted once only, 7 (14%) were admitted twice, and one (2%) person was admitted three times.

Day Cases

According to the primary carers, 24 (3%) individuals were admitted to a hospital as a day case, of whom 21 individuals stated the location; eight (38%) went to the Mater, five (24%) individuals were admitted to private hospitals, four (19%) went to Beaumont and three (14%) went to Temple Street (Appendix 5).

The majority (98%) were satisfied with the service they had received. The main reason given for being satisfied was that they had received good treatment or care (77%). Only one person gave a reason for feeling dissatisfied and this respondent said that the staff had not been friendly.

Of those who used the day patient service in the last year, almost three quarters (17/23, 74%) used it once and 6 (16%) individuals used it between two and four times.

3.8 HEALTH SERVICES FOR WOMEN

Uptake of family planning and cervical smears

The female primary carers aged between 18 and 45 years were asked three questions about family planning practices (Table 3.20). Almost 50% reported that they were using a method of family planning. Of those who were currently using a method of family planning, 18% of the women (or their husbands) had been sterilised, 77% were using a temporary method of contraception while 5% were using a natural method of family planning. Of those respondents who were not currently using a method of family planning, 29% said that they had no reason for not using a method of family planning.

Fifty two percent of female primary carers aged between 18 and 65 years, had a cervical smear in the previous five years and half had a breast examination. Of the women eligible for BreastCheck (the national breast screening programme) in 2000 when Finglas was targeted, 41% had a mammogram within the last five years.

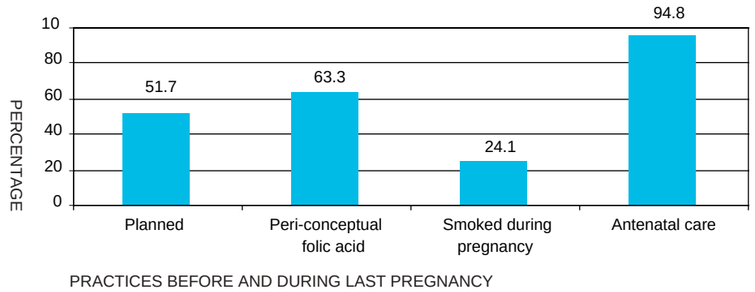
Table 3.20 Primary carers' reported current use of family planning and recent uptake of cervical smear tests and breast examination

	No.	%
Use family planning (women respondents 18 to 49 years)		
Yes	56	49.5
No	57	50.0
n	113	
Method of family planning used		
Natural	3	5.4
Temporary	43	76.8
Permanent	10	17.8
Reason for not using family planning		
Not currently sexually active	18	32.7
No reason	16	29.1
Trying for a child, pregnant, post natal	11	20.0
On medication or fear of negative side effects	7	12.7
Hysterectomy	3	5.5
n	55	
Cervical smear in last 5 years (women respondents 18 to 65 years)		
Yes	96	52.2
No	88	47.8
n	184	
Breast examination in the last 5 years (women respondents 18 to 65 years)		
Yes	92	
No	92	50.0
n	184	50.0
Method of examination		
By a doctor/nurse	47	51.1
Mammogram	45	48.9
n	92	
Mammogram in last 5 years among women respondents 52 to 66 years eligible for BreastCheck in 2000 (n=82)		
Yes	34	41.4
No	48	58.6

Births and associated maternal health practices and services

According to the primary carers, 64 children were born to 58 mothers who currently reside in the study area between January 1997 and April 2002. Eleven of the women (19%) were aged between 17 and 19 years during their most recent pregnancy (Table 3.21).

Figure 3.11 Practices of women before and during their most recent pregnancy (if it occurred between January 1997 and April 2002) as reported by primary carers (n=58)



Fifty-two percent of the women's last pregnancies were planned (Figure 3.11). Of those who planned their last pregnancy, over three fifths (19/30, 63%) had taken folic acid prior to conception. Almost a quarter had smoked during their last pregnancy, 5% did not attend antenatal care and 7% did not have a postnatal examination six weeks after delivery (Table 3.21). According to the primary carers, almost three fifths of the expectant women had antenatal care in a maternity hospital and over one third had their care shared with their general practitioner (Table 3.18). Over four fifths of the women had their youngest child in the Rotunda Maternity Hospital (Table 3.21).

Table 3.21 Primary carers' reported number of pregnancies in their households between January 1997 and April 2002, as well as health practices and service uptake by pregnant women for the most recent pregnancy

	No.	%
Women in household who have given birth since January 1997 and number of births to each woman		
One child	52	89.7
Two children	4	06.9
Three children	2	03.4
n	58	
Information on the most recent pregnancy		
Age when became pregnant		
18 to 19	11	19.0
20 to 29	18	31.0
30 to 42	29	50.0
n	58	
Place where antenatal care was received		
Maternity hospital	31	58.5
Combined or shared care	20	37.7
Consultant private clinic	2	03.8
n	53	
Place of delivery		
Rotunda	49	84.5
National Maternity Hospital	5	08.6
Coombe Womens Hospital	4	06.9
n	58	
Attended 6 week post natal check up		
Yes	53	91.4
No	4	06.9
Don't know	1	01.7
n	57	

Satisfaction with maternity services

As one of the last three health services used, 15 women were admitted to a maternity hospital in the twelve months preceding the survey. Eleven of them reported satisfaction levels, of whom seven were satisfied with the service (Table 3.22). The main reason for satisfaction was that they received good treatment or care (5/7, 71%). For three of the four individuals dissatisfied with the service the long waiting period encountered was the reason given.

Table 3.22 Primary carers' reported number (%) of the individuals admitted to maternity hospital in the year prior to the survey and level of satisfaction with services

	No.	%
Admitted to maternity hospital		
Yes	15	07.3
No	190	92.7
n (women aged 15 to 49 years)	205	
Satisfied with care and treatment (1 very satisfied to 6 very dissatisfied)		
Yes (1 to 3)	7	63.6
No (4 to 6)	4	36.4
n	11	

3.9 COMMUNITY HEALTH SERVICES

General practice

The primary carers reported that 559 (58%) of the 963 individuals residing in the survey households attended their general practitioner in the year prior to the survey. This figure was adjusted to take account of the over representation of the population in the sample who lived in low deprivation district electoral divisions compared to the proportion living in high deprivation district electoral divisions, and following adjustment, 57.7% of household members had attended their general practitioner in the year prior to the survey.

The respondents were also asked to recall the purpose of their most recent visit. Acute onset of illness, medical check up and repeat prescriptions were the most common purposes cited (Table 3.23).

Of those who attended their general practitioner in the last year, just over 57% attended a general practitioner in Finglas while a further 20% attended in Glasnevin (Table 3.23). Four out of every ten individuals who attended their general practitioner in the last year walked to the surgery while a further one in every ten travelled by public transport.

Table 3.23 Primary carers reported purpose for most recent use of the general practitioner by individuals in their household in the 12 months prior to the survey

	No.	%
Purpose for visit		
Sudden illness	235	42.2
Medical check up	144	25.9
Repeat prescription	132	23.7
Vaccinations	29	5.2
Advise	17	3.0
n	557	
Location of the surgery		
Finglas	315	57.1
Glasnevin	110	19.9
Ballymun	32	05.8
Doctor in the work place	8	01.4
Other	87	15.8
n	552	
Transport used to travel to hospital		
Private car	256	46.0
Walked	228	40.9
Bus	46	08.3
Taxi	16	02.9
Home visit	8	01.4
Cycled	3	00.5
n	557	

Of the 599 individuals who attended their general practitioner in the last year, the primary carer reported a level of satisfaction with the service provided for 487 individuals (Table 3.24). Eighty three percent were satisfied with the service provided while 17% were dissatisfied with the service. Among those who were satisfied, the main reasons were, the doctor provided good treatment or care (65%), the doctor listened to the problem (46%), and the staff were friendly (38%). Among those who were dissatisfied, the main cause was the doctor did not listen to the problem (46%).

Table 3.24 Primary carers' reported number (%) of the individuals visited their GP in the year prior to the survey, the level of satisfaction with services and their reasons for satisfaction/dissatisfaction

	No.	%
Visited GP		
Yes	559	58.0
No	404	42.0
n	963	
Satisfaction with care and treatment from GP		
(1 very satisfied to 6 very dissatisfied)		
1	261	53.6
2	100	20.5
3	43	08.9
4	39	08.0
5	26	05.3
6	18	03.7
n	487	
Satisfied with care and treatment from GP		
Yes (1 to 3)	404	83.0
No (4 to 6)	83	17.0
n	487	
Reason satisfied with care and treatment from GP (n = 404)		
Nearby	67	16.6
Staff courteous and friendly	153	37.9
Short waiting period	46	11.4
Doctor listened to the problem	184	45.5
Doctor explained the condition	145	35.9
Doctor explained the treatment possibilities	131	32.4
Doctor provided good treatment or care	263	65.0
Service easily available on a 24 – hour basis	31	06.7
Pleasant environment	29	07.2
Affordable	9	01.7
Organised appointments	27	06.7
Longterm relationship with GP	3	00.7
Reason dissatisfied with care and treatment from GP (n = 83)		
Too far	0	00.0
Staff unfriendly	17	20.5
Long waiting periods	15	18.0
Doctor did not listen to the problem	38	45.8
Doctor did not explain the condition	17	20.5
Doctor did not explain the treatment possibilities	19	22.9
Doctor provided inadequate or incorrect treatment	19	22.9
Service difficult to access outside normal working hours	4	04.8
Unpleasant environment	0	00.0
Expensive	9	10.8
No aftercare	8	09.6
Other	10	12.0

Similar proportions of household members who visited the general practitioner in the twelve months prior to the survey were living in the less deprived areas and the more deprived areas (261/444, 59% versus 298/ 519, 57%, p=0.7).

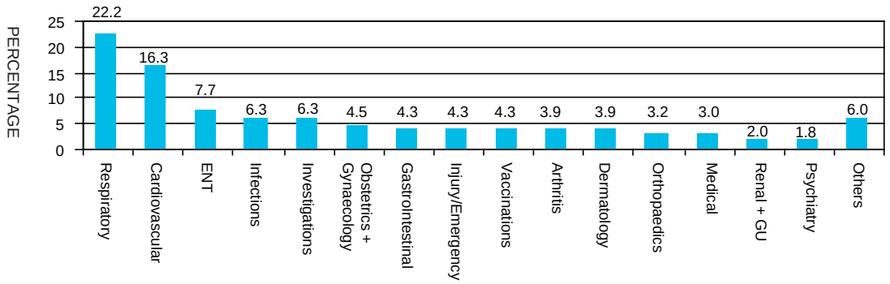
Primary carers were asked what service they would access when seeking a doctor after hours (Table 3.25). Sixty two percent would contact their general practitioner practice and 12% said they would go straight to the accident and emergency department. When primary carers were asked about satisfaction with current 'out of hours' general practitioner service, 16% said that they were unhappy with the service and 49% did not know whether or not they were satisfied or dissatisfied with the service.

Table 3.25 Primary carers' reported use of and satisfaction with 'out of hours' medical services

	No.	%
Services used for doctor out of hours		
Call GP practice	200	61.7
Go to hospital accident and emergency	40	12.3
Depends on situation	30	9.3
Never had to use the service	54	16.1
n	324	
Satisfied with choice of out of hours service		
Yes	113	35.0
No	52	16.1
Do not know	158	48.9
n	323	

According to the primary carer, the most common illnesses suffered by household members at the time of their most recent visit to their general practitioner were respiratory (22%) and cardiovascular conditions (16%) (Figure 3.12).

Figure 3.12 Household members' medical reasons for attending the general practitioner on their last visit (n=559)



Of the 508 individuals for whom the primary carer reported the number of times they attended the general practitioner in the 12 months prior to the survey; 9% (44/508) attended their general practitioner service twelve or more times, 21% (106/508) had visited the service between five and eleven times, 50% (255/508) between two and four times and 20% (103/508) had visited the service only once.

Characteristics and factors associated with those attending a general practitioner in the last year

Bi-variate analysis using seven groups of variables (demographic characteristics, socio-economic characteristics, chronic illness, disability, health related behaviours, other health services utilised and waiting for health care) indicated that several factors were significantly associated with attending a general practitioner, as one of the last three health services used, in the year prior to the survey.

Logistic regression models were constructed to clarify the independent associations between the significant variables and the likelihood of attending a general practitioner in the year prior to the survey. Significant factors were retained in the final model (Table 3.26). The relationships presented are those that remained statistically significant or were deemed clinically important after taking account of confounding. The associations are expressed as odds ratios adjusted for confounding.

Table 3.26 Logistic regression model to identify determinants of attending a general practitioner as one of the last three health services used in the year prior to the survey among the Finglas population (563/963)

	Total	Attended GP	Proportion %	Adjusted Odds ratio (95% CI)	p-value
Gender					
Male	491	247	50.3	1	
Female	471	306	65.0	1.7 (1.3 to 2.2)	0.0004
Missing	0				
At home fulltime					
No	608	304	50.0	1	
Yes	347	248	71.5	1.5 (1.1 to 2.1)	0.009
Missing	8				
Chronic disease					
No	671	311	46.3	1	
Yes	291	242	83.1	3.8 (2.7 to 5.6)	<0.0001
Missing	1				
Used a hospital service in the year prior to the survey					
No	635	296	46.6	1	
Yes	319	257	80.6	3.5 (2.5 to 5.0)	<0.0001
Missing	9				
Whole model $\chi 2$=203, p<0.0001					

The initial model included variables significant at the 0.05 level and these were gender, age, time spent in the home, living alone, chronic illness status, used a hospital service in the year prior to the survey and waiting for health care at the time of the survey. Significant factors were retained in the final model.

Female household members were more likely to have attended their general practitioner in the year prior to the study than their male counterparts (adjusted OR 1.7, CI 1.3 to 2.2). Household members who did not work or study outside the home (adjusted OR 1.5, CI 1.1 to 2.1) were also more likely to have attended their general practitioner in the previous year than those who were studying or working outside the home. Household members reporting a chronic illness were almost four times (adjusted OR 3.8, CI 2.7 to 5.6) more likely to have attended their general practitioner than those without a chronic illness. Individuals using a hospital service in the past year were three and a half times (adjusted OR 3.5, CI 2.5 to 5.0) more likely to have attended their general practitioner than those not using a hospital service in the same time period.

Uptake of childhood vaccines and child development assessments

Motivation for childhood vaccines is done by public health nurses and subsequently the vaccines are administered at general practice. Primary carers reported that 84% of children aged between two and five years residing in their households had completed the routine childhood vaccines and 82% of these children have had the vaccine to prevent meningitis C (Table 3.27).

Table 3.27 Primary carers' reported vaccination uptake for children aged between two and five years residing in their households

	No.	%
Children's vaccination status		
Started but incomplete	2	16.4
Completed all vaccines	46	83.6
Don't know	3	
n	51	
BCG		
Yes	49	96.0
No	0	00.0
Don't know	2	04.0
n	51	
DPT and Polio 3		
Yes	49	96.0
No	0	00.0
Don't know	2	04.0
n	51	
HIB3		
Yes	49	96.0
No	0	00.0
Don't know	2	04.0
n	51	
MMR		
Yes	48	94.1
No	3	05.9
n	51	
Meningitis C		
Yes	42	82.3
No	5	09.8
Don't know	4	07.9
n	51	

The Area Health Boards notify mothers (in writing) and public health nurses remind mothers to bring their infants, when they are nine months old, for a developmental assessment by the area medical officers. Fifty (98%) mothers reported that they had brought their infant for its developmental assessment, the one individual who did not bring their child for the developmental examination said that they had not received any notification about it.

Community nursing service

According to the primary carers, 27 (3%) household members were in contact with a community nurse as one of the last three services used in the year prior to the survey (Table 3.28). The primary carers reported that 96% of the individuals were satisfied with the service. Among those who were satisfied 17 (70%) individuals stated that they found the community nurse to be courteous and friendly, twelve (50%) said that they received professional care and attention and nine said that the nurse listened to them and explained the treatment possibilities. One person was dissatisfied with the service, stating that the nurse did not listen to him/her. Eleven individuals had been visited by the community nurse four or more times in the previous 12 months, of these, two individuals were visited weekly and one person was visited monthly.

Table 3.28 Primary carers' reported number (%) of the individuals seen by the community nursing service in the year prior to the survey, and their level of satisfaction with services.

	No.	%
Seen by community nurse		
Yes	27	02.8
No	936	97.2
n	963	
Satisfied with care and treatment (1 very satisfied to 6 very dissatisfied)		
Yes (1 to 3)	24	96.0
No (4 to 6)	1	04.0
n	25	

Pharmacy services

Almost all (94%) of the primary carers said that there was a community pharmacy located nearby and the majority (92%) were satisfied with the quality of the service provided at their local pharmacy (Table 3.29).

Table 3.29 Primary carers' reported distance from pharmacy services and their level of satisfaction with their usual pharmacy

	No.	%
Pharmacy located near by		
Yes	306	94.4
No	17	5.3
Never used a pharmacy since I moved here	1	0.3
n	324	
Satisfied with service at usual pharmacy		
Yes	298	92.0
No	15	4.6
No opinion	11	3.4
n	324	

Dental services

The primary carers reported that just under 12% of the population had visited a dentist, as one of the last three services used in the 12 months prior to the survey (Table 3.30). According to the primary carers, 91% were satisfied with the service while 8% were dissatisfied with the service. Among those who were satisfied, the main reason was that the dentist provided good treatment or care (59%). Among those who were dissatisfied, the main causes were incorrect or inadequate treatment (56%) and that the service was expensive (56%). Of those who attended a dentist in the last year, 46% (51/112) attended once, 31% (35) attended twice and 17% (19) attended between three and 12 times.

Table 3.30 Primary carers' reported number (%) of the individuals who visited their dentist in the year prior to the survey, the level of satisfaction with services and their reasons for satisfaction /dissatisfaction.

	No.	%
Visited dentist		
Yes	113	11.7
No	850	88.3
n	963	
Satisfaction with care and treatment from dentist		
(1 very satisfied to 6 very dissatisfied)		
1	53	52.0
2	30	29.4
3	10	09.8
4	3	02.9
5	6	05.9
6	0	00.0
n	102	
Satisfied with care and treatment from dentist		
Yes (1 to 3)	93	91.2
No (4 to 6)	9	08.8
n	102	
Reason satisfied with care and treatment from dentist (n = 93)		
Nearby	17	18.3
Staff courteous and friendly	32	34.4
Short waiting period	15	16.1
Dentist listened to the problem	12	12.9
Dentist explained the condition	20	21.5
Dentist explained the treatment possibilities	25	26.7
Dentist provided good treatment or care	55	59.1
Service easily available on a 24 – hour basis	5	05.4
Pleasant environment	13	14.0
Affordable	5	05.4
Organised appointments	7	07.5
Reason dissatisfied with care and treatment from dentist (n = 9)		
Too far	0	00.0
Staff unfriendly	1	11.1
Long waiting periods	1	11.1
Dentist did not listen to the problem	1	11.1
Dentist did not explain the condition	0	00.0
Dentist did not explain the treatment possibilities	0	00.0
Dentist provided inadequate or incorrect treatment	5	55.6
Service difficult to access outside normal working hours	0	00.0
Unpleasant environment	0	00.0
Expensive	5	55.6
No aftercare	1	00.0

3.10 WAITING FOR HEALTH CARE

Proportion of households with one or more members waiting for health care

According to the primary carers, at least one person in 55 (17%) households was waiting for health care at the time of the survey; six households had two people waiting for health care and one household had three people waiting for health care (Table 3.31).

Table 3.31 Primary carers' reported numbers (%) waiting for health care

	No.	%
On a waiting list for health care		
Yes	55	16.9
No	270	83.1
n	325	
Number per house on waiting list		
None	270	85.8
One person	48	13.4
Two persons	6	0.9
Three persons	1	
n	325	

Proportion of individuals waiting for health care in participating households

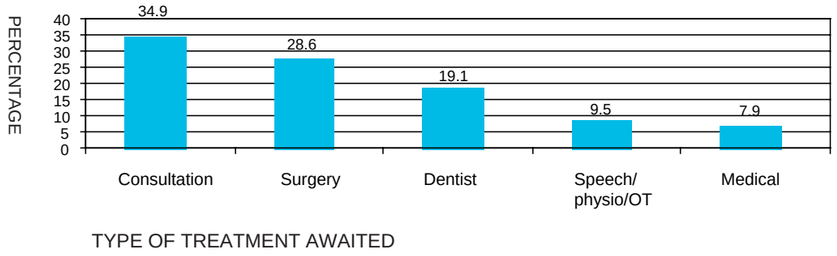
The primary carers reported that 63 (6.5%) of the 963 individuals residing in the survey households were on a waiting list for health care (Table 3.32). This figure was adjusted to take account of the over representation in the sample of the population who lived in low deprivation district electoral divisions compared to the proportion living in high deprivation district electoral divisions and following adjustment, 6.7% of household members were on a waiting list for health care at the time of the survey.

Table 3.32 Primary carer reported number (%) of the individuals residing in the household waiting for health care, length waiting for service, location of service and satisfaction with waiting period

	No.	%
On a waiting list		
Yes	63	06.5
No	900	93.5
n	963	
Length of wait in months		
Less than 3	18	29.0
4-6	16	25.8
7-12	14	22.6
More than 12	14	22.6
n	62	
Area in which service being waited for is provided		
Mater	17	27.0
Beaumont	11	17.5
Temple Street Children's Hospital	7	11.1
Dental Hospital	5	07.9
Health centre	5	07.9
St James Hospital	4	06.3
James Connolly Memorial Hospital	3	04.8
Elsewhere	11	17.5
n	63	
Opinion on waiting time (1 very reasonable to 5 very unreasonable)		
1	9	14.5
2	5	08.0
3	6	09.7
4	14	22.6
5	28	45.2
n	62	

The primary carer reported that, of those who were waiting for health care 35% awaited an outpatient consultation and 29% awaited surgery (Figure 3.13). Almost seven out of every ten were waiting for more than three months. Over two thirds of the primary carers thought that the waiting time was unacceptable (Table 3.32). A similar proportion of household members who were waiting for health care were living in less deprived areas and more deprived areas (26/443, 5.9% versus 37/519, 7.1%, p=0.4).

Figure 3.13 Type of treatment awaited by household members as reported by primary carers (n=63)



Factors associated with those waiting for health care

Bi-variate analysis using six groups of variables (demographic characteristics, socio-economic characteristics, chronic illness, disability, health related behaviours, and health services utilised) indicated that several factors were significantly associated with reported waiting for health care at the time of the survey.

Logistic regression models were constructed to clarify the independent associations between the significant variables and the likelihood of reported waiting for health care at the time of the survey (Table 3.33). The relationships presented are those that remained statistically significant or were deemed clinically important after taking account of confounding. The associations are expressed as odds ratios adjusted for confounding.

Table 3.33 Logistic regression model to identify determinants of those waiting for health care in the Finglas population (63/963)

	Total	Awaiting health care	Proportion %	Adjusted Odds ratio (95% CI)	p-value
Used a hospital service in the 12 months prior to the survey					
No	635	26	4.1	1	
Yes	319	37	11.6	2.4 (1.4 to 4.2)	0.002
Missing	9				
Whole model $\chi 2$=271, p<0.0001					

The initial model included variables significant at the 0.05 level and these were: chronic illness status, used a hospital service in the 12 months prior to the survey and attended a GP in the 12 months prior to the survey. Significant factors were retained in the final model

Household members using a hospital service in the year prior to the survey are twice (adjusted OR 2.4, CI 1.4 to 4.2) as likely to be awaiting health care than those not using hospital services in the same time period.

3.11 PRIMARY CARERS' SOURCES OF HEALTH INFORMATION

According to the primary carer, the most important sources of health information were the general practice (including the receptionist, nurse and general practitioner), family or friends, followed by leaflets (Table 3.34).

Table 3.34 Primary carers' reported sources of information on health (n=324)

	No.	%
Source of information on health services n=324		
GP/pharmacist	154	47.5
Family/friends	74	22.8
Health centre receptionist	59	18.2
Health information leaflet	45	13.9
At work, school or college	22	6.8
Television	19	5.9
Newspapers	19	5.9
Public health or community nurse	16	4.9
Other community based service providers	15	4.6
Internet	13	4.0
Telephone/help lines	11	3.4
Radio	10	3.1
Practice nurse or hospital nurse	4	1.2

3.12 PRIMARY CARERS' SUGGESTED ADDITIONAL HEALTH SERVICE NEEDS

Seventy percent of primary carers identified additional health service needs in the area. Table 3.35 presents the suggested enhanced or new health services and facilities required. Eighty-three primary carers (36%) requested one or more services for the elderly. These included additional day services (26%), long term care (25%), respite services (20%) and almost seven percent of the carers requested home visits for the elderly.

Eighty-one primary carers (35%) suggested that the 'out of hours' general practitioner services be reorganised. They suggested that this service be located either in accident and emergency (18%) or be attended by a general practitioner from a group practice in the area (17%) (rather than the currently utilised radio-doctor facility).

Sixty-eight primary carers (31%) suggested services to promote 'a healthy lifestyle' in the form of well woman, well man, well child clinics and student health clinics. Forty-seven (21%) primary carers specifically requested services dedicated to adolescents, 28 respondents said there was a vital need for psychological support for this age group and 40 respondents requested contraceptive advice for teenagers. Overall, 37 (16%) of primary carers requested counselling and/or psychological services.

Table 3.35 Additional health care services suggested by primary carers

	No.	%
Additional services needed		
Yes	229	70.7
No	54	16.7
Do not know	41	12.6
n	324	
Suggested additional health services (n=229)		
Day care services for the elderly	59	25.8
Long term care for the elderly	57	24.9
Respite services for the elderly	47	20.5
Home services to support elderly in independent living	15	06.5
GP in accident and emergency	42	18.3
Out of hours local GP service	39	17.0
Improved general practitioner service	16	07.0
Free primary care for all	30	13.1
Free primary care for children	8	03.5
Clinic specially to promote women's health	54	23.5
Clinic specially to promote men's health	47	20.5
Clinic specially to promote child health	46	20.1
Clinic to support student health	2	00.9
Contraceptive advice for adolescents	40	17.7
Psychological services for adolescents	28	12.2
Psychological services for children	2	00.9
Counselling service	16	07.0
Enhanced dental services	26	11.3
Enhanced drug/alcohol services	14	06.1
Drug rehabilitation service	2	00.9
Enhanced public health nurse service	13	05.7
Enhanced occupational therapy service	7	03.0
Enhanced social work service	5	02.9
Enhanced physiotherapy service	4	01.7
Enhanced speech and language service	4	01.7
Enhanced services for the disabled	4	01.7
Enhanced mental health services	3	01.3
Chiropody	5	02.9
Complementary health	4	01.7
Services for the homeless	2	00.9
Ophthalmic service	1	00.5
Accessibility to health services		
Information on local health services	19	08.3
Locally based health centre	8	03.5
Improved local bus services	5	02.9
Secondary care		
Improved hospital based care and reduction of waiting lists	59	25.8
Improved maternity services	1	00.5

DISCUSSION
PART 1

The high response rate indicates a high level of interest in health in the Finglas area. The researchers noted that the respondents were very willing to participate in the survey and were keen to offer their opinions about the health services and the health service needs in the area. There were similar response rates in the areas classified as high deprivation and low deprivation.

Finglas has a larger proportion of individuals aged 65 years and older than the proportion living in the total Eastern Regional Health Authority area (16% versus 10%).[9] The higher proportion of older people is also reflected in the proportion of the population requesting services for the elderly, with 36% of the primary carers requesting community services and/or additional institutional services for older people. When the suggested additional services for the elderly were further analysed, it was clear that older people (and indeed their carers) wanted to be supported to live in their own homes for as long as possible.

The population living in Finglas is less mobile than the populations living in either Tallaght or the Docklands.[3 6] For example, 25% of the population in Finglas moved into the area in the last ten years compared to 33% who moved into Tallaght and 50% who moved into the Docklands in the same time period.

Outright home ownership is higher in Finglas (44%) than in either Tallaght (21%) or the Docklands (25%) indicating a relatively stable (long term) population.[3 6] Forty-six percent (62/142) of the primary carers aged 65 years and over owned their own home and although this is desirable for older people, it has implications in terms of upkeep, repairs and maintenance. Several older respondents mentioned that their sons or daughters, who wanted to live in the Finglas area, were unable to buy or rent a house in the locality due either to cost or availability. This reduces the ease with which younger (or middle aged) family members could possibly support their older relatives, which results in older people feeling isolated, reduces opportunity for family support in the home environment and indeed has implications for the work loads of health service providers in Finglas.

At all stages of this investigation, people mentioned that personal security was a major problem in the area, particularly for older people. The recent RAPID report describes the various types of crime (burglary and anti-social behaviour) commonly perpetrated by individuals in the Finglas area and this supports the fears of intimidation or injury expressed by community members participating in this survey, in particular the elderly.[10] It is important to note that the proportion of primary carers (12%) reporting experience of violence or intimidation in the year prior to the survey was similar to proportions in both Tallaght (10%) and the Docklands (11%) which implies violence is a problem in urban areas of Dublin.[3 6] In all three surveys a high proportion of respondents sought medical care (Finglas 32%, Tallaght 23% and the Docklands 33%) following a violent incident. This highlights two factors, first that the violence experienced resulted in injury and secondly that violence is a health care issue.

A higher proportion (30%) of people living in Finglas had a chronic illness than the proportions in either Tallaght (22%) or the Docklands (27%).[3 6] Respondents reported higher utilisation of general practitioner services in Finglas (58%) than the proportions reported in Tallaght (38%) or the Docklands (47%), which indicates a high level of dependency on community based services. The high proportion of older people living in Finglas, and of these, the high proportion with a chronic illness (66%) may partly explain this excess utilisation.

The proportion of respondents (39%) with private health insurance in Finglas is lower than the proportion (45%) for the Irish population as a whole.[11] For those less than seventy years old, the medical card is a good indicator of economic status as it is means tested. The proportion (35%) of the population in Finglas with a medical card is similar to the national coverage rate (32%),[11] but higher than the average for the Eastern Regional Health Authority area (26%),9 indicating that poverty is concentrated in specific geographical areas of this region. One quarter of the households in Finglas have neither private health insurance nor a medical card indicating a sizeable minority dependant on their own resources for primary health care. Of note, the proportion (26%) without either private health insurance or a medical card was higher in the Finglas area than in the Docklands (12.5%) and lower than in Tallaght (37.5%)[3 6.]

Interestingly, in both Finglas and Tallaght a considerable proportion had availed of adult education opportunities (9% and 15% respectively).[3] However, similar high proportions of primary carers living in both Finglas (40%) and Tallaght (36%) reported that they had not completed primary education though these are lower than the proportion of respondents who had not completed primary education living in the Docklands (50%).[3 6] The level of educational attainment for people living in Finglas has implications in terms of written communications, development of health education materials and indeed clinical consultations.

In both Finglas (49%) and the Docklands (49%), similar proportions of households had at least one person who smoked cigarettes.[6] Although lower than Tallaght (69%), this indicates considerable levels of passive smoking.[3] Among household members 18 years old or over, 28% smoked, which is just below the national figure for cigarette smoking (28% versus 31%).[12]

The proportions reporting alcohol or drug misuse across all three surveys (Tallaght 2%, the Docklands 1% and Finglas 1%) are lower than expected.[3 6] We are of the opinion that alcohol and drug related problems were under reported to our researchers by respondents in Finglas, as health and social issues relating to substance misuse were frequently raised by primary carers. Also, two of the individuals for whom a cause of death was provided indicated that the two deaths were related to drug or alcohol misuse. Furthermore, several of the primary carers requested extended alcohol and drug services and two primary carers specifically discussed the need for services for people who have become homeless as a result of their substance misuse.

Stress has been identified as a factor, which can negatively affect one's sense of physical or mental well being.[13] Almost two thirds of primary carers (63%) reported experiencing stress in the year prior to the survey. This was similar to levels reported in the Tallaght (59%) and the Docklands (53%) surveys.[3 6] In Finglas the majority acknowledged experiencing negative consequences of stress such as, anxiety, insomnia and depression. These symptoms can have a negative impact on an individual's general health.

In all three surveys the primary carers cited family related issues as the main source of stress. As in the two previous surveys,[3 6] the majority (67%) sought help from family or friends to relieve the stress and 40% sought help from their general practitioner. Interestingly, more individuals (16%) sourced alternative medical treatments to relieve stress in Finglas than in either Tallaght (10%) or the Docklands (3%). However, as in the previous surveys there is little other evidence of community based non-pharmacological support for stress. This highlights the need for health service providers to provide and promote alternative methods of stress management.

The teenage population in Finglas is large and is a major source of stress for parents, the majority of whom are concerned about physical violence and substance misuse problems. According to anecdotal evidence there has been a number of tragic deaths among young males in the Finglas area. The impact of these deaths on the young people living in the area is a source of concern for all community members in particular the parents of teenagers. Psychological and counselling support services for young people were identified as additional services required todeal with these issues in the area. The apparent high rate of young male deaths has already been identified by the Northern Area Health Board to be a concern and a report has been commissioned which is due to be published shortly.

Primary carers who were parents of children aged between two and five years were asked about their children's immunisations. Although numbers are small, vaccine uptake rates in Finglas were reported to be higher than those quoted by the National Disease Surveillance Centre from the Regional Interactive Child Health System (84% versus 70%).[14] The respondents in Tallaght (82%) and the Docklands (96%) also reported higher vaccination completion rates.[3 6]

Interestingly, many respondents requested the provision of additional clinics to promote health for men, women and children. This suggests that the community would be receptive to meaningful local community based health promotion. The Finglas survey indicates that health promotion campaigns have had a positive impact in the area. For example, a higher proportion of women had taken peri-conceptual folic acid (63%) than in Tallaght (28%) and the Docklands area (38%).[3 6] A higher proportion of women aged 52 to 66 years, who were within the BreastCheck age criteria when Finglas was targeted in 2000, had a mammogram (41%) in the five years prior to the survey than their counterparts in the Docklands (29%).

The new primary care strategy states that primary care needs to become the central focus of the health system. [1] It aspires to an integrated community based service, which can lead to better outcomes, improved health status and increased cost effectiveness. In order to fulfil this vision, it acknowledges that primary care must be readily available to all people regardless of who they are, where they live, or what health or social problems they have. [1]

This report contains a wealth of information regarding the health needs in the Finglas area. We hope that the information will be used to advocate for the provision of appropriate and, where needed, additional health services to address the health needs of the Finglas community. These services should be available to all those living in the area, thus enhancing and improving their sense of health and well being.

REFERENCES

1. Department of Health and Children. Primary Care - A New Direction. Dublin: Stationary Office, 2001:34.

2. Small Area Health Research Unit. A National Deprivation Index for Health and Health Services Research. Dublin: Department of Community Health and General Practice, Trinity College, 1997:49.

3. Department of Community Health and General Practice. People living in Tallaght and their Health, A community based cross-sectional study. Dublin: Trinity College, 2001.

4. Lemeshow S, Robinson D. Surveys to measure programme coverage and impact: a review of the methodology used by the expanded programme on immunisation. World Health Statistics Quarterly 1985;38:65-75.

5. Primary Healthcare Management Advancement Programme. Assessing Community Health Needs and Coverage. Geneva: Aga Khan Foundation, 1993.

6. Department of Community Health and General Practice. People living in the Dublin Docklands and their Health. Dublin: Trinity College, 2002.

7. Sall J, Lehmen. A. JMP Start Statistics: Version 3.2. Belmont New York: Duxbury Press, 1996.

8. STATA Corporation. Reference manual - STATA release 3.1. 6 ed: College Station, 1993.

9. Department of Public Health - Eastern Region. Public Health at the turn of the century. Dublin: Eastern Regional Health Authority, 2000:6.

10. Finglas Area RAPID Implementation Team. Baseline Action Plan for the Finglas RAPID Area 2001-2003. Dublin: Department of the Enviornment and Local Government, 2002.

11. Watson D, Williams J. Perceptions of the Quality of Healthcare in the Public and Private Sectors in Ireland. Dublin: The economic and Social Research Institute, 2001.

12. Freil S, NicGabhainn S, C Kelleher. The National Health & Lifestyles Surveys. Dublin: Health Promotion Unit, Department of Health and Children, 1999:20.

13. Friel S, NicGabhainn S, Kelleher. C. The National Health & Lifestyles Surveys. Dublin: Health Promotion Unit, Department of Health and Children, 1999:14-15.

14. Fitzgerald M, O'Flanagan D. Immunisation uptake statistics for Ireland, Quarter 1. Dublin: National Disease Surveillance Centre, 2002.

PEOPLE LIVING IN FINGLAS AND THEIR HEALTH

The health needs of people living in Finglas area

PART 2 THE HEALTH SERVICE PROVIDERS' PERSPECTIVE

Jillian Deady
Frances O'Keeffe
Jean Long
Tom O'Dowd

Summary

The main research findings are presented in this summary. More detailed findings are available in the results section.

What we set out to do

We set out to gain a better understanding of the health needs and the current service provision in the area from the health and social service providers' perspective. We also explored the participant's perceptions of co-ordination and teamwork amongst service providers and sought suggestions on how to facilitate the primary care team to work together effectively.

How we conducted the study

We obtained permission from the General Manager of Community Care Area 6, in the Northern Area Health Board to contact the senior manager of each health service discipline within the health board. We contacted persons employed in private practice individually. We informed service providers about the study and asked them to discuss with their colleagues the health needs in the area. We sent them a topic guide to assist with their discussion. We requested that they nominate a colleague from their discipline who would be willing to be interviewed on their behalf.

Twenty service providers agreed to participate. They represented a broad spectrum of health and social service providers in the community including dentist, doctors, nurses, pharmacist, therapists and other staff including those involved in care of the elderly. We collected the information through taped semi-structured interviews.

What we found

The results are presented under three broad categories: the health issues in the community; services and resources available or required in the community, and co-ordination and teamwork in the area.

The health issues in the community

The health service providers were asked what were the main health issues in the area. The responses were allocated into one of three categories: physical, mental and social.
The respondents reported that:

- The physical problems covered a broad spectrum of diseases affecting all age groups, though older people were more likely to have chronic illnesses.
  - The main problems were respiratory diseases, cardiovascular conditions, arthritis, diabetes and terminal illness. In addition the elderly experienced decreased mobility, increasing frailty and chronic leg ulcers.
- Depression was the main mental health problem among people in Finglas and this affected both young and old.
  - The main factors associated with depression were bereavement, loneliness, isolation, fear of assault and social deprivation.
- Overall the main social issues that had an impact on the health of the community were: the effects of substance misuse (including associated crime); increasing loneliness and isolation; fear for personal safety; and factors associated with social deprivation such as poor housing and inadequate nutrition.

Services and resources in the community

The health service providers were also asked to elicit the main barriers or difficulties they experienced in delivering their service, to suggest methods on how to improve existing services and to identify additional services required.

The main barriers described were insufficient staff, difficulties encountered in attempting to access other health services and long delays waiting for hospital consultations. Problems in the health centre facilities; inadequate privacy for clients and a lack of adequate administrative staff, were other barriers to effective service delivery.

SUMMARY - PART 2

Respondents were asked what resources were required in the area. Most of the respondents stated they did not have enough resources and reported the need for:

- More staff within their own specific service and within other services.
- Expanded services for the elderly including additional local day care and respite facilities, extension of the meals on wheels service and increased access to the personal security schemes.
- Facilities for parents of young children,
    - for example, a family resource centre where parents are supported and child centred services are based.

Respondents were asked for suggestions on how to improve services. Apart from the many resources already mentioned the main suggestions were:

- Improve formal communication between disciplines so as to improve teamwork.
- Incorporate more health promotion and prevention activities in their daily work.
- Collate information on the different services available in the area and disseminate the information to both service providers and service users.
- Provide ongoing training and further education for service providers to ensure they continue to provide a good service.

Co-ordination and Teamwork in the area

The respondents were asked to discuss the level of co-ordination amongst service providers in the area. Most of the respondents said that there was some level of co-ordination (ranging from good to poor) in the area.
They reported that:

- There was no formal structure for communicating within the health services and most co-ordinating occurred on an informal basis.
- Communication was mainly by telephone with very little 'face to face' meetings with the other disciplines.
- The level of co-ordination depended on the inter-personal skills of the individuals working within the different disciplines and how long they had worked in the area.
- The service providers worked in isolation and this negatively affected the delivery of the service.
- Respondents said that there was poor integration of health services and poor co-ordination between the acute hospital services and the community health services.
- Co-ordination was generally much better if the services were in close proximity to each other.

Respondents were asked to give suggestions as to how the primary care team could work better for the community. The majority of the participants made very positive suggestions and displayed a great willingness to work together.
The respondents suggested that:

- The community need to be guaranteed that high quality of care can be delivered through the primary care services.
- The service providers should be trained and supported to facilitate effective inter-agency co-ordination.
- It was important to have structured team meetings and good communication between the different public and private service providers.
- The service providers needed to be based within a geographical area.
- Knowing the individuals in the team and using information technology would improve communication.

Conclusion

The service providers were very positive about the value of different disciplines working together as a team, a philosophy which is endorsed in the primary care strategy. They displayed a willingness to facilitate a team approach to primary health care in order to enhance the health care service for the people living in the Finglas area.

METHODS
PART 2

Methods

1.0 INTRODUCTION

In November 2001, the Northern Area Health Board commissioned a study to investigate the health needs of the people living in the Finglas area. The Department of Community Health and General Practice, based at the Trinity College Centre for Health Sciences, Adelaide and Meath Hospital, Dublin, incorporating The National Children's Hospital, was requested to undertake the study.

The first part of the study consisted of a household survey in the community and the results are presented in Part 1 of this report. During January and February 2002, the service providers were contacted and informed of the household survey. They were also invited to participate in a study to ascertain the needs from the service providers' perspective. Representatives from the different disciplines within the health services were interviewed prior to commencement of the household survey.

1.1 AIM

The study set out to gain an understanding of the health needs and the current service provision in the area from the health service providers' perspective. The research also sought to explore the participants' perceptions of co-ordination and teamwork amongst service providers and sought suggestions on how to facilitate the primary care team to work together effectively.

1.2 RESEARCH DESIGN

Given the importance of exploring the service providers' understanding and experiences from their own perspectives this study employed a qualitative methodology, using a grounded theory approach.

Grounded theory is a method of collecting and analysing qualitative data with the aim of developing theories that are grounded in real world observations. The goal of grounded theory is to provide a description or an explanation of events as they occur in reality, and not just as they have been perceived anecdotally.

The information was collected through a semi-structured in-depth taped interview. The semi-structured interview is used when the researcher knows the type of questions to be asked but cannot predict the answers. This approach was chosen as it ensures the researcher obtains the information required while at the same time permitting the participants' freedom to describe their experiences and understandings in their own words.

1.3 STUDY POPULATION

In studies employing a grounded theory approach individuals are chosen based on their knowledge and expertise of the research topic. In this study the population consisted of the health service providers within the Finglas area.

1.4 SAMPLING

The selection of an appropriate and adequate sample is crucial in qualitative research.[1] The process of purposeful sampling selects individuals for inclusion based on their knowledge of the research topic. For this study a purposeful sample of health service providers within the study area was chosen. Between 15 and 20 participants were deemed necessary to achieve maximum saturation.[2]

1.5 FIELDWORK

Permission was obtained from the General Manager of Community Care Area 6 to contact the senior manager of each health service discipline within the area. Persons employed in private practice were contacted individually. All the personnel contacted were informed about the study and asked to discuss with their colleagues the health needs in the area. A topic guide was sent to the respondent prior to the interview (Appendix 6). They were asked to nominate a colleague who would be willing to be interviewed on behalf of their discipline.

The participants who agreed to be interviewed were contacted by phone to arrange the interview. The researcher allowed full flexibility regarding the time of the interview and each interview was held at the service provider's workplace.

The interviews took place between the 31st January and the 26th February 2002. A total of 20 health service providers were interviewed. The interviews lasted between 20 and 50 minutes with most lasting approximately 30 minutes. Prior to commencing each interview a full explanation of the research was given to each individual participant. The researcher reassured the participants about confidentiality and anonymity. Participants were then invited to sign a consent form, indicating their voluntary participation in the study (Appendix 7). Participants were also made aware of their freedom to withdraw from the interview at any time.

Each interview started with a general introductory question. A topic guide was used to probe the areas of interest (Appendix 6). As the interview progressed the researcher asked the participants to clarify issues that emerged during the interview process. In order to ensure that the researcher would not influence emerging data, the interviewer refrained from offering opinions or answering questions during the course of the interview. Notes were taken at the end of the interview in which the researcher recorded personal reflections on the interview.

1.6 DATA ANALYSIS

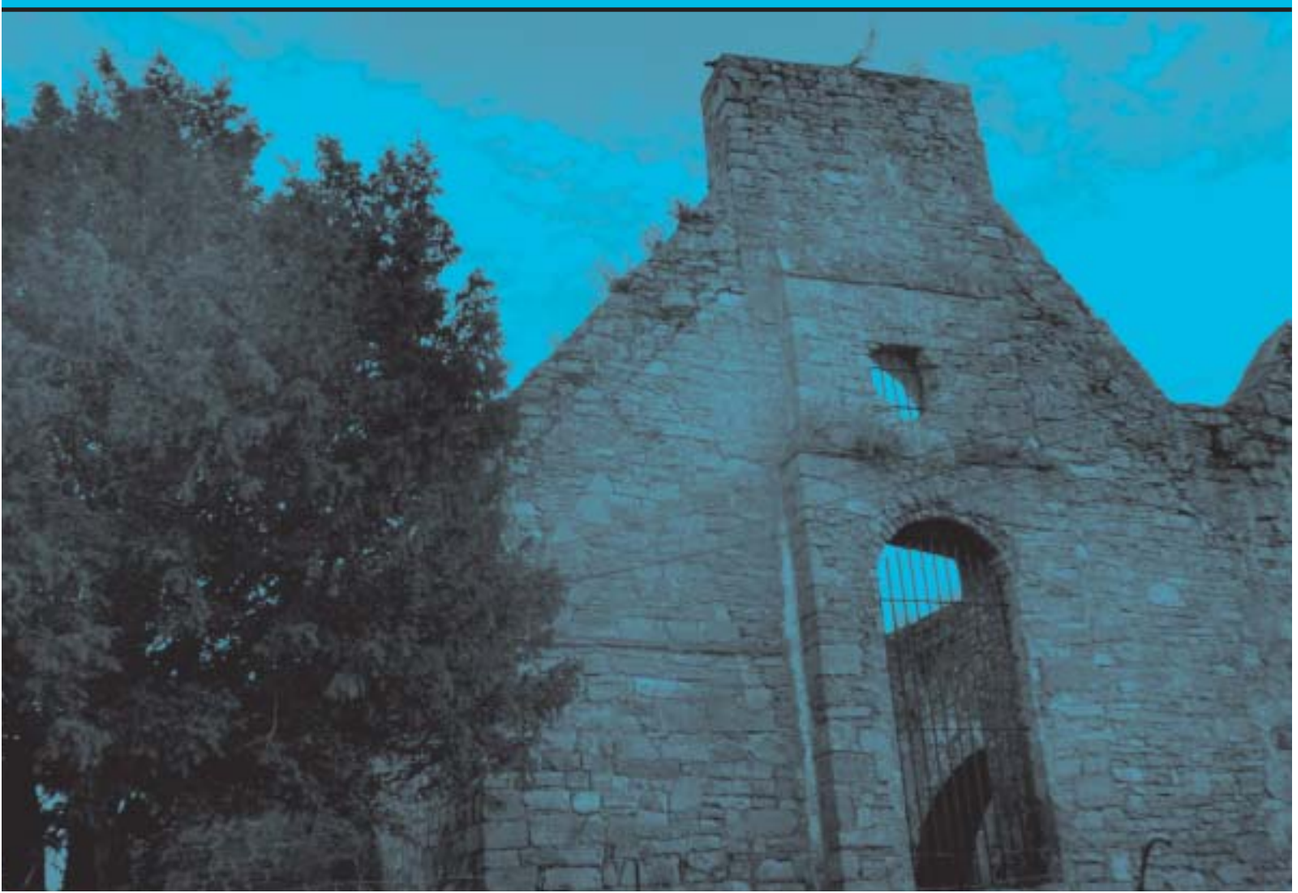
All interviews were transcribed verbatim. Silverman's transcription symbols were used to indicate information on pauses and gaps, as well as comments in brackets (Appendix 8). The researcher read the transcripts while listening to the tapes. This served to improve familiarity with the data collected and helped to verify accuracy of transcriptions.

Five interviews were analysed manually through detailed scrutiny of the transcripts to identify common concepts and these were coded. The coded transcripts were reviewed by JL and FO'K (an experienced researcher and a research fellow respectively) to ensure the interviews were coded correctly.

All the interviews were then coded using a qualitative research software programme 'Ethnograph' and subjected to analysis. Similar concepts or codes were then grouped together. A number of categories and sub categories were identified in the study.

A copy of the findings was sent to five of the participants. They were asked to read through the report and to comment on whether they felt it accurately represented their views. This was done to enhance the credibility of the study.

RESULTS
PART 2



Results

2.0 INTRODUCTION

Twenty health service providers were interviewed, six of whom were male. They represented a broad spectrum of health and social service providers in the community, both health board staff and independent practitioners. These included dentist, doctors, nurses, pharmacist, therapists and other staff including those involved in care of the elderly.

Participants were asked how long they had worked in the area. On average the health service providers interviewed had worked for over six years in the area (ranging from four months to 25 years). Half of the respondents had worked in the area for three years or more.

The health service providers' experiences and recommendations are presented under three broad categories:

- the main health issues for people living in Finglas;
- the current health services and the resources required to respond to the people's health needs;
- the level of co-ordination and teamwork among health service providers in the area.

2.1 THE HEALTH ISSUES IN THE COMMUNITY

The health service providers were asked what were the main health issues in the area. The responses are presented in three categories: physical, mental or social.

Physical problems

According to the health service providers, the most common chronic illnesses included respiratory problems (affecting young and old), cardiovascular problems, arthritis, diabetes, physical disabilities (including multiple sclerosis, spina bifida and cerebral palsy) and the problems associated with the care of patients with cancer and terminal illness.

A quarter of the respondents (5) specifically mentioned the impact of smoking on the physical health of the community.

'…the most common kind of physical things would be….ultimately the wages of smoking….chronic obstructive airways disease, coronary heart disease and then all the other ramification' (HSP 12)

Many respondents (11) spoke about health problems associated with older people resulting in decreased mobility, increasing frailty and a reduced ability to care for themselves. The common conditions among the elderly included arthritis, chronic obstructive airways disease, chronic leg ulcers and cancer.

The respondents raised women's health as a health need in the area. In particular they mentioned problems relating to reproductive health and the lack of appropriate locally based health screening facilities. According to the respondents, young children had problems relating to speech, hearing and dental caries. Some respondents (4) said that poor nutrition contributed to ill health within the community.

Mental health problems

Over half of the health service providers (11) said that depression was the most common mental health problem in the area. According to most of the respondents the prevalence of the major psychiatric diseases was no greater in Finglas than in other parts of the country.

'I wouldn't say I have any more other kind of mental illnesses than you get across the board, elsewhere, you know' (HSP 12)

Health service providers said that depression and anxiety affected people of all age groups in the area.

'Depression and anxiety really is up there….it is probably the commonest its definitely a mental health issue….across the age groups, young and old' (HSP 6)

'…elderly people living alone, poorly supported ….so I'd say depression is the primary mental health problem' (HSP 13)

'The most common mental health problem is, I'd say top of the list would be depression and a lot of poor social problems, housing, substance abuse' (HSP 19).

'…people who are depressed….most are single people….not really aged. You have some like would be fiftyish' (HSP 5)

Respondents also said that bereavement was a source of anxiety for all ages in the community and in particular, the tragic deaths of a number of young men in the area. This was seen as a source of depression and anxiety for the whole community.

The respondents (2) highlighted the incidence of depression among young mothers, including postnatal depression.

'…in general depression and just anxiety, stress, they would be the main things, I mean again, very young mums, a lot of children, not a lot of money' (HSP 16)

Loneliness and isolation was said to be another cause of depression and anxiety.

'…with the elderly, the most common problems would be like loneliness, isolation….which results in depression' (HSP 15)

A number of respondents (5) also said that dementia was a mental health problem commonly encountered in the area. According to the respondents, people with this condition were inadequately supported due to a lack of facilities and the poor support services for their carers.

'…there is a big lack of services for Alzheimer's patients in the area and they cause a lot of problems at home, you know, and with the carers….its very hard you know, because they are the same age group and you know, if they're getting on a bit it's, it's hard, It's very hard for the carer' (HSP 9)

In general respondents said that ill health and socio-economic factors also contribute to poor mental health.

'…where they have ill health and depressed as well….because they have no support financially or practically' (HSP15)

'…there is a lot of misery….you get a lot of depression….if the person was in better surroundings they wouldn't be depressed' (HSP 13)

Social problems

All the health service providers mentioned that deprivation and social issues had an impact on the health of the community. The service providers described a clear association between substance misuse, social isolation, loneliness, deprivation and ill health.

Alcohol and drug misuse

Respondents described the effect of alcohol (8) and drug misuse (6) not only on the individual but also on the family and the community at large. The lack of services for those with an alcohol addiction was stressed.

'…people forget about alcohol, alcohol causes a lot of problems in the area….alcohol abuse is ubiquitous ((ever present)) and I think certainly in areas which are less deprived that people are able to cope with alcohol abuse better….alcoholism is universal, it's spread through, right throughout the community but I think in a disadvantaged area, those who abuse alcohol, well I think there are going to be more who have a serious problem with it and I don't think the services are there for them' (HSP 17)

'The mental health problems, I get, there's a lot of alcohol and substance abuse in this community. And whether there's just treating their own depression or whether this is, you know what happens in a deprived community anyway goodness knows' (HSP 12)

'…the younger population definitely seems to be more drugs orientated but the older population…a lot of women and men would be alcoholics….I see the consequences of that' (HSP 16)

'…what we mainly come across is, its like people with cross addictions, where they have a heroin addiction and also have developed an alcohol addiction….and that is where the problem lies ….trying to access alcohol services or treatment for their alcohol addiction while trying to treat their heroin addiction….the clients….may come from a background where there has been a background of addiction, a lot of the time it is alcohol addiction….there's a whole kind of cohort of, of addiction in the family' (HSP 4)

Loneliness and isolation

Respondents described loneliness and isolation among members of the community. According to a number of respondents (8), the elderly are often isolated and lonely. This is mainly as a result of inadequate family support. The respondents said that families were busy and generally lived a long distance from their elderly parents thereby reducing opportunities for support.

'I think a big thing for the elderly….they can feel quite isolated….because families are very busy these days you know. They don't really have the same time to, to come, so I think loneliness is a big problem' (HSP 10)

'…a lot of those elderly live alone, they've very little support and getting access to support structures can be difficult….gone are the days where there are families around to look after these people' (HSP 18)

A health service provider said that loneliness was also associated with marital problems.

'…certainly the homeless problems is something that raises it's head regularly, with people coming in, even in people, shall we say who have marital difficulties, the man is, whose, the house he's left out on his own it can cause depression and the isolation of having to follow that kind of thing and will probably end up in the service' (HSP 19)

Social deprivation

A number of respondents (6) spoke about the effect of poverty or deprivation upon the health of a community. Issues such as low income, poor nutrition, housing problems were mentioned.

'It's (there is) full range of reasons why people would be unwell but nearly all of them link back to the fact that they are living in poverty or very close to poverty' (HSP 16)

'…men wreck themselves so much and particularly working class men, you know, they're just not good at caring for themselves or they think they should cope but they don't go to the GP….((they)) have had a tougher life in Finglas, generally, they've had hard working lives and I just feel that there's a whole kind of quality that is missing' (HSP 2)

'…there's a problem and it is getting worse over the last couple of years…lone parents are on the waiting list for housing for longer periods, and in some cases you have two or three generations living in one house…there is a lot of overcrowding' (HSP 10)

Personal safety and security

According to the health service providers (5) the community are also concerned about security, in particular the elderly are anxious about their personal safety and security. Respondents reported that some elderly were at risk of becoming socially isolated because they are afraid to go out alone. The incidence of crime in the area was mentioned as a problem for the community. The events mentioned included recent murders, anti-social behaviour and the high level of house burglaries.

'I suppose we get strange things in Finglas…we've had three shootings, three murders since December ((in seven weeks))' (HSP 14)

'Another thing that would have come up would have been security, in the sense that people feel, don't always necessarily feel safe in their own homes, I don't think they do, and a lot of them have been broken into of late, so in the last two months there's been at least sixty-five houses broken into in Finglas' (HSP 1)

'Because of their (the elderly's) fear, because of their own personal safety. And that would be a problem, now you definitely would notice that getting more, you know. Like they'll go ((out)) if they, kind of they can go together in groups or get taxis, or get a lift. Maybe one of the family takes them or whatever' (HSP 10)

What occupies most of your time?

Health service providers were asked what occupied most of their time. Some of the respondents (5) said that they spent their time working on their designated workload. Many highlighted the aspects of their workload that consumed most of their time, for example, care of the elderly (9), and dealing with people with chronic health problems (4). However, over half of the respondents (11) reported that a lot of their time was spent handling social problems, which though not specifically within their job remit, impacted on the health and well being of their client.

'…really, I spend an awful lot of time dealing with social problems believe it or not….it takes time and you're not getting anywhere with them unless you actually listen to what they have to say' (HSP 12)

According to some of the respondents (6) a high proportion of their time is spent referring clients to other services and following up the referrals. Respondents noted that a significant proportion of their time is spent trying to secure access to services for clients, especially if these services have long waiting lists.

'…we find then we end up chasing up a lot of referrals for various different reasons and it is always us that people come back to because they just don't have that connection with any other service' (HSP 7)

'…trying to organise services for people you know like completing forms and things ….like there is a lot of paperwork in organising, referring to all the different services. The problems you come across is they tend to have long waiting lists' (HSP 10)

'…((following up referrals)) involves having to browbeat, cajole, work the system, almost pull a stroke, ring colleagues and try and get a favour from them' (HSP 17)

2.2 SERVICES AND RESOURCES IN THE COMMUNITY

The health service providers were asked about the adequacy of services in the area, to suggest methods to improve existing services and to identify additional services required.

Barriers to effective delivery of services

The respondents were asked what were the main barriers or difficulties they experienced in delivering their service. The main issues raised were: staff shortages; the accessibility and availability of health services both in the primary and secondary care areas; and social deprivation.

Staff shortages

Almost half of the respondents (9) said that staff shortages and frequent staff changes both within their own service and in other services was the main barrier to effective service delivery in the area. Low staffing levels was said to impact negatively on staff morale and result in more staff leaving the area.

'…I just feel that we are snowed under, you know, and it is not great for morale' (HSP 11)

'…people (staff) were leaving over stress because we had hundreds of people on the waiting list….it is actually appalling at the time and it is so appalling that one of the staff left, he felt it was too stressful a situation to work in' (HSP 2)

Some respondents said that inadequate numbers of staff resulted in a lowering of the quality of the service being delivered.

'…that means we are doubling our cases….the girls feel it is unmanageable, it's not, you know, you're just tipping the iceberg….you're not doing any, it's impossible to do any health promotion or any initiatives or anything because you're too busy doing, catching up every day' (HSP 15)

'Getting local GP's ((involved in the drug service)) is a huge issue because if we had more local GP's on board, we would be able to take the clients who are stabilised out of the clinic's, you know' (HSP 4)

Accessibility and availability of health services

The respondents' spoke about the difficulty they encounter in trying to refer clients to other health service providers both in the primary and the secondary care service areas.

'…it can be difficult at times, you know, when you refer people to the different services and people don't communicate back with you of whats available or how long they're going to be waiting or whatever' (HSP 10)

'…given that people have problems and given that they've come to the doctors and their problems are identified….there is definitely a difficulty in accessing services to try and alleviate or correct these problems and we, it comes back to the question of we have a very clear and distinct two-tier health care system in this country and it permeates every aspect of the health service….for the bulk of people here who don't have health insurance cover or who aren't financially independent or both, they are at a decided disadvantage' (HSP 17)

According to respondents (7), the long delays encountered waiting for hospital consultations was a barrier to service delivery. This delay can have negative implications for the clients, their families and the community at large.

'…for the respite centres locally you have to have had your geriatric assessment ….but at times they ((families)) are very tired and maybe even while they're waiting for a geriatric assessment the family are worn out or whatever…they just need that, you know, that leeway of having something in a hurry' (HSP 10)

Premises and local facilities

Respondents (4) reported problems with either the physical structure of the health centres or their accessibility using the public transport system.

'I suppose the health centre is very, very busy. There is no real spare rooms….so not having a spare room can be a problem, if you want, you know, if somebody comes in….and they need a room to talk' (HSP 14)

'…our building structure could do with a huge improvement….the building is antiquated there is no music that a person could listen to even though they could be waiting for up to three hours….structurally the building is cold, the people complain of the cold while sitting there' (HSP 19)

'…we would do a lot of house calls to our elderly and it's mostly because they can't get down, it's not that they physically need me to go up but it's, they've no one to drive them down, they have no one to bring them down….it ((transport)) is a problem' (HSP 6)

Some spoke about the need to reduce the amount of what they perceived to be unnecessary paperwork.

'…again we'd like to have somebody even, at least two days a week who'd come out on-site and do things for us, because, you know, you do waste a lot of time photocopying because, you know, the nature of our work you've to give children photocopies and homework and everything, so you have a lot of time that, you know, could be spent on more client contact, that is wasted on admin' (HSP 8)

'…we have to reduce the work load of nurses and doctors in regard to things which are ridiculous, like for example writing ridiculous letters' (HSP 18)

Barriers within general practice

Respondents within general practice (5) spoke of barriers within the primary care system from their perspective and some (3) spoke of feeling somewhat isolated from the health services in general.

'I feel very isolated here, you see, and because of my isolation, I don't even get a good feel for what services are out there, I wouldn't pretend to be for a minute, an expert in what services I can get' (HSP 12)

'You see we have very little to do with the additional services. Because we have very little to do with them, and there, sometimes seems to be here one day and not there the next….And so we don't, we have very little to do with them. We have a feeling that they are quite peripheral to the real world of what we're doing with, what we're going on with here' (HSP 13)

'…there isn't a formal structure, there aren't formal meetings organised….so that we all work very much, and indeed GP's use to work very much in isolation. And eh, but the more integrated community based approach towards patients now I think it's very important that doctors link in with other health care professionals and mechanisms need to be put in place for that, even starting off at an informal level and then maybe going on to something more formal' (HSP 17)

They highlighted the lack of direct access to hospital services such as radiology and physiotherapy. The current system requires that a client be seen first by a hospital consultant prior to accessing these services. They had some useful suggestions on how some of these barriers could be overcome.

'In our local area we have Cappagh, Cappagh is under utilised. It has a full x-ray facility, including ultrasound, including CAT scan and it is under utilised. We should have access to that' (HSP 18)

'…I'm actually negotiating at the moment to get a physiotherapist in here….but unfortunately, all my GMS patients will be precluded from seeing her. But if the Health Board were to provide funding for referrals across, we could provide a service here and again alluding to myself as a tax payer I would be very pleased about it be a much more efficient system and costing the system far less, rather than having to send somebody on the merry-go-rounds of expensive outpatients for rubber-stamping by a consultant' (HSP 17)

'…((given the correct facilities)) I'm trained in surgery….I'd be very happy to do minor surgery which I was trained for' (HSP 12)

A respondent also spoke of the need to ensure adequate security for both the staff and the clients using a health care facility.

Resources required to address the needs of the community

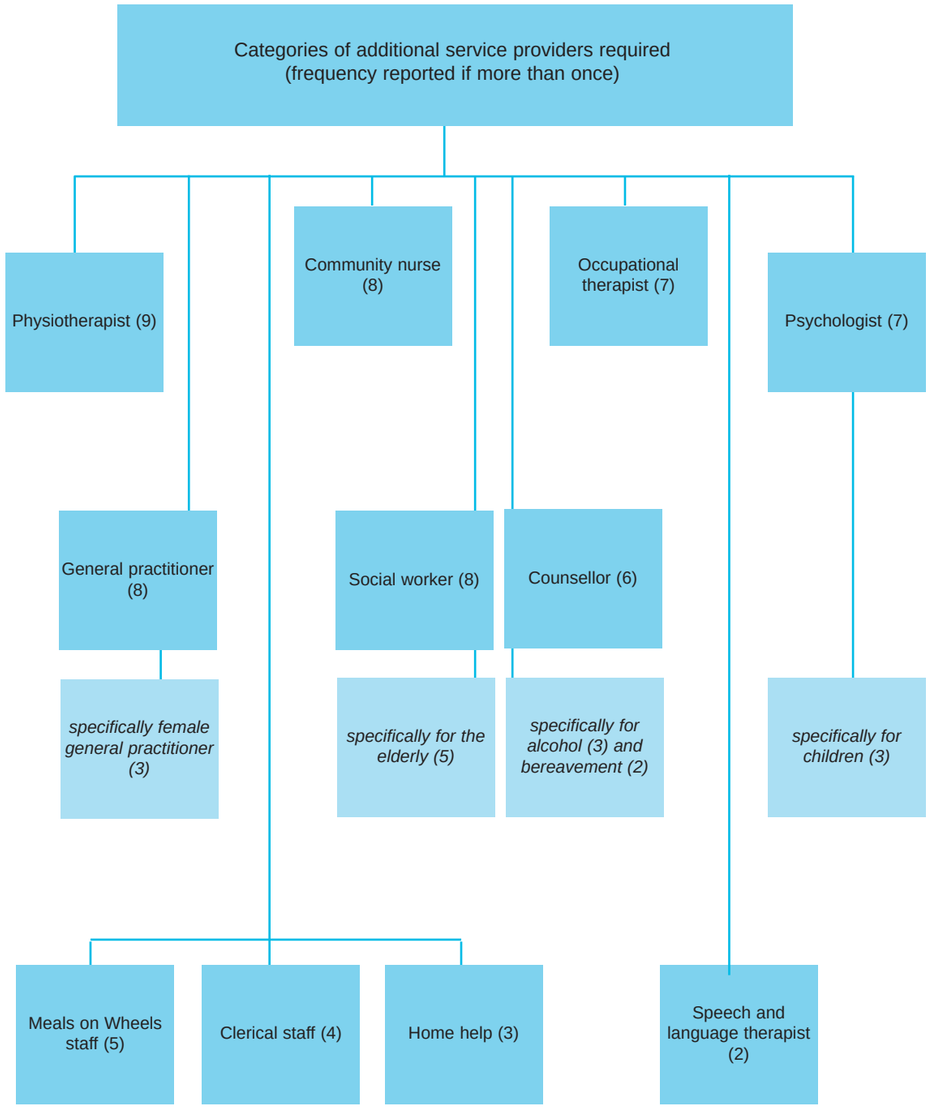
Health service providers were asked whether they had adequate resources to address the needs of the community. Just over half of the respondents (11) stated they did not have enough resources.

Some respondents (7) said that they had sufficient facilities within their own service but if other support services were better resourced the quality of their own service would improve.

Staff

Respondents were asked what resources were required in the area and for suggestions on how to improve services. Half of the respondents (10) spoke about the need to obtain and maintain adequate and appropriately trained staff within the services in the area. Figure 2.1 details the type of additional staff required in the area and also the frequency with which each service was mentioned.

Figure 2.1 Categories of additional service providers required (frequency if service reported more than once)



Expanded services for the elderly

The most commonly mentioned resources required were to address the needs of an increasing elderly population, in particular those living in their own homes. Respondents (12) spoke about the need to improve and enhance community based services for the elderly living in the Finglas area, including additional day care facilities (7), respite facilities (5) and increased visiting of the elderly in their own homes (3).

The new Kildonan Day Care Centre was said by many (6) to be a wonderful resource in the area. However, some participants highlighted that there is already a large waiting list for this service. This indicates the need for expansion of day care services in the Finglas area.

'…there is a huge amount of older people in Finglas and Finglas West Day Centre (Kildonan Centre) I think has been a great initiative' (HSP 2)

'…they (the clients) like it…you can even see the improvement in the quality of life for a couple of people that were , you know, very much housebound….I imagine that it has even helped one or two of them to, kind of keep them out of hospital and their general well being and everything' (HSP 10)

'…the day centres, there doesn't seem to be enough of them' (HSP 7)

Some respondents spoke of the need for improved and enhanced respite services for the elderly.

'…there's no such thing as home based respite…. a lot of carers get very possessive of their care, you know, of the person they have in their care, which is understandable, and a lot of the time the person does not want to leave the home…because they are afraid that this is the start of them being, ending up in a nursing home or, long term care….so respite at home would mean someone to come in and look after the person at home' (HSP 15)

'…there's no respite care for these people. There's a lack of respite care for people in the community. It's difficult to access' (HSP 18)

Meals on Wheels Service

Respondents (5) spoke about the need to improve the Meals on Wheels service in Finglas, saying that in some areas meals are available only two days per week. According to respondents (3), the use of volunteers to deliver the meals led to a lack of continuity and reliability of this service. Respondents (2) described how members of the home help service have had to try to address this problem.

'…they don't have volunteers to deliver them to the houses, so we, I then have to get a home help to collect them….in some areas I think they have more volunteers but they never really had them here, and probably the few they had have become less because of, you know, people have gone back to work for different reasons and they mightn't, the transport mightn't be as freely available as in other areas' (HSP10)

'…there's a waiting list at the moment for Meals on Wheels and invariably what ends up happening is if there is somebody who is in dire urgent needs of Meals and Wheels, invariably we end up using the Home Help service to actually make a meal for them, so that you're using another service and depleting that service in order to provide another one' (HSP 7)

'…the Health Board needs to have input in to a proper Meals on Wheels system, if you don't have people who are basically eating well on social welfare, all the services need to be coordinating together, if people don't eat well they get sick' (HSP 18)

Personal Alarm

Respondents (4) said that personal alarms were beneficial to the elderly living alone but spoke about the difficulty with the waiting time for the service and its ongoing costs.

'I tried getting in alarms pendants for the clients living alone….and any of those aids, spy holes, you know any of those things and the client can get a grant but like that, that's budget based….but there could be a lot more money put in to those services' (HSP 9)

Information about local services and entitlements

Half of the respondents (10) spoke about the lack of information regarding the services available in the area and who was entitled to them. Many suggested that if they as service providers had difficulty knowing what was available it is likely that the community at large experienced the same difficulties.

'…you might need some kind of structure where you'd maybe know all the services in Finglas…that maybe a secretary could update every six months….because you find a lot of services come and go….a kind of up-to-date information thing, sometimes like I've found after referring people to maybe different services that I've said is available, then when they actually go to find them they've now gone or whatever' (HSP 10)

'…there should be a directory of what services exist in the area' (HSP 18)

'…a lot of people don't know their entitlements….a lot of people wouldn't have known that they were entitled to a chiropody service you know' (HSP 1)

'…I know one lady, a patient with MS, she said to me, 'you know, you'd need a directory to get around all the different services' (HSP 10)

More health promotion

The importance of preventative health care and health promotion was mentioned by a number of respondents (9) as being a need for the area. The health service providers spoke of ideas and initiatives involving all age groups within the community including support to young parents. According to the respondents young parents require family planning information and parenting skills. Respondents also said that screening programmes for men and women were required.

'…the teenage mums group….a special approach for them….they are really at risk, and some of these young girls have moved out into flats on their own, they've got their apartments, but were still terribly unsupported, had left home, they were sixteen, seventeen with a baby on their own in a flat' (HSP 2)

'…good parenting courses….there are a limited number and again I think there are times for some parents which don't suit' (HSP 8)

'…there's a lot of smoking in this area and addiction, so services to work with those' (HSP 15)

Health promotion for the older population was also suggested, for example, strategies to improve balance and reduce the risk of falls.

'…over fifty-five exercise groups, stay on your feet programmes…because as we get older we lose our balance and coordination naturally' (HSP 2)

Locally based therapy services

Respondents (7) expressed frustration at the fact that some services are not based locally, for example, the occupational therapy and physiotherapy services. This frustration is felt not only by the service providers based outside the area, but also by other services who are trying to communicate with them.

'…our biggest barrier is not being out in the health centres. That really drives me mad because everybody wants to work together, its one client you know' (HSP 2)

In-service training

Respondents (6) said there was a need for in-service training and further education for service providers to ensure they continue to provide a good service.

'…we should have on-going education….and there should be workshops and a lot more structured education in the community, you know….it keeps you alert, it keeps you, you don't go stale and you need that, you have to have that' (HSP9)

'…skills training in the line of work we're in' (HSP 1)

Family resource centre

Respondents (4) identified a lack of facilities for parents with young children in the area. They suggested that a family resource and support centre would be beneficial. Some (3) suggested that a locally based child psychology service was also required.

'…some kind of a, family centre or a child and family centre, where maybe parents could meet or, you know, learn from each other or whatever, because there's a lot of parents who are very young and very inexperienced and things that I think would benefit from maybe the support of other parents or maybe some guidance as well you know' (HSP 10)

Other resources required

Respondents suggested an alcohol dependency support centre (3) and female general practitioners available to the women living in the community (2).

2.3 CO-ORDINATION AND TEAMWORK IN THE AREA

This section presents the respondents perceived level of co-ordination between services in the area and suggestions on how best to facilitate the primary care team to work better.

Level of co-ordination between service providers and teamwork in the area

Five respondents were happy with the level of co-ordination between services in the area and four respondents said there was no co-ordination. The remainder and the majority said that there was some level of co-ordination, but that it was mostly on an informal basis and that it occurred as a result of efforts made by individuals rather than through a formal structure.

Over half of the respondents (11) said that there was no formal structure for communicating within the health services and that co-ordination occurred in an 'ad hoc' or informal basis.

'…I'd say it's a bit ad hoc, you know. We do our best to communicate as well as possible….its probably not as good as it possibly could be' (HSP 10)

'…there is (coordination) but the impression I get, its very much on a ad hoc basis, most of the coordination I've had have been making myself known or responding to professionals who have made contact with me….I certainly felt that it has been well worth going to events….you get a chance to meet and greet' (HSP 17)

For many respondents (9) the telephone is the main method of communication between services available.

'…you could spend a lot of time chasing phone calls, and you're trying to ring schools on their lunch breaks or in between, you know, and you can waste an awful lot of time trying to create links' (HSP 8)

Some respondents (5) said that the level of communication depended upon an individual's inter-personal skills and upon the length of time they are working in the area.

'Well we don't sit down and have meetings with the public health nurses, we actually have quite a good relationship in this practice because my mum did work in the clinic for many years, so we know them all and we've met up with them and stuff' (HSP 6)

Respondents (9) said that they felt that at times the services were not integrated. They said that services often worked in isolation, with little sharing of information and this negatively affects the delivery of the service from the community perspective.

'…our communication between services, between the hospital ….and the community….is disjointed' (HSP 19)

'There is no continuity of care between hospital and community' (HSP 18)

'…we'll say maybe somebody coming home after a stroke or something, they maybe take them out on a visit to the house from the hospital with the OT and the physio from the hospital….and they suggest that maybe they get the special bed or they get grab rails or whatever. So the lady is sent home then and they're kind of waiting on these pieces of equipment to arrive….then you realise that no, that it doesn't happen like that,…they refer them to the community OT and the community OT has to go back and check them again' (HSP 10)

Many respondents (11) said that they felt that there is better co-ordination and communication between services when they are located either in the same building or nearby. Some respondents (8) provided examples of their experience cooperating with the local community nursing service.

'…in some ways there is, like between ourselves and the public health nurses there would be, you know, its quite good, but because I suppose physically they are in the same building it's very easy, you can like see them around' (HSP 8)

'…its quite good. I mean, again because we are working in the one building with the public health nurses which is an agency that we would be dealing with most. They're great. We have no problem with that' (HSP 16)

'…we would generally have a lot of discussions with OT's (who are situated in the same building) about particular patients….and they would sort of make recommendations that well maybe they need to be seen a little more urgently than their waiting list would reflect' (HSP 3)

For those respondents (4) who stated that there was no co-ordination between services, their reasons were pressure of work and poor orientation for new staff.

'…because every service is fraught, we're all at the ends of our tether, we're just trying to survive ….we don't have time to talk to anybody' (HSP 13)

'There is no (co-ordination), you know when you start working here you come, you just meet people by accident really in the corridor, its only you and that's it, there's no, there's no introduction to the area' (HSP 15)

Respondents were then asked for suggestions as to how to improve the level of teamwork and communication between the local health service providers. All the respondents reported a willingness to work together in an integrated manner to improve the service overall.

The primary care team

The majority of the health service providers (18) made positive suggestions, described below, as to how to achieve a greater level of teamwork among the local primary health service providers or the primary care team. However, some respondents did have some concerns about the concept of the primary care team. There was some discussion about the need to ensure that primary care was available to all members of society. The inequity within the health system was a source of concern. According to the respondents the structure of the Irish health care system led to a prompt health service to those who could pay and a less accessible service for those who had to use the public system.

'…we have a very clear and distinct two-tier system in this country, and it permeates every aspect of the health service' (HSP 17)

Respondents said that there was a need to guarantee the community that a high quality of care could be delivered through the public aspect of the primary health care system.

'…people have a low expectation of health centres ((people need to be assured that)) they are not getting a second class service, I think people do say to me, 'wouldn't bring the child to the dentist in the health centre sure, as if they were less then the local dentists and if they have money they might bring them to the other dentist and get their teeth done,….other people then have an idea that they're getting a less of a service than if they were paying it' (HSP 14)

Some respondents (3) spoke about the need for the primary care team to be appropriately managed to aid inter-agency co-ordination and ensure that the team reach their working potential. It was also suggested that training or support might be needed to facilitate the primary care team to learn to work together in a co-ordinated manner.

'And we're missing a lot of that synergy and energy….that you get from bringing different people together and look at things from….so that's the holistic' (HSP 2)

'I think training ((on learning how to work together)) is a huge thing….so I think the whole thing is to look at stuff from a different angle. I mean a lot of the time when someone suggests a different way of doing whatever it is, we say no, first. You know, we don't say 'well maybe that would work, we'll have, that's a bit mad or whatever, but we'll have a look at it'. I think we're too ready to say 'that's the way we always did it' …' (HSP 14)

Respondents spoke of the services that should be based locally within the primary care setting, they included physiotherapists, occupational therapists, general practitioners, community nurses, psychologists, counsellors, speech and language therapists dieticians, and other health care professionals as required or indicated through local health needs assessments. Some respondents spoke of the possible benefit to the community of running certain hospital outpatient clinics within a primary care building and the importance of the provision of a suitable transport system to service the centre.

'…all coordinated,….generally in primary health care, you have a GP there as well, you've got a chiropodist (who) will run a group, to teach people how to care for their own feet, and then the physio will come in and do exercise so that you can lift you're leg up….so everything, even the chiropody is integrated with physiotherapy' (HSP 2)

'…the warfarin clinic….couldn't we have a little machine for checking their INR ((International Normalised Ratio, giving blood clotting time)), right there ((in the primary care building)) and then give them the advice they need and send them off home' (HSP 12)

'The designated leg ulcer clinics with doctor assessment, attachment to hospital consultants for referrals and assessment, eh, I think certainly I would feel too that, you know, maybe specialist, clinical nurse specialists would be useful because like it's very difficult in our field to be an expert in every aspect of your work' (HSP 10)

Respondents (9) said that the service providers needed to be based within a geographical area and some (8) strongly recommended that they should be in one building.

'I suppose that having maybe that main services in the same building would be, you know, definitely helpful' (HSP 8)

'…having an integrated centre where there are people and where we are all talking to one another about services and where we can tip one another off, rather quickly about the services that may be available, that would be appropriate to the sort of troubles which we could discuss in a mutually supportive environment' (HSP 12)

'But if it's under the one roof….yeah, I mean, you've a better chance of you know, that that client will link in with the person that, you know, that you want them to, and also that there's a better chance that there will be liaison between the services as well, you know' (HSP 4)

Respondents (8) highlighted two important functions of structured and regular team meetings, which would enhance communication between the primary care services. First, the meetings would be a forum for service providers to describe their role in the community and exchange information. Also, such meetings would facilitate primary carers to meet and discuss specific cases.

'Because of this waiting list problem….and staffing….and location I think the more you solve things in a team, and it's amazing when you work on a team, we had to look at some ideas for the RAPID in Finglas' (HSP 2)

'…there have been a series of meetings going on intermittently for years and years where health care professionals would simply stand up and say, over lunch time break, say what they do in the community ….I've found those very useful because you get a description of what other peoples jobs are, rather than having a muddy idea of what they're about' (HSP 17)

'I suppose more meetings, you know, people to meet informally and just to share ideas as to how they're doing' (HSP 1)

'I'd say possibly more, maybe team meetings, you know, maybe teamwork and team meetings where we all get together maybe to discuss a case or a client or whatever…you'd probably understand each other's role better and that, like you know' (HSP 10)

When asked about how to facilitate the primary care team to work better a number of respondents (5) spoke of the importance of information technology in enhancing communication. Respondents (2) spoke of the recent improvements made to the health centre telephone system but commented on the lack of voicemail facilities.

'…we got direct lines which has made a difference….that was just the end of last year. Because before that clients would be trying to ring and just weren't getting through, whereas now they can get through, I suppose the one thing you'd like to have is voicemail, so that if you're not in the office, you know, they get it' (HSP 8)

'So I think if message minders were put on, at least when the clients ring, they could leave a message and you could get back to them' (HSP 9)

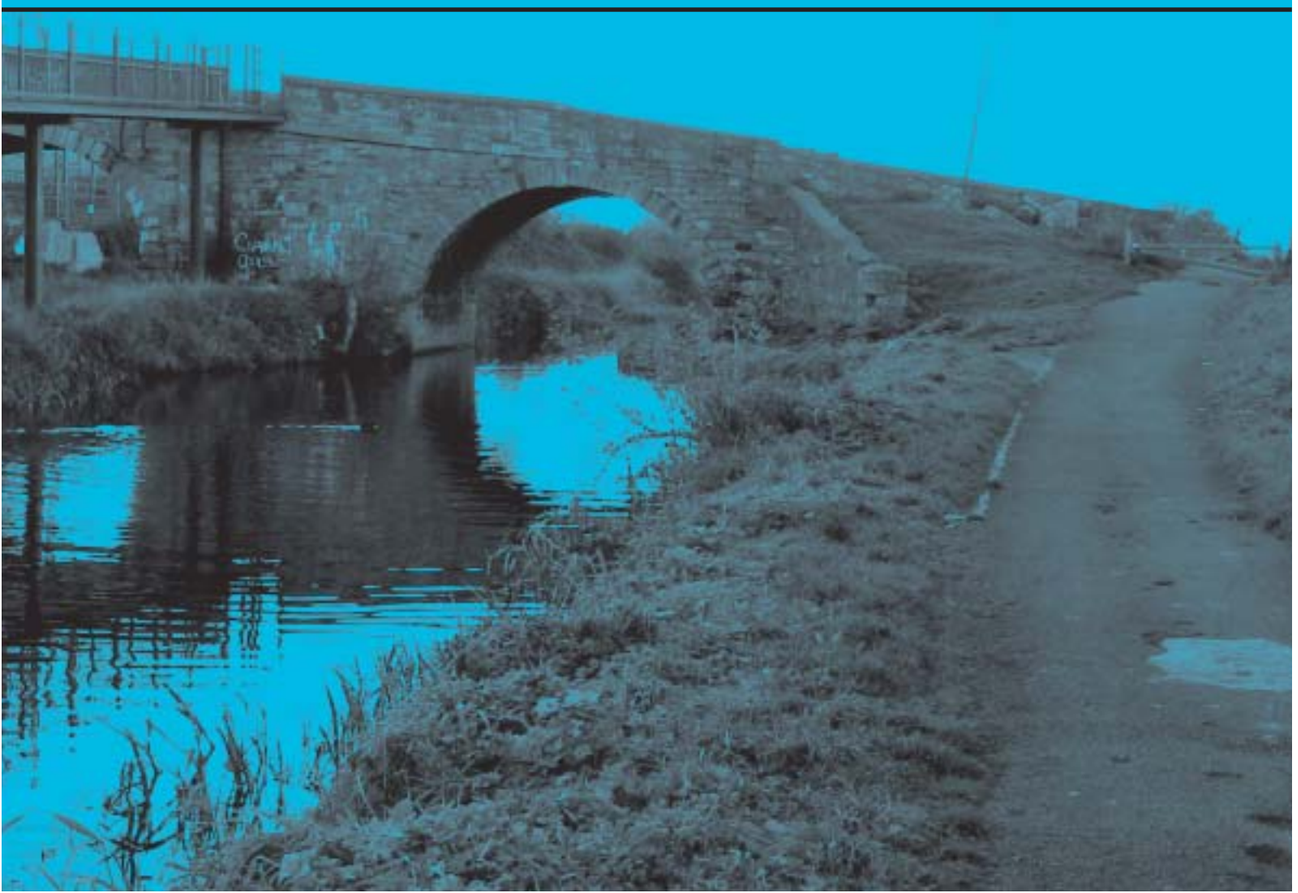
'I think communication is a big issue and I think if there was that computer system between the hospital and community, it, you know, if we picked up about e-mails we don't even have a fax machine that's working properly, you know, it would make life that so much easier' (HSP 19)

'For example you can have technology links, there needs to be funding of technology links between practices, between the Health Board, between the public health nurses, we should have access to each other, link between, by way of a mobile phone, we should have each others fax numbers, we should have computer links with each other such as we can e-mail each other' (HSP 17)

The respondents spoke of the benefit to the community of effective teamwork and inter-agency co-operation.

'…and we looked at it as different disciplines and I would have, you know, from my background in training and education, I'd have a couple of ideas, but it was amazing the different ideas you get because people are coming from a different place(discipline) and the things they think of, people ((say)), oh that is a great idea' (HSP 2)

DISCUSSION
PART 2



Discussion

This study was undertaken as part of the health needs assessment in the area. In general, the issues raised by the service providers support the findings of the household survey, which indicates a consistent perception of the health needs in the Finglas area.

In the household survey, it was reported that over 16% of the surveyed population were aged 65 years or older which is higher than in the Eastern Region (10%). The service providers working in the study area reported that the main health needs were associated with an elderly population profile. In the household survey, many primary carers identified enhanced services for the elderly as the most important resource required in the area, in particular services to help older people to remain in their own home. The service providers reiterated this finding.

The RAPID report conducted earlier in the year in West Finglas identified a high incidence of both home burglaries and anti-social behaviour in the area.[3] Both service providers and primary carers highlighted the vulnerability of older persons living in their own homes, in particular they raised the issue of their personal safety. Research has shown that older people can experience physical and psychological ill-health following a criminal episode perpetrated on them or on someone in their neighbourhood.[4] The service providers said that in their experience, social isolation, loneliness and depression can be a consequence of crime in the neighbourhood.

The service providers also spoke of the need for and gave suggestions on how to enhance the home-based services for the elderly. They stated that the reduced availability and flexibility of the Meals on Wheels service, for the unsupported elderly living alone, has increased their social isolation and decreased their weekly nutritional intake.

The main health problems reported by the service providers were similar to those reported by the primary carers in the household survey. The most common chronic illnesses reported in both studies were cardiovascular disease, respiratory disease, arthritis, diabetes, depression and anxiety.

Research has shown that deprivation is strongly linked with ill-health.[5 6] The service providers described the social problems that (in their experience) have a negative effect on health which included substance misuse, poor housing, loneliness and isolation. The results of the household survey indicates that this is a deprived area with 35% of households having medical card cover, 25% living in government supported or private rented accommodation and 40% having primary education or less. The service providers reported that substance misuse (in particular alcohol) was a major issue in the area and had associated physical, mental and social implications. In contrast, drug and alcohol problems appear to be under reported in the household survey. The service providers stressed the lack of services in Finglas for those who misuse alcohol.

The service providers were very positive about the value of different disciplines working together as a team, a philosophy which is endorsed in the primary care strategy.[7] They displayed a willingness to facilitate a team approach to primary health care in order to enhance the health care service for the people living in the Finglas area.

According to the service providers, team work at the primary care level could be enhanced through: additional human resources; team building exercises; formal and officially recognised team meetings between both private and public service providers; privacy for clients during consultations, and communication technology. In their opinion this would lead to an effective primary care team.

DISCUSSION - PART 2

References

1. Morse J, Field A. Nursing Research The application of Qualitative approaches. 2nd ed. Cheltenham: Stanley Thornes Publishers Ltd, 1998.

2. Treacy M, Hyde A, Thomas A. Nursing Research Design and Practice. Dublin: University College Dublin Press, 1999.

3 Finglas Area RAPID Implementation Team. Baseline Action Plan for the Finglas RAPID Area 2001-2003. Dublin: Department of the Environment and Local Government, 2002.

4. National Council on Ageing and Older People. Crime, Aging in Ireland Fact File No. 11. Dublin: National Council on Ageing and Older People, 2001.

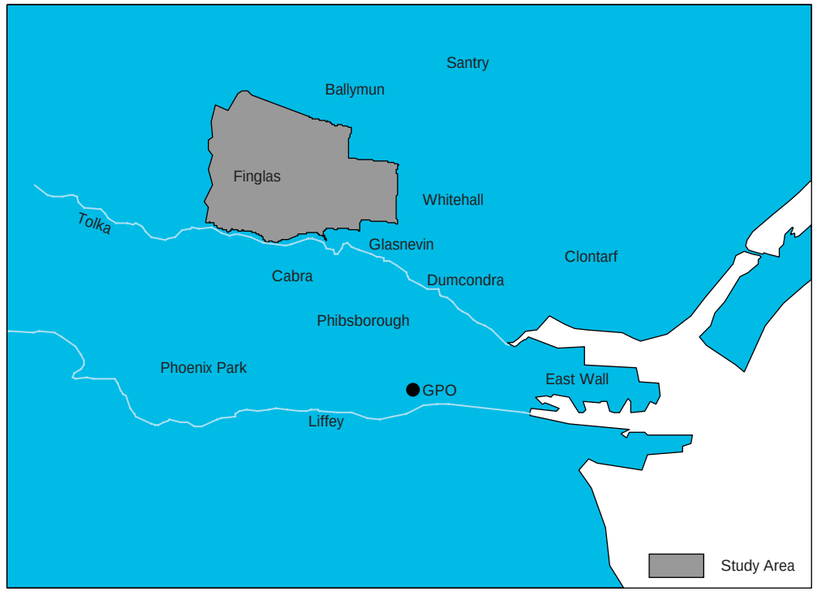
5. Euchus J, Williams M, Chan P. Deprivation and cause specific morbidity: evidence from Somerset and Avon survey of health. British Medical Journal 1996;312:287-292.

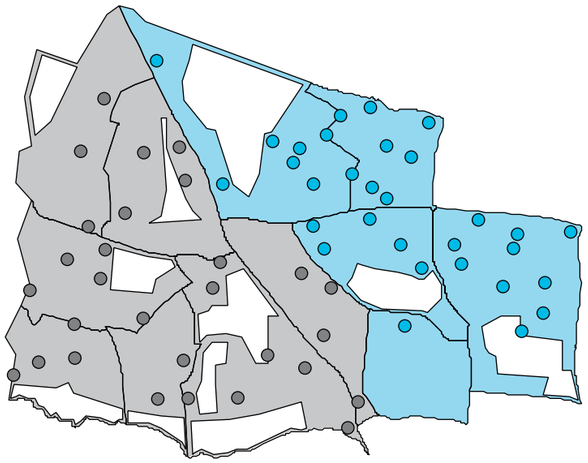
6. White I, Blane D, Morris N. Educational attainment, deprivation-affluence and self reported health in Britain: a cross sectional study. Journal of Epidemiology and Community Health 1999;53:535-541.

7. Department of Health and Children. Primary Care - A New Direction. Dublin: Stationary Office, 2001:34.

APPENDICES

MAPS OF THE STUDY AREA





CLUSTERS BY LEVEL OF DEPRIVATION

- MORE DEPRIVED
- LESS DEPRIVED

AREA STATUS

- MORE DEPRIVED
- LESS DEPRIVED
- NON RESIDENTIAL

INFORMATION LEAFLETS

Appendix 2a Poster

Attention!

A voluntary survey of households health needs and experiences of the health services will be carried out in the Finglas area shortly.

The purpose of the survey is to ensure you have a say in the future health care services

and

to get information to plan better health care for the people living in the area

If requested we hope you will take part

INFORMATION LEAFLETS

Appendix 2b Letter to participants

Dear Householder,

The Northern Area Health Board are interested in responding to the health needs of the people in the area. We have asked the Trinity College Centre for Health Sciences to carry out a survey on our behalf.

In the next two weeks one of our researchers will call on you asking you to take part in a household survey. We would like to interview the person who looks after the health of the people in the house. We will ask about the health of the household members and satisfaction with the services provided. We want to find out what other health services you think are needed in the area.

We hope you will be willing to complete the interview, which will take between 20-30 minutes. We plan to conduct the interviews between 6 and 9pm each evening. If this time does not suit you the researcher will arrange a more suitable time for you to be interviewed.

You are of course free to refuse to take part in the survey, but this is a good opportunity for you to ensure that you have a say in the planning of the health care services in the area. All the information collected will be treated in the strictest confidence and will not be disclosed to anyone outside the research team.

Thanking you for reading this letter and looking forward to obtaining your views. If you have any queries whatsoever, please contact Ailbhe @ 6081087 or Deirdre @ 6082293.

Yours sincerely

Noel Mulvihill
General Manager CCA 6
Northern Area Health Board.

Tom O'Dowd
Professor of Community Health and General Practice
Trinity College, Dublin 2.

INFORMATION LEAFLETS

Appendix 2c Information sheet for interviewers

Hello, I am show ID

We are research assistants employed by the Northern Area Health Board and are carrying out the survey on their behalf. Did you receive a letter in the post?

If yes, as you are aware the Northern Area Health Board are interested in responding to the health needs of the people in the area.

If no, apologise and explain…… 'they are interested in responding to the health needs of the people in the area'

We would like to interview the person in the household who manages the health of the people in the house.

We will ask questions about your background, health status, health services used, satisfaction with them and other health services you need.

The interview will take 20 to 30 minutes .

You are of course free to refuse to take part in the survey but this is a good opportunity to ensure you have a say in the planning of health services in this area.

All the information will be treated in the strictest confidence and will not be disclosed to anyone outside the research team.

Is this a convenient time to talk to you?

If yes, can I come inside?
If no , can you give me an alternative time?

Once inside ask if you can sit side by side, preferably at a table

Place the flashcards in front of the respondent

Ensure the respondent can see the questionnaire

Remind the respondent that if there is any question you do not wish to answer please say **pass**.

Go through the questionnaire following the instructions provided in the questionnaire

When finished recheck the questionnaire to ensure it is complete

Thank the respondent for his/her time

Tell them the health centre number for enquiries about public health services such as vaccination, child health and cervical screening. All other enquiries to their own GP.

Before handing in the questionnaire ensure all coding is completed and correct.

APPENDIX 3 - Survey team

Ms Angela Adams	Data collector from the Community
Ms Jillian Deady	Research Fellow
Mr Yousef El-Gohary	Medical Student
Mr James Gilleran	Data collector from the Community
Ms Malebogo Kebabonye	Medical Student
Dr Jean Long	Lecturer in International Health
Mr Des McMahon	Medical Student
Ms Sinead McNulty	Data collector from the Community
Ms Edosa Odaro	Medical Student
Prof. Tom O'Dowd	General Practitioner
Ms Frances O'Keeffe	Research Fellow
Ms Boitumelo Tumie Pule	Medical Student
Ms Phyllis Sheill	Data collector from the Community
Ms Nicola Sweeney	Research Assistant
Ms Maria Thornberry	Data collector from the Community
Ms Sinead Tyer	Data collector from the Community

APPENDIX 4

Procedures Employed to Ensure Good Ethical Practice

The main ethical problems associated with the research project are as follows:

- The need to ensure informed consent from the primary carer
- The need to ensure confidentiality

The following measures were taken to deal with these issues:

Informed Consent

Each household was sent a letter detailing the purpose of the survey, the data collection methods and the proposed dates.

Information leaflets describing the purpose of the study, the data collection methods, the study population, and the use of results were provided to guide the interviewers when visiting the households.

The respondents were then asked if they wished to take part. No inducements were offered. Those who agreed completed the questionnaire. Agreement to complete the questionnaire was taken as consent for the survey.

Those respondents who did not fully comprehend the explanation, e.g. those with language difficulties, were excluded from the survey.

Maintaining Confidentiality

Confidentiality was assured as no household members surnames were recorded on the questionnaires. Each questionnaire was assigned a number for data entry purposes.

SATISFACTION WITH HOSPITAL SERVICES

Table 5a Primary carer reported number (%) of the individuals used accident and emergency services in the year prior to the survey, the level of satisfaction with services and their reasons for satisfaction/dissatisfaction

	No.	%
Attended accident and emergency department		
Yes	87	09.0
No	876	91.0
n	963	
Satisfaction with accident and emergency service (1 very satisfied to 6 very dissatisfied)		
1	32	40.5
2	13	16.5
3	7	08.9
4	8	10.1
5	9	11.4
6	10	12.6
n	79	
Satisfied with accident and emergency service		
Yes (1 to 3)	52	65.8
No (4 to 6)	27	34.2
n	79	
Reason satisfied with service accident and emergency (n = 52)		
Nearby	2	03.8
Staff courteous and friendly	22	42.3
Short waiting period	19	36.5
Doctor/health professional listened to the problem	16	30.8
Doctor/health professional explained the condition	20	38.5
Doctor/health professional explained the treatment possibilities	15	28.9
Doctor/health professional provided good treatment or care	30	57.7
Service easily available on a 24 – hour basis	4	07.7
Pleasant environment	4	07.7
Affordable	4	07.7
Organised appointments	7	13.5
Reason dissatisfied with accident and emergency (n = 27)		
Too far	1	03.7
Staff unfriendly	1	03.7
Long waiting periods	17	63.0
Doctor/health professional did not listen to the problem	3	11.1
Doctor/health professional did not explain the condition	4	14.8
Doctor/health professional did not explain the treatment possibilities	2	07.4
Doctor/health professional provided inadequate or incorrect treatment	11	40.7
Service difficult to access outside normal working hours	1	03.7
Unpleasant environment	6	22.2
Expensive	2	07.4
No aftercare	3	11.1
Other	2	07.4

Appendix 5b Primary carer reported number (%) of the individuals attended the outpatients department in the year prior to the survey, the level of satisfaction with services and their reasons for satisfaction/dissatisfaction

	No.	%
Attended outpatients department		
Yes	191	19.8
No	772	80.2
n	963	
Satisfaction with service in the outpatients department (1 very satisfied to 6 very dissatisfied)		
1	58	48.6
2	40	22.9
3	13	07.4
4	11	06.2
5	15	08.6
6	11	06.2
n	175	
Satisfied with service in the outpatients department		
Yes (1 to 3)	138	78.9
No (4 to 6)	37	21.2
n	175	
Reason satisfied with outpatients' service (n = 138)		
Nearby	6	04.3
Staff courteous and friendly	63	45.7
Short waiting period	34	24.6
Doctor/health professional listened to the problem	46	33.3
Doctor/health professional explained the condition	52	37.7
Doctor/health professional explained the treatment possibilities	46	33.3
Doctor/health professional provided good treatment or care	74	53.6
Service easily available on a 24 – hour basis	7	05.1
Pleasant environment	2	01.4
Affordable	2	01.4
Organised appointments	20	14.5
Long term relationship with doctor	1	00.7
Reason dissatisfied with outpatients service (n = 37)		
Too far	0	00.0
Staff unfriendly	4	10.8
Long waiting periods	24	64.9
Doctor/health professional did not listen to the problem	5	13.5
Doctor/health professional did not explain the condition	6	16.2
Doctor/health professional did not explain the treatment possibilities	2	05.4
Doctor/health professional provided inadequate or incorrect treatment	8	21.6
Service difficult to access outside normal working hours	1	02.7
Unpleasant environment	4	10.8
Expensive	0	00.0
No aftercare	2	05.4
Other	3	08.1

Appendix 5c Primary carer reported number (%) of the individuals admitted to hospital in the year prior to the survey, the level of satisfaction with services and their reasons for satisfaction/dissatisfaction

	No.	%
Admitted to hospital		
Yes	53	05.5
No	910	94.5
n	963	
Satisfaction with care and treatment as an inpatient (1 very satisfied to 6 very dissatisfied)		
1	24	52.2
2	8	17.4
3	1	02.2
4	7	15.2
5	1	02.2
6	5	10.9
n	46	
Satisfied with inpatient care and treatment		
Yes (1-3)	33	71.7
No (4-6)	13	28.3
n	46	
Reason satisfied with inpatient care and treatment (n = 33)		
Nearby	1	03.0
Staff courteous and friendly	17	51.5
Short waiting period	1	03.0
Doctor/health professional listened to the problem	13	39.4
Doctor/health professional explained the condition	14	42.4
Doctor/health professional explained the treatment possibilities	11	33.3
Doctor/health professional provided good treatment or care	24	72.7
Service easily available on a 24 – hour basis	1	03.0
Pleasant environment	7	21.2
Affordable	1	03.0
Organised appointments	4	12.1
Reason dissatisfied with inpatient care and treatment (n = 13)		
Too far	1	07.7
Staff unfriendly	5	38.5
Long waiting periods	2	15.4
Doctor/health professional did not listen to the problem	4	30.8
Doctor/health professional did not explain the condition	2	15.4
Doctor/health professional did not explain the treatment possibilities	0	00.0
Doctor/health professional provided inadequate or incorrect treatment	5	38.5
Service difficult to access outside normal working hours	1	07.7
Unpleasant environment	5	38.5
Expensive	0	00.0
No aftercare	1	07.7
Other	1	07.7

Appendix 5d Primary carer reported number (%) of the individuals admitted as a day case in the year prior to the survey, the level of satisfaction with services and their reasons for satisfaction/dissatisfaction

	No.	%
Admitted as a day case		
Yes	24	02.5
No	961	97.5
n	963	
Satisfaction with care and treatment as a day case (1 very satisfied to 6 very dissatisfied)		
1	15	62.5
2	7	29.2
3	0	00.0
4	2	08.3
5	0	00.0
6	0	00.0
n	24	
Satisfied with care and treatment as a day case		
Yes (1-3)	22	91.7
No (4-6)	2	08.3
n	41	
Reason satisfied with care and treatment as a day case (n = 22)		
Nearby	2	09.1
Staff courteous and friendly	8	36.4
Short waiting period	4	18.2
Doctor/health professional listened to the problem	5	22.7
Doctor/health professional explained the condition	4	18.2
Doctor/health professional explained the treatment possibilities	2	09.1
Doctor/health professional provided good treatment or care	17	77.3
Service easily available on a 24 – hour basis	1	04.5
Pleasant environment	2	09.1
Affordable	1	04.5
Organised appointments	3	16.6
Reason dissatisfied with care and treatment as a day case (n = 2)		
Too far	0	00.0
Staff unfriendly	1	50.0
Long waiting periods	0	00.0
Doctor/health professional did not listen to the problem	0	00.0
Doctor/health professional did not explain the condition	0	00.0
Doctor/health professional did not explain the treatment possibilities	0	00.0
Doctor/health professional provided inadequate or incorrect treatment	0	00.0
Service difficult to access outside normal working hours	0	00.0
Unpleasant environment	0	00.0
Expensive	0	00.0
No aftercare	0	00.0

APPENDIX 6 - Topic guidelines

Job Title
Length of time working in the area

Topic 1 (Health problems)
In your experience what are the most common physical/mental health problems that you encounter?
What problems occupy most of your time?

Topic 2 (Services and resources)
Do you have sufficient resources in your service to address the needs of the community?
What are the main difficulties/barriers to effective delivery of services?
Can you make suggestions how your service can be improved?
In your opinion are there additional health services required in the area?

Topic 3 (Co-ordination/teamwork)
Is there co-ordination between services in the area?
Are you satisfied with the level of co-ordination between services in the area?
What facilities / services do you feel are required to facilitate the primary health care team to work better?

The above questions are some guidelines as to the type of information we are looking for.

APPENDIX 7 - Consent form for the service providers who participated in the study

CONSENT FORM

Health needs assessment of the people living in the Finglas area

All participants interviewed will be asked about their perception of the health needs of the people living in the area, their service provision and the issue of co-ordination in a primary health care setting.

Each interview will take 45 minutes. The details of the interview will be recorded on tape. Only the research team will use the tape. The tape will be erased once the tape has been typed. No individual will be identifiable once the interview is typed.

Only the research team will have access to the information collected. Individual names will not be recorded.

The information will be written up detailing common issues, differing opinions and some individual quotes to emphasise points made by the participants. No quotes will be attributed to any individual study participants.

I have read the above explanation, and where required additional issues have been explained.
On the basis of this information I agree to take part in the survey.

Signed Date

APPENDIX 8

Silverman's Transcription symbols

The tape number indicates the interviewer number so all conversation attributed to the interviewee is denoted by the tape number, for example, HSP2 for tape number 2 and HSP3 for tape number 3 and so on up to tape number 20 (indicated by HSP20)

The interviewer was JD so all of the interviewer's questions, clarifications or comments are attributed to JD.

When each person speaks on the tape and you attribute the conversation to them,
can you please format the text as follows:

JD: Okay, em, have you ever treated leg ulcers?.

HSP4: Yeah.

JD: Now I'm going to ask you a little about your experiences treating leg ulcers, okay?,

HSP4: Yeah.

JD: Okay?. So just feel free to tell me anything you want to tell me.

HSP4: I couldn't tell you why I started treating leg ulcers. When was about 12 years ago I'd say, em,.

Save document as 'text' only. Do not use automatic line spacing or paragraph spacing instead use the enter or return button.

When transcribing the interviews will you please use the following notations.

( ) 'empty parentheses' indicates talk too obscure to describe.
hhh indicates hearable aspirations length proportional to number of hhhs
] left sided bracket indicates over lapping conversation begins and [right sided indicates over lapping conversation ends
(( )) double parentheses indicates transcriber's comments
- indicates unfinished word such as "unfin -"
Underlining of text indicates stress or emphasis