Community Consultation process to assess the needs of the community in relation to the Mountainview Court Health Care Facility, Summerhill, and the services to be provided there.

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Report on the Consultation Findings

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Community Consultation conducted on behalf of
ICON –Inner City Organisations Network

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July 2008

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Executive Summary

Background and Introduction:

This report presents the background to, rationale for and findings from a recent community consultation process undertaken within the North East Inner City (NEIC) Dublin, on behalf of the Inner City Organisation Network (ICON) Health Action Forum. ICON is a network of community based projects, organisations and individuals living and working in the North East Inner City. *'The ICON Health Action Forum is comprised of local community organisations and individuals living and working in the North East Inner City, who are exercising their right to participate in health and service development'* (ICON documentation, 2008).

The North East Inner City (NEIC) is widely acknowledged as one of the most disadvantaged and deprived areas within the country. On a broad range of indicators, including health and deprivation, the North East Inner City contains some of the most deprived localities in the country. The SARHU index, a nationally accepted indicator of deprivation, combines unemployment, low social class, car ownership, rental accommodation and over crowding. This index allocates its highest (i.e. worst) rating of 10 to all but one of the electoral divisions within the North East Inner City.

A comprehensive literature review undertaken as part of this process, and presented in Appendix 1, highlights the myriad of social, economic, political, educational, environmental, living and working conditions and individual genetic and lifestyle factors that impact, mainly negatively, on the lives of those living in the NEIC community. Issues relating to equity of access to health services are extremely relevant for the community with very poor or little access to relevant and much needed services for all life stages. Many of those experiencing difficulty in accessing services suffer from multiple disadvantage and include refugees and asylum seekers, people with physical and intellectual disabilities, homeless people and people with problem drug use.

The North East Inner City and Primary Care provision:

Despite extreme poverty and social disadvantage, the NEIC has yet to be provided with a comprehensive Primary Health Care Facility. "Primary Care is a model of local health service delivery with a strong emphasis on the participation of local

communities. At the core is a structure which facilitates the coming together of health, social service professionals and community representatives to address, in an integrated and co-ordinated way, the health needs of the community. This structure recognises that people are the experts on their own needs and have the right to be involved in the planning, implementation and delivery of their own health services" *(Lifford/Castlefinn Primary Care Project, 2004)*.

Proposed developments for the Primary Health Care Facility in the NEIC:
Within the NEIC, it is now proposed that a new health care facility is to be built on the Mountainview Court site in Summerhill. This site, and proposed building, is the property of the Dublin City Council and it is envisaged that the HSE, as tenants, will buy space in this building, primarily with a view to relocating the existing primary care services from the North Strand and Summerhill health centres to this new site.

In line with the Primary Health Care Strategy (2001), the planning and provision of Primary Health Care Services should be informed by a comprehensive health needs assessment. To date, a health needs assessment has not been carried out in the NEIC. In the absence of any comprehensive health needs assessment, the ICON Health Forum has undertaken this initial community consultation in order to provide an opportunity for the NEIC community to identify their health needs and to identify the range of services that should be provided within this new facility.

NEIC Community Consultation Process:
A community consultation process was undertaken within the NEIC in April/May 2008 with a broad range of population groups and special interest groups including children, young people, women, men, older people, residents' group, new communities, people with problem drug use, people who are homeless and people with disabilities.

This consultation is the first phase of a two phase strategy to identify health needs in the North East Inner City. It is envisaged that the second phase will involve a detailed health needs assessment to further facilitate the participation of the community in Primary Care planning at a local level. It is hoped that this initial consultation will be useful in supporting the community in the process of determining health and service needs. Further details of the consultation methodology are presented in Section 2.

Summary of main themes and associated recommendations arising from the Community consultation in the NEIC:

The key themes and recommendations emerging throughout the consultation process are presented as follows:

1. Community participation in health service planning and decision-making:
Fundamentally, primary care should be focused on keeping people well. Any primary health care facility must deal with as many population groups as possible ensuring that particular groups are not excluded. A primary health care facility can provide a focal point for health care in the community which is 'community-led'. Being 'community-led' involves ensuring that the community's needs must inform the provision of services at all times. A mechanism must be established to take account of evolving and emerging needs which are responded to accordingly. In this regard, the specific needs of different population groups must be accounted for at all times.

Additionally, formal structures, such as a community representation structure, are required to enable the community to actively participate in planning, decision-making and monitoring in relation to the development and provision of services. The HSE User Involvement Strategy (2008) recommends using existing local structures to facilitate this process. In this regard, the ICON Health Action Forum is well placed, in the short-term, to represent community needs and views within the NEIC until such time as the community representation structure is established. This model was proven to be very effective in the Lifford/Castlefinn Primary Care Project – A Model for Community Participation in Primary Care (2004).

Furthermore, Community Development Workers, already in place in the HSE, have well established links with, and knowledge of the local community. They can act as a link between the Primary Care Team and the community, build capacity within the community and facilitate community involvement mechanisms. It is important to acknowledge, in this regard, that Community Development Workers have played a critical role in the development of Primary Care nationally.

2. A 'rights based approach' underpinning the co-ordination and integration of services:

The provision of this facility is one of many developments taking place within the NEIC. Initiatives such as the Integrated Services Initiative, the Young People at Risk Initiative and the work of the Drug Task Forces recognise the need for integration of service provision between the various statutory and voluntary/community service providers and within health services. Generally these initiatives are informed by both a community development and a 'rights based' approach to service delivery. Such approaches are characterised by:

- A focus on preventative and support approaches to addressing health and social needs;
- A 'one stop shop' approach where key staff within the primary health care facility act as gateways or links to other specific services and supports both internal and external to the facility;
- The provision of clear and relevant information within the facility;
- The need for a quality assurance mechanism ensuring accountability of service providers to guarantee high quality service.

3. General Medical Service (GMS) GPs & medical card provision:

Critical to the success of this primary health care facility is the availability of GMS GPs within the core Primary Care Team. This report identifies the potential crisis with regard to diminishing numbers of GPs within the inner city and an increasingly overstretched and inadequate service. Additionally, this report highlights issues in relation to difficulty in accessing medical cards and GMS GPs. Therefore, the case for the provision of GMS GPs at the core of this facility is crucial.

4. Supporting the community to use the primary health care facility:

Every consultation conducted highlighted the necessity of supporting the community to use the primary health care facility. In order to ensure this there are three key strategies that require attention as follows:

(i) **Information** about the facility, its services and its links to the community and other relevant external services must be provided to coincide with the opening of the facility and updated on an ongoing basis thereafter. Any information must be presented in a 'user-friendly' way for all population groups to take account of issues such as language, literacy, culture, age, gender and equality

(ii) **Outreach** services must be provided to ensure access to those populations that are difficult to reach and particularly at risk e.g. drug users, people who are homeless, undocumented migrants etc.

(iii) The need for **Community Health Workers** emerged consistently throughout this consultation. Ideally a number of Community Health Workers would be appointed to provide information, advice, support and capacity-building in order to link the community with the facility. The Traveller Community Health Worker model is a good example in this regard. Community Health Workers, trained in basic health promotion and early intervention strategies, could play an essential role in creating awareness about the health care facility and the services therein. These Community Health Workers could also link with other service providers, agencies and existing outreach workers already engaged with women and families in the community and through this liaison, raise awareness about, and encourage women and their families to use the new facility. These Workers could be trained and paid under an appropriate FÁS scheme. This model would also offer employment opportunities to local people.

5. Accessibility:

Issues of accessibility emerged consistently throughout the consultation. This facility must be accessible to the community. This means flexible opening hours as well as late evening and weekend service provision, adequate public transport options to and from the facility and sufficient car parking to facilitate those who need private transport. Additionally, specific attention should be paid to the provision of clear signage (taking account of literacy and language issues) directing people to the facility. Furthermore, interpreting services are essential to enable new communities to use the facility.

6. The physical environment:

Many recommendations were made throughout the consultation in relation to the physical environment within the facility. These included the provision of a spacious, bright, colourful reception and waiting area/s, the provision of a specific, supervised childcare area, the provision of refreshments, the use of TV to convey health messages, the use of design features such as fish tanks and graffiti walls to entertain people while they wait.

Additionally, the use of meeting rooms for community activities, educational programmes and support groups would provide a sense of community ownership and encourage people to come in to the facility. Wheelchair access and the use of handrails where required are important in ensuring that those who are disabled or have mobility issues can easily access the facility. Furthermore, given that the Lourdes Day Care Facility will be co-located with the primary health care facility, a link corridor between the two buildings would facilitate easier access for older people.

7. The social environment:

The importance of the social environment was rated as importantly as the physical environment within the consultation. This includes ensuring that all people are treated with respect and that staff are trained to respond appropriately and consistently to the needs of those using the facility. It also involves the development of a set of policies and procedures that take account of the needs of people with specific issues (e.g. domestic violence, rape, homelessness etc) to ensure consistency in the delivery of a quality service. Furthermore, a comprehensive and user-friendly complaints procedure is essential.

8. Research and data collection:

A comprehensive system of data collection and research should be built into service delivery to take account of emerging and changing needs and issues. This is particularly important given the ever increasing, multi-cultural population within the NEIC.

Suggested model for the Mountainview Court Health Care Facility

Underpinning principles

Equity, people-centredness, quality and accountability

Core Primary Health Care Services:

- GMS GPs (mixed gender)
- Practice nurses
- PHNs
- Dietitians/Community Nutritionist
- Physiotherapist
- Occupational therapist
- Speech & Language Therapist
- Social Worker
- Home help / home support workers
- General health screening (with gender specific clinics)

Services accessed through the Primary Care Network:

- Chiropodist
- Community Welfare Worker

Support Services:

- Family Support Services
- Health promotion & information service to include information on social and welfare entitlements
- Outreach services specific to the needs of different population groups
- Outreach mobile medical service
- Community Health Workers
- Equality officer
- Interpretation and support services for new communities
- Alternative therapies
- On-site pharmacy

Specialist Services:

- Sexual Health Service (with clinics for specific population groups at specific times to aid 'user-friendliness')
- Child health clinic with paediatrician
- Diabetic Clinic
- Minor Injury Clinic
- Comprehensive Addiction Service
- Mental Health Service (with Mental health nurse, counsellors, psychologist and psychiatrist)
- Sight/ophthalmic service
- Audiological Service
- Dermatologist
- Dental health Service
- Cancer screening Service
- Orthopaedic Service

Youth Café

Policies, procedures and protocols

A 'rights-based approach'

Supporting the community to use the facility

Accessible for everyone

Community participation In health service planning

Staff training

Efficient referral pathways to more specialised services

Section 1: Introduction & Background

1.1 Introduction to the report

This report presents the background to, rationale for and findings from a recent community consultation process undertaken within the North East Inner City (NEIC), Dublin on behalf of the Inner City Organisation Network (ICON) Health Action Forum. This community consultation process was completed by Siobhán Mc Grory and Louise Monaghan, Independent Consultants in April/May 2008. It is envisaged that the findings from this community consultation process will provide the ICON Health Action Forum with a valuable insight into the health and service needs of the NEIC community, and specifically, with a blueprint for negotiating with the HSE regarding the range of primary care and other health services to be provided in the new Mountainview Court Primary Health Care Facility in Summerhill, Dublin 1.

1.2 Structure of the report

This report is presented as follows:

Section 1 provides an introduction to the report. It also presents the background to and rationale for the community consultation process in the North East Inner City (NEIC).

Section 2 introduces the community consultation process undertaken in the NEIC and outlines the methodology employed during the consultation process. Additionally, it identifies some challenges encountered in organising and conducting the community consultation process

Section 3 presents the findings of the community consultation process in relation to a broad range of population groups and special interest groups including children, young people, women, men, older people, residents' group, new communities, people with problem drug use, people who are homeless and people with disabilities.

Appendix 1 presents a comprehensive literature review undertaken to set the context for this community consultation process. Firstly, information on the profile and demographics of the NEIC is provided. The literature review then addresses key

issues relating to poverty and health inequalities and the determinants of health. It clearly sets out the links between poverty and ill health, including equity of access to health services. It identifies key National policy and strategy documents which highlight approaches for addressing health inequalities. This section then focuses on the importance of community participation in health service planning and sets out the principles and approaches for facilitating community involvement and participation in health service planning.

Appendix 2 provides a breakdown of participation in the community consultation process by number and gender and highlights some key challenges encountered with this process.

A bibliography is also provided at the end of the report.

1.3 Background to and rationale for the community consultation in the North East Inner City (NEIC)

1.3.1 ICON and the Health Action Forum:

The Inner City Organisations Network (ICON) is a network of community based projects, organisations and individuals living and working in the North East Inner City. A key focus of the network is to create a forum for debate and local policy making on issues identified within the community and to initiate the development of relevant service responses. Inherent in the aims of the organisation is a commitment to pursuing a partnership approach between statutory and non-statutory sectors as well as actively encouraging the participation of local tenants and residents.

The Health Action Forum:

'The ICON Health Action Forum is comprised of local community organisations and individuals living and working in the North East Inner City, who are exercising their right to participate in health and service development' (ICON documentation, 2008)

Aims of the Health Action Forum:

- To help the community to improve their own health and services through raising awareness and creating dialogue on health matters among community groups and with health services.
- To positively influence the health of the population through gathering of relevant data and information.
- To enable the community to make informed choices through access to appropriate health information and intelligence.
- To work with the statutory agencies in developing strategies to improve access to health services.
- To ensure the rights of the community to be consulted at local level regarding their health needs through representative community groups.
- To ensure that services for the community are appropriate, responsive to local needs, accessible and delivered in a manner that respects their privacy, dignity and individuality.
- To facilitate the most appropriate delivery of the Primary Health Care Strategy for the ICON area.

1.3.2 The current situation:

The North East Inner City (NEIC) is widely acknowledged as an area of extreme poverty and disadvantage. On a range of indicators, including health and deprivation, the North East Inner City contains some of the most deprived localities in the country. It has been recognised, however, that electoral division level statistics mask the true deprivation in some areas. Practically all local authority housing estates are in the most disadvantaged categories. ICON proposes that more emphasis should be placed on targeting those individuals, families and neighbourhoods that experience greatest need in terms of health service planning.

The SARHU index, a nationally accepted indicator of deprivation, combines unemployment, low social class, car ownership, rental accommodation and over crowding. This index allocates its highest (i.e. worst) rating of 10 to all but one of the electoral divisions within the North East Inner City. The following statistics, supplied by ICON (2008) highlight the significance of the deprivation in the NEIC.

- The highest density of medical card ownership in the North City is also in the North East with over 40% ownership in some electoral divisions.

- Deaths from all causes are 'geo-coded' so that they can be given per electoral division. The most recent data on mortality by electoral division is almost 10 years old. The NEIC contains the highest standardised mortality rates (SMR's) or death rates. Mountjoy A has the highest SMR, almost twice the rate of the Eastern Regional Health Authority (former Health Board Region), followed by Rotunda A and North Dock C, both over 70% higher than the ERHA as a whole.
- In 2006, 646 people on methadone had addresses in the NEIC. In Mountjoy A, 6% of the population aged less than 15 years are on methadone.
- Generally, in Ireland there are 68 GPs for every 100,000 people. In the ICON geographical area, there should be approximately 25 GPs working, but there are only 14 and only 2 of those offer methadone treatment.

(Source: O'Reilly. F. (2007). An Analysis of Health and Deprivation in the North Inner City for the ICON Health Forum. ICON.)

Further to clarification sought from the HSE with regard to GMS GP services within the NEIC, the following information relates to the current situation as of July 2008:

Based on a mapping of the GMS population in the Summerhill, North Strand and East Wall area, the number of GPs with a minimum Local Health Office – Dublin North City GMS (LHO-DNC) patient population of 50 patients is currently 24 GPs (16 practices). The HSE also points out that a number of other GPs would also have GMS patients in the area but these are not included in the above figure as they have less than 50 GMS patients in the LHO-DNC area. Furthermore, it should be noted that some people living in this geographical area may be listed with GPs outside of the immediate area.

(Source: HSE Local Health Office, Dublin North Central, July, 2008)

Additional statistical data provided by ICON (July 2008) is a further indication of the extent of poverty and deprivation in the NEIC:

Families and extent of lone parent households:

- In the NEIC RAPID area (of 5 DEDS) there are 1,881 family units with children in a population of just under 20,000. Of these 1,881 family units with children, 1,324 are lone parent families (70.39%). In the ICON area there are 3,642 family units with children, 2,000 of these are lone parent families.

- Across the NICDTF area there are 5,973 family units with children, 4472 (75%) of these are lone parent families.
- These statistics are in stark contrast with those relating to Dublin City where 38% (27,804 of 73,628) of family units with children are lone parent families. Furthermore, in Dublin City & County, 29% (59,594 of 199,368) of family units with children are lone parent families. Finally, in Ireland as a whole 25% (189240 of 749626) of family units are lone parent families.

NEIC Household Types:

- There are just under 7,300 households in 5 DEDS making up NEIC RAPID Area. Of these, nearly 66.5% are apartments, flats and bed-sits. In the ICON area (of 11 DEDs) apartments, flats and bed-sits make up 57.5% of all households. Across NICDTF area (of 19 DEDs) apartments, flats and bed-sits represent 55% of all household types. In contrast, 31% of households in Dublin City comprise of apartments, flats and bed-sits while the figure is 10% for Ireland as a whole.

Indicators of Drug Use:

- In Ireland over 9,000 people are treated with methadone for heroin use, over 80% of methadone service patients reside in the greater Dublin area. In NEIC Rapid Area there are approximately 460 people attending for methadone treatment. In the ICON Area there are over 600 attending methadone treatment services. In NICDTF area as a whole there are now estimated at over 1,000 people receiving methadone treatment.
- In Mountjoy A & Ballybough A between 1 in 20 and 1 in 25 adults between 18 & 64 attend methadone treatment services. These figures are estimates for 2006 and are indicative of drug use prevalence for heroin and other drugs. The National Advisory Committee on Drugs conservatively put prevalence estimates of active drug users for NICDTF area at between 1,500 to 2,000 in 2005.

NEIC Foreign National Population:

- In NEIC RAPID Area 6,435 individuals (35%) of the population, are of foreign national or ethnic origin (non-white Irish). In 3 other NIC DEDs this rises to over 50% of the resident population (4,292 of 8,271) of foreign nationals.
- This contrasts with a figure of 15% for Dublin City this group and a figure of 10% for Ireland as a whole. According to Dublin Inner City Partnership analysis this population is made up of over 50 nationalities.

A comprehensive literature review, presented in Appendix 1, provides further detailed information in relation to poverty, ill health, health inequalities and equity of access to health services and associated impacts on the population of the NEIC.

1.3.3 Primary Health Care in the NEIC:

Despite extreme poverty and social disadvantage, the NEIC has yet to be provided with a comprehensive Primary Health Care Facility. It is now proposed that a new health care facility is to be built on the Mountainview Court site in Summerhill. This site, and proposed building, is the property of the Dublin City Council and it is envisaged that the HSE, as tenants, will buy space in this building, primarily with a view to relocating the existing primary care services from the North Strand and Summerhill health centres to this new site. This development has provided an opportunity for the NEIC community to identify their health needs and to identify the range of services that should be provided within this new facility.

Section 2: Community Consultation Process & Methodology

2.1 Community consultation process:

In spring 2008, the ICON Health Action Forum sought tenders to facilitate a series of community consultations in the NEIC to assess the health needs of the community in relation to the Mountainview Court health care facility and to identify the services that should be provided there. The Forum was particularly concerned to include the views of marginalised groups including the homeless population, people with problem drug use and minority ethnic groups living in the area.

The Health Action Forum identified that the planning stages for the health care facility were underway in both Dublin City Council and the HSE and that it was imperative that the consultation process was initiated quickly to ensure that the community was facilitated to identify their own health and service needs. This approach is in line with that stated in the Primary Care Strategy (2001):

> ' *the coverage, composition and number of primary care teams in each health board area will be established on the basis of needs assessments consistent with a population health approach…….Needs assessments should specifically identify special needs or areas of disadvantage to ensure that primary care teams can be targeted to meet those needs'*.

2.2 The brief & tasks for the community consultation process:

This consultation is the first phase of a two phase strategy to identify health needs in the North East Inner City. It is envisaged that the second phase will involve a detailed health needs assessment to further facilitate the participation of the community in Primary Care at a local level. It is hoped that this initial consultation will be useful in supporting the community in the process of determining health and service needs.

The tasks:

- To organise and host a series of consultations (circa. 10) in the community with the support of the ICON Health Action Forum.
- To include the views of marginalised groups (e.g. homeless population, drugs users and minority ethnic groups) living in the area.
- To determine the health and service needs of the community in relation to the Primary Health Care Facility.
- To produce a final report with recommendations.
- To use creative and participatory methodologies.

2.3 Expected outcomes from the consultation process:

- Increased awareness at community level of the new primary health care facility.
- Health being placed on the community agenda.
- Increased information/knowledge regarding health concerns of community.
- Increased capacity to participate in a health needs assessment in phase 2.

2.4 Key stakeholders in this community consultation:

A broad range of stakeholders in the North East Inner City were identified for inclusion in the consultation process as follows:

- Parents
- Children and young people
- Older people
- People with special needs
- Gender specific groupings - men & women

- **Representatives of groups that are particularly marginalised;**
  - Homeless populations
  - Drug users
  - Minority ethnic groups
  - The agencies that work with these groups in the community

- **Service providers in the area;**
  - Local GP / Public Health Nurses
  - Youth Service Providers
  - Community Service Providers

- Health Service Providers
- ICON & the Health Action Forum

2.5 Methodology:

A community consultation process was undertaken within NEIC and included the following:

(i) Community consultation meetings;

(ii) Expert panel consultation;

(iii) Individual interviews.

(i) Community consultation meetings:

Six general consultation meetings were held ensuring representation across the key life stages as follows:

- Young people
- Parents (identifying children's health issues as well)
- Men
- Women
- Older people
- Local residents

Three consultation meetings were held with specifically identified marginalised groups as follows:

- Homeless population – contacted through Rendu
- Recovering drug users – contacted through Soilse (this group represented the views of drug users as well as those in recovery)
- Minority ethnic groups –contacted through Cairde Ethnic Minority Health Forum.

(ii) Expert panel consultation:

A half-day consultation meeting was facilitated with an 'expert panel' i.e. a panel of service providers in the area. This panel was representative of a broad range of service providers and was extremely useful in identifying the health and service needs of the community from an evidence-based perspective. These views complimented the views of the community itself.

(iii) Individual interviews:

In addition to the 10 community consultation meetings, a series of one-to-one interviews were conducted with key stakeholders working in the NEIC area. These individuals were selected based on their involvement in the community and their ability to contribute usefully to identifying community health and service needs, particularly in relation to those groups that were difficult to access in the community.

Those interviewed included:

- North East Inner City Drugs Task Force Co-ordinator
- Co-ordinator from Uisce (Union for Improved Services, Communication & Education)
- Two Public Health Nurses working in the NEIC
- Women's Health Officer, HSE Dublin North East
- Teen Health Co-ordinator, HSE Dublin North East
- Researcher in Primary Care
- Chair of ICON
- Co-ordinator of Neighbourhood Youth Project (NYP2), Summerhill
- Staff Team from Cairde

The selection of approaches was informed by the HSE document *'Stepping Forward – A Guide to Local Health Needs Assessment' by Jennings and Burke, 2005*. Specifically, a community development approach was central to the process.

"This approach is about getting local people to participate in needs assessment. It helps you to find out what they think their needs are, and the priorities they have. Finding out the priorities, as the community sees them, is a good first step towards working with the community to address its problems" (Jennings & Burke, 2005)

The consultant team used a range of methodologies for these consultation meetings. Each consultation meeting included:

- A creative visioning exercise which enabled individuals to creatively visualise what they would like to see provided in the new Primary Health Care Facility;
- Facilitated discussion on a number of key questions which included:
    - Identify the health needs of the community against the key life stages and specific target groups (i.e. the health needs of children,

young people, parents, women & men, older people, people with disabilities, homeless, drug users, minority ethnic groups, others as may arise);

- Identify the services required to address these health needs;
- Identify the priority health services that should be provided by the Primary Health care Facility;
- Identify a set of general recommendations from the community for the HSE in relation to the provision of the new Primary Health Care Facility.

Specific methodologies for exploring these questions were selected on the basis of each group's composition taking account of issues such as literacy, language, mobility and culture. Overall, the methodology was participatory and qualitative rather than quantitative in nature.

2.6 Challenges encountered in organising and conducting the community consultation process:

While it was not possible to consult directly with a specific group of men or women, all of those who engaged in the remaining focus groups brought both perspectives to the consultation. It was particularly difficult and challenging to access men to participate in a consultation meeting in the community. Two attempts were made to organise a meeting, without success. Furthermore, at the request of the Health Action Forum, a specific questionnaire was developed for use with men. It was envisaged that this questionnaire would be used by male staff as the basis for a one-to-one interview with a representative sample of men in the community. However, this strategy did not happen either. As a result, the report draws on existing research and other relevant consultation findings with regard to these population groups.

With regard to people with disabilities, again, it was not possible to convene a focus group. However, once again relevant research was referenced in the report. Finally, the limited scope of this consultation process validates the need for a more extensive in-depth needs assessment process which should include a door-to-door survey of all households in the NEIC as well as further focus groups and interviews.

Section 3: Community consultation findings

Introduction:

This section reports on the findings of the community consultation process conducted in April/May 2008 within the North East Inner City. Presentation of the findings is structured under the headings of key population groups as follows:

- **Children**
- **Young people**
- **Women**
- **Men**
- **Parents**
- **Older people**

Additionally, consultation findings in relation to special interest groups focus on the following groups:

- **Local residents**
- **Minority ethnic groups / new communities**
- **People with problem drug use**
- **People who are homeless**
- **People with disabilities**

Please see Appendix 2 for a breakdown of focus groups and interviews by number and gender.

Under each of the above headings, the consultation feedback is presented under four key headings as follows:

- ***Health needs identified*;**
- ***Experience of current service provision*;**
- ***Health and social services required in the new primary health care facility*;**
- ***Recommendations on making the new facility more 'user-friendly' for each specific group.***

As indicated in Section 2 on the consultation process, the consultation findings have been gathered via facilitated consultation meetings with specific population

and special interest groups and via a range of one-to-one interviews with key service providers and community representatives.

Please note that the findings from all those engaged in the evaluation have been analysed using content analysis. Key themes emerging have been structured and are presented collectively from all stakeholders under the headings outlined above. Where additional information has been required, key research documents have been drawn upon and referenced accordingly.

3.1 Children

Health needs identified:

While this consultation process did not focus specifically on children, a range of health and services needs pertaining to children were identified through the consultations with many of the other population groups.

In general, the health needs of children included the following:

- Access to paediatric services to respond to the general health needs of children e.g. colds, infections, viruses;
- Access to specialist paediatric services to respond to specific childhood conditions.
- Speech and language issues.
- Diet and nutrition and the impact of fast food and low levels of physical activity on childhood obesity.
- ADHD and autism.
- Basic developmental issues and special needs e.g. learning and physical disabilities.
- Hearing and sight problems.
- Dental health.
- Child psychological, emotional and behavioural problems including childhood depression.
- Social and family exposure to drug and alcohol misuse and crime in the community.
- Childhood bullying.

Experience of current service provision:

Throughout the consultation process, parents spoke about their experience of accessing health services for their children. This experience was mixed. The key issues reported were as follows:

- Access to specialist health services for children proved challenging for some. For example, parents experienced long waiting lists, particularly for those with medical cards or for those without private health insurance.
- Some children with particular conditions who needed to see a number of specialists experienced significant delays in terms of referral. Additionally, communication between specialists dealing with the same child was uncoordinated and led to further delays.
- Overall, the developmental checks and services provided by the PHNs were experienced in a very positive manner.
- Where parents had access to parent and toddler groups, they reported that these provided great support and networking opportunities.
- The main issue identified in relation to GPs was a lack of time during consultations.

Health and social services required for children within the new primary health care facility.

- Core primary health care services including GPs, practice nurses, PHNs, immunisation clinics, mother and baby clinics, social worker. Core services should also include child health clinics and home visiting up to 4 years and beyond, with additional services for those children with special needs.
- Paediatrician.
- Dentist, sight/ophthalmic service, audiological services (i.e. hearing checks).
- Dermatologist
- Physiotherapy.
- Child psychology and psychiatric services (clinic basis) as well as counselling and bereavement support services.
- Community dietician (for advice and support on diet and exercise).
- Minor injuries clinic.

***Recommendations on making the primary health care facility 'child friendly'*:**
For parents, bringing children to a health care facility can be extremely stressful. In this regard, parents involved in the consultation process suggested the following:

- The facility should provide a bright, colourful, spacious, child-friendly waiting area with a designated play area with toys, books and background music.
- Access to a safe external play area such as a courtyard, where parents could also sit in the fresh air was recommended.
- An efficient appointments system (cutting down on waiting times) is required.
- The facility should be serviced by a frequent and efficient public transport network. Parking spaces should also be available.
- Extended opening hours e.g. late evenings and weekend opening hours to facilitate ease of access is essential.
- A health information service, including information on all relevant child health issues and associated services and support groups is necessary. This information service should take account of those with literacy issues.

3.2 Young people

Health needs identified:
Young people (aged 15 -18 years), and service providers, involved in the community consultation identified the following health needs pertaining to this population group as follows:

- **Diet and nutrition**: Young people identified the need for information about healthy food choices and easier access to healthy foods. They highlighted the effect of lifestyle factors and the over dependence on fast foods and convenience foods. Additionally, some service providers identified the need to address issues related to diet and nutrition such as eating disorders.
- **Lack of facilities for leisure and recreation activities:** Young people identified the need for more access to safe play and recreation areas within the NEIC.
- **Emotional and mental health:** Young people identified a broad range of issues impacting on emotional and mental health including family problems,

depression and suicide. Furthermore, isolation experienced by some members of new communities was emphasised.

- **Drug and alcohol use:** This population group highlighted the regular use of many drugs, especially cannabis and alcohol among young people in inner city areas. They also highlighted the early age at which young people are regularly using drugs and alcohol – *'they are as young as 11 or 12 years smoking hash and drinking vodka'*.
- **Sexual health:** This group identified that there is a considerable lack of knowledge among young people in relation to sexual health, STIs and contraception. They stated that many young people are sexually active, some from a very young age i.e. as young as 12 or 13 years. Some of these young people are engaging in risky sexual behaviours and not practicing safe sex. *'Most young people know nothing about STI's, only pregnancy'*.

Experience of current service provision:

In general, owing to their age, the young people consulted had limited experience of engaging with health services. Their contact was usually as a result of a parent's instruction to visit the doctor. Therefore, when asked about their experiences with health professionals to date, the vast majority spoke about their experience of visiting the GP, as this is the service most commonly used by them. Their experience in this regard was mixed. Those who had used the 'D Doc' services were very positive about this service. This service was described as follows: *'quick, easy and they don't judge you'*.

Conversely, some young people had a less positive experience with some of their own GPs and practice nurses. They felt that some doctors could be very judgemental and tended to lecture them. They also found some services to be somewhat patronising to young people. One of the young people was involved with social services and had her own social worker and reported a positive experience of this service.

Health and social services required for young people in the new primary health care facility.

Both the young people themselves and service providers identified the need for 'young person friendly' health services to respond to the health needs identified above. Specifically, they suggested that the new primary health care facility should include the following:

- Core health professionals such as doctors and nurses, social workers, counsellor etc.
- A 'young person friendly' sexual health and information service, although the group felt that this service would only be used by girls and not by boys. They suggested that this service should provide free and confidential STI screening, contraception and sexual health information. They also suggested that this service should build links with local schools and provide posters and speakers in the schools.
- This group suggested that the facility should build links with local gyms to encourage young people to use exercise and leisure facilities at affordable rates.
- The need to provide a general health information service within the facility was also recommended. This information service should provide information for young people on the services available to them in the community, how to access these services and address issues such as parental consent and payment.
- In terms of making the facility 'young person friendly', the group suggested the provision of alternative therapies such as aromatherapy etc. This may encourage young people to use the facility more frequently.
- Finally, this group highlighted the need for an outreach service/worker who would link with existing groups in the community, provide information for young people on the services available within the facility and provide health education programmes on a variety of topics for young people.

Recommendations on making the primary health care facility 'user friendly' for young people:

- The design of the building itself should arouse people's interest and curiosity and encourage them to visit and find out what is being provided there. This group mentioned another building currently under construction in East Wall which has created a curiosity among local residents as a result of its eye catching design… *'it looks like lego land…all the kids are dying to get into it'*.
- The design of the inside of the facility should also be interesting and possibly include graffiti walls and interesting paintings.
- The facility should include an area where healthy food and drinks are provided for those waiting.

- The waiting area should have a 'flat screen TV' showing health-related messages and advertisements such as the 'mind your mental health' advert.
- This group felt that it was very important that staff in the facility should be friendly and use age-appropriate language when dealing with young people. *'…people should be treated well….they shouldn't use big words'*.
- This group suggested that where possible young people would feel more comfortable talking to younger staff.
- Service providers suggested that within the facility a 'young person specific service' or Youth Café should be provided which is holistic in nature, promoting a 'wellness model of health'. This service could also be linked with local schools. Examples such as The Base in Ballyfermot and The Gaf in Galway were identified. Such a model could also consider the specific needs of young mothers and young fathers and the links between education and health.

3.3 Women

Despite a number of attempts to consult specifically with women during this process, a specific group of women was difficult to access. However, throughout the process women were involved across the various other consultation groups and provided the following views and opinions.

Health needs identified:

The following provides a summary of the women's health needs identified throughout the consultation process:

- **Sexual and reproductive health** including family planning, access to cervical screening, STI screening and maternity and ante-natal care. Additionally, specific sexual health needs relating to prostitution require particular attention.
- **Access to cancer screening services** such as Breast Check.
- **Mental and emotional health** including depression/post natal depression, social isolation e.g. young mothers at home with small children, high levels of stress and anxiety and emotional health difficulties arising from dysfunctional relationships and domestic violence.

- **Substance misuse issues** including smoking, alcohol, recreational and problematic drug use and over use of prescription and over the counter medicines.
- **Diet and nutrition and lack of physical activity** leading to overweight and obesity.
- **Poverty and unemployment** resulting in negative impact on both physical and emotional health. It is widely known that women experiencing poverty and disadvantage smoke more and are more likely to be medicated.
- **Physical health needs** e.g. blood pressure, heart problems, diabetes and osteoporosis.
- **Stress and anxiety** as a result of the 'caring role' adopted by many women e.g. grandmothers taking care of grandchildren as a result of parental drug use etc.
- **Poor health outcomes**, e.g. stress, anxiety, and depression, experienced by female lone parents coupled with poor educational achievement, poverty and social disadvantage.
- **Access to health information** and advice on self-care particularly in relation to lifestyle, pregnancy and child care.

Experience of current service provision:

Throughout this consultation process, women themselves and key service providers with a particular interest/remit for women's health have highlighted significant issues relating to women's experience of current health service provision. Many of these issues have been validated and summarised in a 2005 HSE document entitled 'Why Target Women's Health?'. The main issues emerging are as follows:

- The relationship between gender and the other key determinants of health is complex. While, officially, the Irish health system now accepts that there are gender differences in the incidence, symptoms and prognosis of a wide range of health problems, gender-related targets are required if outcomes are to improve. Women's experience of current service provision reflects the following:
- The lack of real targeting of women's health is counter productive. It is particularly damaging in the context of current health service development because:

- It means that many health services are based on generalised needs and therefore, are less effective for women's health;
- It limits the efficiency of the health services and the well-being of women and results in a high demand on scarce resources;
- It compromises the accessibility, equity and people-centeredness to which the National Health Strategy aspires;
- It neglects real opportunities to improve health status.

- As a result;
  - Women experience ill health needlessly, women die unnecessarily, families lose out, demand for health services rise, premature dependency on acute services increases and there is greater, and avoidable strain on health services funding and resources.
  - Irish women's health status is among the lowest in the developed world. The gap between the health status of disadvantaged and of better-off women living in Ireland is widening. Women still do not experience Irish health services as holistic or enabling e.g. women continue to request counselling rather than medication for mental distress, but without general success. Irish women are increasingly taking risks with their health, particularly in relation to lifestyle behaviours.

Health and social services required in the new primary health care facility to respond to women's health needs:

- Core primary care services e.g. GPs, (including the option to have access to female GPs) PHNs, practice nurses, social worker, occupational therapist and physiotherapist.
- Access to a chiropodist and community welfare officer through the Primary Care Network.
- A comprehensive, professional, easily accessible and user-friendly sexual and reproductive health service including family planning and contraception, STI screening, cervical screening and maternity and ante-natal care. This service should be available to all women aged 16 – 60 years and be provided by female staff.
- Appropriate access to Breast Check and other relevant cancer screening services. Local HSE information highlights that there has only been a 25%

uptake rate for Breast Check in this geographical area (HSE Women's Health Service, 2008).

- An appropriate counselling service where women can self refer as well as being referred by the GP and other health professionals. The emphasis here must be on counselling and support rather that on prescribed medication for depression, stress and anxiety. Appropriate counselling can positively prevent women from requiring psychiatric services. The ideal model is that provided by Genesis Counselling Service in Corduff. Additionally, in planning this service, particular attention should be paid to the Report entitled 'Perspectives on the Provision of Counselling for Women in Ireland' (Women's Health Council: www.whc.ie/publications/counselling_perspectives.pdf
- A holistic addiction service to include access to addiction counselling and appropriate referral pathways on to more specialised addiction services when required. The issue of women and alcohol requires particular attention as evidence suggests that women frequently do not present with alcohol problems because of fear of having children taken into care. A pro-active response to the alcohol issue is required as a priority.
- Within the new facility, the Primary Care Team (PCT) must have appropriate mechanisms in place to respond to issues such as domestic violence, rape and sexual assault. Appropriate referral pathways are essential on to specialised services in this regard. Additionally, key service providers recommend that the facility must have a range of policies and protocols on issues that impinge particularly on women, such as domestic violence, rape and sexual violence, in order to ensure a consistent approach and response to these issues by all health care professionals within the facility. Health care professionals also require training in relation to how to respond appropriately to these difficult and sensitive issues.
- Family support and early intervention strategies for women and families 'at risk' is essential.
- A health promotion/health information service providing a broad range of information on women's, and family health issues, support services, referral agencies, prevention and early detection strategies around issues such as female specific cancers and other relevant women's health issues is required.

Recommendations on making the primary health care facility 'user friendly' for women:

A number of key recommendations were made by women themselves and by key service providers in terms of how primary care services should be delivered to meet women's health needs. These included the following:

- GPs within this new facility require an in-depth understanding of the lives of the women living in the NEIC to enable them to respond to their needs accordingly.
- The need for greater capacity building for women in communities. Women are a valuable resource in any community and can act as a significant link between other women in the community and health services. However, women require support with literacy, access to relevant information and confidence building to be able to carry out this role. Social and educational programmes delivered from this new facility could usefully contribute to such capacity and confidence building, and in turn, local women can become advocates for the health services.
- A comprehensive outreach service is required to develop and maintain formal links between the health services and the community. Community health workers, trained in basic health promotion and early intervention strategies, could play an essential role in creating awareness about the health care facility and the services therein. These community health workers could also link with other service providers, agencies and existing outreach workers already engaged with women and families in the community and through this liaison, raise awareness about, and encourage women and their families to use the new facility. Links with Barnardos and Women's Aid as well as drugs services, homeless agencies, representative groups for minority ethnic groups and youth services would be particularly beneficial in this context.
- Policies, procedures and training for the PCT and other health professionals is critical to ensure a consistent response to issues such as prostitution, domestic violence and sexual violence. Professionals working in the primary care facility need to be fully aware of the social situations they are working in, be able to readily identify 'at risk' families and individuals and respond accordingly with appropriate early intervention strategies.
- Finally, it is critical to highlight that *'focusing on women's health and specifically targeting women does not imply neglecting men's health, nor that women's health is more important than men's health or that men's*

health should not be targeted. Gender is one of 12 highly interactive determinants of health. Many of these, such as socio-economic status, are significant determinants of health for both women and men. However, these determinants intersect differently for men and women and affect women and men differently' ('Why Target Women's Health?': HSE, 2005) Therefore, in terms of women's health, a dedicated approach to women's health is vital within the new health care facility.

3.4 Men

Health needs identified:

Despite a number of attempts to consult specifically with men during this process, men were difficult to target. However, throughout the process men were involved across the various other consultation groups. This section summarises the findings in relation to men's health and service needs, drawing on both the consultation process and key research on men's health carried out in recent years.

Similar to women, there are many factors that impact on men's health such as socio-economic status, marital status, family status, race, ethnicity, sexual orientation, age, disability and lifestyle factors. As stated above, these determinants impact differently on men than women.

- **Morbidity and mortality**: Irish men die on average nearly 6 years younger than Irish women do, and have the second lowest life expectancy in the European Union. Underpinning men's lower life expectancy is the fact that in Ireland, men have higher death rates for all leading causes of death.
- **Suicide, mental and emotional health**: Recent research indicates the following:
    - There is a consistent pattern of higher admission rates to psychiatric hospitals for males compared to females.
    - Men from the lowest occupational group are over five times more likely to die from suicide and sixteen times more likely to die from alcohol abuse, compared to men from the highest occupational group.
    - Men are less likely than women to report concerns relating to mental or emotional problems. Suicide is the most frequent cause of death in 15-34 year old age group.

- High alcohol consumption, marital breakdown and isolation from traditional family supports such as the extended family are all factors leading to an increased incidence of young male suicides. (Daly and Walsh, 2003 & 2006); Richardson, N (2004); NEHB, (2004)
- Additionally, some men require specific interventions around the issue of violence, including domestic violence and anger management.

- **Lifestyle issues:**
  - Men are at greater risk than women in relation to lifestyle issues such as smoking, alcohol consumption and dietary patterns. It is also well established that men engage in a variety of other risk behaviours and at much higher rates than women. (Kelleher et al, 2003).
  - Less well-off men are significantly more likely to engage in 'negative' self-care practices, to have a low level of knowledge/awareness of health, to report having neglected or paid little attention to their health, and to report weekly binge drinking and more sedentary lifestyles (Richardson, N, 2004).
- **Illegal drug use:**
  - Throughout this consultation process, the issue of illegal drugs use within the NEIC, particularly heroin and cocaine, was highlighted as significant. Data on illegal drugs use is patchy because of the illegal and hidden nature of this activity. However, evidence suggests that males are 12 times more likely than females to be prosecuted for drugs offences (Connolly, 2006).
  - Furthermore, other research suggests that seven out of ten persons receiving treatment for drug abuse are male (Long, Lynn & Kelly, 2005).
  - Over the last decade, drug related deaths in Ireland were between three and eighteen times higher among males than females (Long, Lynn & Keating, 2005).
  - Anecdotal evidence, backed up in this consultation, suggests that the vast majority of hard drug users come from backgrounds of social and economic deprivation, and that their drug habit further reinforces their marginalisation (de Brún & Du Vivier, 2007). Furthermore, it has been suggested throughout this consultation that there are significant links between heavy drug use and male suicide.

- **Cardiovascular disease:** In Ireland, nearly half of all men die from heart disease and related conditions such as stroke. Men's death rates from ischemic hearth disease (IHD) and stroke rise more quickly with age than women. 35% of premature deaths in men are from IHD.
- **Sexual health:** This consultation highlighted that men's sexual health needs attract less attention because of the focus on reproductive health, mainly for women. However, men require sexual health services that are 'male friendly' and 'male specific' and focus on the broad spectrum of sexual health issues for men including STI screening, contraception, advice and information and screening for male specific cancers e.g. testicular and prostate cancers.

Experience of current service provision:

Recent research (Richardson, N. 2004) has highlighted that, in general, men are reluctant to engage with primary health care services.

- Playing down symptoms, cost and losing out on work are attributed most to this sense of reluctance. Usually, men only attend when pressurised to do so. Research shows a number of factors associated with men's fear or anxiety about attending a doctor which are: (i) concern about having a serious condition diagnosed; (ii) concern about being admitted to a hospital as a result of the visit; (iii) the prospect of having private parts examined.
- In relation to mental health, the stigma that is associated with a mental health issue appears to prompt some men to 'self-medicate' with alcohol, and/or to resort to violent behaviour rather than deal with the impact of a mental health diagnosis.
- This consultation highlighted the following issues impacting on men's use of primary care services as follows:
    - Primary care services are perceived to be more geared towards women and children than specifically towards men, therefore, men sometimes feel excluded. Men feel that services are not user-friendly for men and are expensive without the medical card.
    - There is also a perception among men that many of the frontline staff in primary health care are female and this presents a barrier for men accessing services.
    - Consistently, in relation to addressing men's health needs, health services experience major challenges in targeting and accessing men. There are particular challenges in accessing men in areas of

depravation and disadvantage owing to the considerable social and cultural issues that prevail e.g. *'…the working class culture dictates that men don't talk about their health….'*

Health and social services required in the new primary health care facility *to respond to men's health needs:*

- Core primary care services e.g. GPs, PHNs, practice nurses, social worker, occupational therapist and physiotherapist.
- Access to a chiropodist and community welfare officer through the Primary Care Network.
- Male specific sexual health services including STI screening, contraception, advice and information on sexual health and wellbeing.
- General health screening to include relevant cancer screening and cardiovascular health screening appropriate to the different life stages.
- Addiction services (this will be dealt with in more detail under the heading of drug use and addiction).
- Mental health services including counselling and appropriate referral pathways to more specialist and appropriate mental health services when required.
- Health information service with a particular emphasis on user-friendly health information for men.
- Outreach services to target and access 'hard to reach' males within the community. Once again, male community health workers could play a significant role in linking with men in the community, highlighting the services available within the facility and supporting men to access services when required. Additionally, male community health workers could network with other relevant agencies and projects in the community providing services for men.

Recommendations on making the primary health care facility 'user friendly' for men:

Recommendations made throughout this consultation process are once again reinforced in key men's health research (Richardson, N. 2004) as follows:

- **Targeting socially disadvantaged men**: In the context of health inequalities, this consultation report has highlighted clearly the links between low social class, poverty and disadvantage and impaired health

status. As a result, wide ranging social and structural changes are necessary to address the health issues of men in the NEIC. These changes must begin at the heart of the community and within primary care.

- **'Male-friendly' environment:** The new primary care facility must create a physical and social environment which is 'male-friendly' and makes every effort to welcome and integrate men. The provision of 'male only' health clinics at designated times, taking account of men's circumstances is recommended in this regard.
- **Access to male staff within the facility:** There should be a gender balance among staff from those at the frontline right through the various professionals within the facility. Men particularly want access to a male GP, male practice nurses and male community health workers. Male workers within the health information service would also encourage men to use this service.
- **Training for staff:** All staff working in the facility should receive specific training on men's issues and appropriate responses. The significance of masculinities on men's risk-taking and health-seeking behaviours should not be underestimated and should be addressed in training.
- **Facilitating men's networks:** This new facility has the potential to become a focal point in the community whereby, all population groups, including men, can access the space for a variety of social reasons and, as a result, may be more likely to use the specific health-related services provided there. Therefore, particular attention needs to be given to ensuring that meeting spaces/rooms are made available to community groups to enable this to happen.
- **Flexible opening hours:** This facility must extend its opening hours beyond the traditional 9 – 5, particularly, in order to encourage an uptake of services by hard-to-reach groups such as men.

3.5 Older people

Health needs identified:

Older people engaged in the consultation process identified the following health needs:

- **Diet and nutrition:** This group felt that diet is very important and acknowledged that a healthy diet is important in older age.

- **Exercise and physical activity**: Older people need regular exercise which is suited to their needs and which is also enjoyable e.g. walking, dancing, arm chair exercises and access to physiotherapy services.
- **Dental health**: Older people have particular dental health needs requiring ongoing attention.
- **Management of prescribed medication**: Older people require advice and information on taking and managing prescribed medication.
- **Foot care:** Older people can experience a variety of foot-related conditions which can impact on their general health and mobility.
- **Eye care:** Failing eyesight and specific conditions such as glaucoma and cataracts are more common among older people.
- **Emotional and mental health:** The older people emphasised the need to have someone to talk to especially when feeling down or depressed.
- **Diabetes:** Diabetes is a condition which can affect many older people and they require advice and support in managing this condition.
- **Access to health services:** The older people highlighted the need for easy access to particular health professionals including GPs, social workers and occupational therapists.
- **Access to a pharmacy:** This group identified the need for easy access to a pharmacy to enable them to fill their medical prescriptions.
- **Increased access to medical cards**: Particular needs were highlighted in this regard for those that have been diagnosed with long-term illnesses but who may not meet current criteria for eligibility for a medical card, including those under 65 years.
- **Information on health and entitlements:** The older people involved in the consultation reported having experienced difficulties in accessing 'user friendly' information regarding their entitlements (including form filling), their medical conditions and advice on medication.
- **Practical support**s e.g. help with maintaining the home and garden. Age Action provides a service in this regard.

Experience of current service provision:

The older people engaged in the consultation identified mixed experiences of current service provision as follows:

- The D Doc service was described as *'great'*.

- The experience of GPs was mixed, the main criticisms being that time was limited and that they did not always do house visits.
- There was an overwhelmingly positive response to the local public health nurses e.g. *'…they are great for advice and listening and spending time with you'*.
- Access to chiropody services is good if older people are attending a day care centre, however, they do not do house calls. Additionally, some concerns were raised that this service may incur increased costs in the future.
- Access to physiotherapy is again attached to the day care centre and the experience of this service is positive.
- Access to optician services and dental services is good, although some concerns were raised about some premises not being wheelchair accessible.
- Older people's experience of attending A&E was described as 'degrading and distressing' especially at busy times such as night and weekends.

Health and social services required for older people in the new primary health care facility:

- Core primary care services e.g. GPs, PHNs, practice nurses, social worker, occupational therapist. Specifically, an increased number of nurses was suggested to take account of the increased number of people who will be using this facility.
- Access to dietitians and/or community nutritionists e.g. dietetic clinics.
- Access to a chiropodist and community welfare officer through the Primary Care Network.
- Sight/ophthalmic services and dental services.
- Counsellor, especially for bereavement counselling.
- Minor injuries clinic e.g. for stitching, initial assessment, oxygen etc. A model similar to the Swift Clinic in Smithfield was suggested in this regard.
- General health screening services e.g. for cancer screening, diabetes, coronary care, blood pressure, cholesterol etc
- On-site pharmacy.
- Health and social services information providing information on welfare, entitlements and services and help with form filling.

Recommendations on making the primary health care facility 'user friendly' for older people:

- The new facility needs to be wheelchair accessible and provide a variety of aids to make the building accessible to those with limited mobility e.g. handrails, lifts etc.
- The facility should have a pleasant waiting area with access to health information, TV and refreshments available.
- The waiting area could be attached to the general health information service, whereby a health worker would be on hand to deal with general queries and concerns and provide assistance with form filling.
- The health information service should provide information on a broad range of common medical conditions including signs and symptoms, treatment choices and service providers.
- The older people suggested that every effort should be made to ensure that the physical and social environment is welcoming and relaxing e.g. a fish tank and soft lighting were specifically mentioned.
- Given that the Lourdes Day Care Centre will be co-located with the new health care facility on the same site, it was recommended that a link corridor should be built between the two buildings to enable safe and easy access to the health facility.
- An outreach support service to enable older people who are ill to remain at home comfortably for as long as possible was recommended.

It should be noted that many of the themes emerging from this consultation with older people have also been highlighted in two recent pieces of research conducted specifically with older people in the North East Inner City, namely;

- Rourke, S. (2008). 'Changing Times, Changing Needs'. Needs Analysis Project of Older People in North East Inner City of Dublin: Inner City Organisations Network.
- Rourke, S. (2008). East Wall Older Persons Needs Analysis Project. Views of older people living in East Wall about the services being provided to them and about ways in which the lives of older people might be improved. Nascadh Community Development Project.

Special Interest Groups:

3.6 Residents' group:

Health needs identified:

The consultation conducted with a local residents' group reiterated many of the key findings across the other population groups summarised here as follows:

- **Diet and nutrition** was identified as an issue for all population groups and in particular for those with specific health conditions such as diabetes, heart disease etc.
- **Mental and emotional health** was highlighted particularly as an issue for young people in the area. Additionally, linked to mental and emotional health were issues of social isolation and depression and the over use of medication in response to mental health issues.
- **Gender specific health needs:** This consultation highlighted the same issues relating to both women's and men's health needs as have been outlined in the previous sections.
- **Young people's sexual health**: Young people's need for a 'young-person' friendly sexual health service to address contraception, STI and sexual health information was identified.
- **Drugs:** This group identified the need to address the drugs issue within the NEIC but reinforced the need to be discrete and sensitive and not to replicate what is being provided by existing services e.g. City Clinic.
- **Older people's health needs** were highlighted and the need for additional PHNs, specifically for older people was suggested.

Experience of current service provision:

This group's experience of current service provision was mixed, however the following key issues emerged:

- Lack of privacy and perceived lack of confidentiality in relation to accessing some services e.g. where one can be seen queuing publicly for community welfare officer was felt to be 'demeaning'.
- Restricted opening hours and lunchtime closing presents a barrier for residents accessing services, particularly for those who have childcare issues or are working.
- The 'D Doc' service was experienced very positively by residents.

Health and social services required in the new primary health care facility:

The residents' group identified the following services as important:

- Core primary care services e.g. GPs, PHNs, practice nurses, social worker (including child protection services), pre-natal and ante-natal services.
- Access to a chiropodist and community welfare officer through the Primary Care Network.
- Targeted women's health clinics to include mammogram, cervical screening, sexual and reproductive health services.
- Targeted men's health clinics that are 'male only' and 'male-friendly'.
- Dentist.
- Dermatologist.
- Access to dietitians and/or community nutritionists e.g. dietetic clinics.
- Diabetic clinic.
- Sight/ophthalmic services and dental services.
- Counsellor, especially for bereavement counselling.
- Minor injuries clinic e.g. for stitching, x-rays, initial assessment etc
- General health screening services e.g. for cancer screening, diabetes, coronary care, blood pressure, cholesterol etc.
- A drop-in service for people with mental health issues including access to a psychiatrist.
- Access to a general counselling service on a 24 hour basis.

Recommendations ***making the primary health care facility 'user friendly' for all population groups:***

- A bright, well organised, spacious reception area staffed by welcoming and friendly people (and to employ local people where possible).
- An efficient appointments and queuing system.
- Longer opening hours (to include evenings and Saturdays) and no lunchtime closing.
- Designated smoking area at the back of the building so as not to have patients smoking at the front.
- A canteen / tea & coffee facilities to encourage local people to come in and use the facility.
- Good car parking facilities to facilitate those transporting sick relatives and children.
- A supervised play area for children.

- A flat screen TV in the reception area displaying information on health issues and related services available in the area.
- A leaflet dropped to every house in the area clearly explaining what services are available in the facility.
- An open day/open evening to enable local people to come in and have a look around the facility in a relaxed atmosphere.
- Good use of social space and meeting rooms for educational purposes e.g. cookery classes etc.
- An emphasis on environmentally friendly building materials and maintenance of the facility, including recycling.

3.7 Minority ethnic groups/new communities:

A consultation was carried out with Cairde Ethnic Minority Health Forum (EMHF) and subsequently with key staff working with Ethnic Minority groups within Cairde. The following summarises the main findings from this consultation.

Health needs identified:

The following health needs were identified through these consultations:

- **Family reunification:** Family separation has a significant impact on mental and emotional health and the process of family reunification can be very long with limited information being made available to those going through this process.
- **Accommodation:** Inappropriate and sometimes crowded accommodation impacts negatively on both physical and emotional health.
- **Unemployment:** Migrant status can have a significant impact on one's ability to secure meaningful employment relevant to one's background and skills. This, in turn, has a knock-on affect on income, resulting in reduced quality of life and isolation.
- **Access to information:** Language difficulties, cultural barriers and lack of information all lead to difficulties in accessing entitlements e.g. medical cards.
- **Access to a broad range of primary health care services:** Lack of accessible information on how the Irish health service works and where and how to access primary health care services impacts negatively on health status.

Experience of current service provision:

Those consulted in this process identified the following issues in relation to their experience of current service provision.

- Some frontline staff and management in health services are not trained in multi-culturalism/racial awareness. This can result in misunderstandings and a breakdown in communication which, in turn, can result in barriers to accessing health services.
- Current migrant status is directly related to one's ability to access health services. This is a particular problem for undocumented migrants, who, because of their status are reluctant to engage with health and social services.
- Due to lack of accessible information, some members of new communities can end up paying for services to which they are, in fact, entitled to free of charge. This again creates a barrier to accessing services.
- Anecdotal evidence suggests that there may be a lack of clarity with regard to the criteria for entitlement and eligibility to services on behalf of the HSE. Additionally, this issue can be compounded by a lack of communication to minority ethnic groups about the criteria for entitlement and eligibility. There is a need to clarify that all those who are 'documented' and 'resident' in this country, are entitled to free or subsidised health services (Cairde, 2008).

Health and social services required in the new primary health care facility to respond to the needs of minority ethnic groups:

- Core primary care services e.g. GPs (both male and female), PHNs, practice nurses, social workers, physiotherapy, occupational therapy.
- Access to a chiropodist and community welfare officer through the Primary Care Network.
- Access to clinics such as obstetrics, paediatrics, orthopaedics, dental, diabetes, dietetics etc.
- Minor injuries clinic for stitching, emergency treatment, basic blood testing, mobile x-ray and MRI scanning machine.
- Women's health services including Breast Check, family planning, cervical screening with access to a female GP.
- Men's health services including general health and screening.

- Mental health services (provided on a regular clinic basis) including a community mental health nurse, psychology and psychiatric services and general counselling service.
- Community liaison officer/community health worker to provide an outreach service and link the health care facility with new communities.
- Addiction services with a variety of treatment options including a methadone clinic, addiction counselling, support and self help groups.
- A comprehensive health information service including access to a community welfare officer who can provide information on entitlements and eligibility and more general information on education and employment options.
- Equality officer in place to address discrimination and racism.
- Mobile medical services, to respond to minor injuries and to provide information about services available and how to access them.
- Interpreters available who can translate relevant health information as appropriate.

Additionally, while specific health issues including Female Genital Mutilation/Cutting (FGM/C) and male circumcision cannot be appropriately addressed by the PCT, they should be addressed through the provision of information and appropriate referral pathways.

Recommendations on making the primary health care facility 'user friendly' for new communities:

- It is essential that **information on health** services access and rights should be provided in an accessible language for everybody to understand and be reproduced in different languages. Many ethnic minorities do not have English as their first language and so this acts as a barrier to their accessing health services.
- Information sessions should be provided in the local communities about the health care facility and its services.
- **Increased access to medical cards**. Many migrants and students have been denied medical cards and are, therefore, not in a position to seek medical advice or receive medication as they cannot afford to do so. Many lone parents within minority ethnic groups have also lost their medical card due to finding part-time employment. While this provides them with some

income, it is not sufficient to cover both their own and their children's medical expenses and the GP visit only card does not cover other expenses.

- **Training of health personnel** and the development of an anti-racism policy in order to deepen understanding of cultural background and issues faced by new communities. It would also be of great assistance to have members of new communities employed in the facility e.g. as interpreters.
- **Waiting lists** for specialists, surgery and making an appointment to see the GP were another issue which the group felt was important not only for new communities but the wider Irish population. The length of these waiting lists has an effect on the mental as well as the general wellbeing of patients.
- **Community participation** should be encouraged and facilitated to voice people's needs by constantly organising discussion forums. This could happen by nominating EMHF reps to represent ethnic minorities at HSE decision-making levels.
- **Communicational and interpretative resources** should be available when required during all medical consultations. These resources should be built-in to the health system and be utilised, when required on a routine, regular basis, rather than on an ad-hoc basis. Additionally, a computerised information point in the reception or waiting area could provide basic information in a number of languages. Linguistic diversity should ideally be built-in to the organisational structure. Furthermore, an independent complaints procedure should be built in to the overall structure.
- A **childcare area** should be provided within the facility where supervised childcare is provided while parents are waiting to access services.
- Ideally, **opening hours should operate on a 24/7 basis** with reduced services in off-peak hours. Additionally, a mix of appointment and walk-in clinics should be provided.
- All services under the facility's roof should be **discrete and afford maximum privacy** to service users.
- The physical building should be **accessible for people who are disabled** and for those with reduced mobility.
- The facility should be serviced by a **frequent and efficient public transport network**. Parking spaces should also be available.
- Services within the facility need to **network with existing agencies** already working with new communities in order to heighten awareness and facilitate increased access to services provided.

- The facility should provide a number of rooms to be used throughout the day and evenings by community groups for **meetings and educational programmes** etc.
- A comprehensive system of data collection and research should be built-in to service delivery to take account of emerging and changing needs and issues.

(Source: Cairde Community Development and Health Programme, July 2006).

3.8 People with problem drug use

Health needs identified:

The issue of substance use and how the new facility should address this issue was the most controversial within this consultation. While all those engaged in the process identified and acknowledged the general health needs of people with problem drug use and those in recovery, the area of drug treatment raised concerns and diverse opinion. The information included here comes from a number of sources within the consultation including a consultation meeting with former drug users, now in recovery as well as from a broad range of interviews with key service providers and community representatives within the NEIC.

The consultation highlighted the following health needs in relation to people with problem drug use:

- **Physical health needs**: i.e. normal health care, i.e. blood pressure, viral infections, chest infections, flu, etc and general health screening (as per the rest of the population).
- **Specific health needs relating to drug use** e.g. sores, abscesses, hepatitis, pneumonia, HIV/Aids, dental health.
- **General ill health** as result of poor self-care including poor diet and nutrition, lack of exercise, disturbed sleep patterns and additional issues associated with homelessness.
- **Mental and emotional health**: Significant emphasis was placed on the mental and emotional health needs of drug users and the ensuing links with suicide.
- **Sexual health needs** associated with drug use and risk-taking sexual behaviour e.g. STIs, HIV/Aids, pregnancy and the associated impacts on the unborn child.

- **Poly drug use creates particular health needs** related to the effects of using a number of drugs at the same time or a combination of drugs and alcohol and/or prescription or over the counter medicines.
- **Family support needs:** The impact of alcohol, drug use and addiction on families is significant and can negatively impact on the physical, emotional and mental health of families.

Experience of current service provision

This consultation process identified a broad range of challenges encountered by people with problem drug use and those in recovery in terms of accessing and using health services as follows:

- In general, the health needs of people with problem drug use are mostly defined in relation to their drug use and their general health needs are not given adequate recognition. This, in itself, creates a barrier to accessing general and primary care health services.
- Many people with problem drug use, particularly those experiencing poverty and disadvantage, rely on medical cards to access services. However, not all those who require health services have access to the medical card system thereby creating another barrier to accessing services. This can be related to the issue that a GP's signature is necessary in order to access a medical card. Research suggests that GPs are sometimes reluctant to sign applications for people with problem drug use. Furthermore, some drug users attending clinics may not have a GMS GP, and therefore, no medical card. (*O'Reilly, F., Reaper, E. & Redmond, T. 2005)*.
- Additionally, there may be a lack of awareness among people with problem drug use about their entitlements.
- Access to GPs in general, and particularly to GMS GPs is a critical issue since not all GPs provide services to those actively using drugs. It has been reported that there is a distinct lack of GPs within the inner city and particularly in disadvantaged areas. The Irish College of General Practitioners (ICGP) has recently indicated that over the next 5 years a high percentage of GPs will be retiring and that plans need to be put in place now to address this issue. Furthermore, local evidence suggests that at least 40% of those on methadone within the inner city do not have medical cards due to a lack of GMS GPs in the area.

- Because of fears and experiences of prejudice, people with problem drug use often postpone seeking treatment for drug-related conditions such as abscesses etc. Delays in seeking treatment can exacerbate the medical conditions leading to more serious complications.
- All those engaged in this consultation identified that current drug treatment services within the NEIC area are inadequate. Inadequacies particularly relate to excessive demand on current services and insufficient treatment options including structured detox (both inpatient and out patient), a lack of treatment services for cocaine addiction, insufficient counselling and treatment options for poly drug use. Additionally, current service provision such as needle exchange and methadone maintenance should be extended to cater appropriately for the large numbers requiring these services in the NEIC.
- Specifically in relation to methadone maintenance, there are limited options for those being prescribed methadone. In the NEIC Rapid Area there are approximately 460 people attending for methadone treatment. In the ICON Area there are over 600 attending methadone treatment services. In NICDTF area as a whole there is now an estimated 1,000 people plus receiving methadone treatment (*Source: ICON Statistical Data, July, 2008.* Currently City Clinic is treating between 320 – 340 people per week with methadone. Some of those in treatment receive methadone daily, some a few times per week and some once a week. A significant number of those attending City Clinic have stabilised and are progressing in their recovery. These clients could easily receive their methadone prescriptions in a more locally-based facility from a GMS GP e.g. at a primary care level. This would, in turn free up the specialist services for those who are most in need.

Health and social services required in the new primary health care facility to address the health needs of drug users and those in recovery:

- Core primary care services e.g. GMS GPs, PHNs, practice nurses, social worker, occupational therapist and physiotherapist.
- Access to a chiropodist and community welfare officer through the Primary Care Network.
- Sexual health services including STI screening, contraception, advice and information on sexual health.

- Specialist health services for those with HIV/Aids.
- General health screening to include relevant cancer screening and cardiovascular health screening appropriate to the different life stages.
- Mental health services including counselling and support (e.g. re dual diagnosis) and appropriate referral pathways to more specialist and appropriate mental health services when required.
- Health information/health promotion service with a particular emphasis on user-friendly health and drugs information. Additionally, clerical services which would support people in accessing medical cards and provide assistance with other administrative tasks such as form filling.
- Family support service.
- Community dietician.
- Community pharmacy adjacent to the health care facility.
- Outreach services to target and access those who are actively involved in drug use. Community health workers could play a significant role in linking with people with problem drug use in the community, highlighting the services available within the facility and supporting them to access services when required. Additionally, community health workers could network with specific drug treatment agencies and projects in the community.

Addiction services:

In relation to the provision of addiction services in the new facility, three different view points emerged from the consultation as follows:

(i) The addiction service would include addiction counselling and additional services for those stabilised in their treatment and on methadone maintenance. Methadone scripting could be provided on a clinic basis and requires GMS GPs to provide the service. Additionally, this level of service allows for this particular client group to be supported in their treatment and to receive follow-up services and aid compliance. Throughout the consultation process, this level of service provision received considerable support on the basis that those using this level of service are stabilised in their drug treatment and not 'chaotic' in their drug use and, therefore, do not pose a risk to the safety of others.

This is in keeping with the methadone protocol which is based on a 2 tier system where the 1st tier of treatment is provided by GPs in primary

care. Stable drug users maintained on methadone should be treated by their local GP and non stable users should be treated is specialised clinics and centres. *(Review of the Methadone Treatment Protocol. Methadone Prescribing Implementation Committee. DoHC, 2005).*

Evidence has indicated that patients on methadone maintenance can be treated effectively in Primary Care. Precedence shows that people on methadone are currently being treated in Primary Care Centres and GP practices in line with current Department of Health & Children and HSE policy. Best practice guidelines in relation to this have been produced by the Irish College of General Practitioners (ICGP) who support the provision of methadone to patients with opiate addiction in Primary Care. *(ICGP (2003). Working with Opiate Users in Community-based Primary Care. Dublin).*

The implementation of this model would help dispel some of the unfounded fears in relation to methadone and normalise this model of drug treatment within the community. The model of service delivery currently in place within the Ballymun Primary Care Facility was recommended in this regard.

(ii) The second view suggests providing a comprehensive drug treatment service spanning all levels of drug use and recovery including counselling, methadone maintenance, drop-in services, harm reduction, needle exchange and referral to specialised services. Within the consultation, some concerns have been expressed about this view.

(iii) Within the consultation, a minority view suggested that the addiction service provided in the facility should be limited to the provision of addiction counselling coupled with appropriate referral pathways to more specialist drug treatment services as required. Fears were expressed (by this minority) that the provision of a more comprehensive addiction service, as outlined in (i) and (ii) above, could compromise the safety of others using the facility, especially children and older people.

Recommendations on making this facility more 'user friendly' people with problem drug use:

- Irrespective of developments within this new facility, it is critical that the current range of drug treatment services is at least retained and ideally that the level of service provision is extended to meet the needs of a growing population.
- On the one hand, it is essential to extend the opening hours of this facility to provide services for the general public and to allow scope to schedule specialist drug treatment services e.g. as per the Ballymun Model where the methadone clinic and separate needle exchange services take place in the evening time. However, this raises the question as to whether scheduling drug treatment services at specific times can continue to segregate those in receipt of drugs services from the rest of the population and whether or not this further heightens their sense of isolation. Within this context, there is a need to consider the issue of equality and equity of access to services and to integrate the addiction service within the overall service provision in the facility.
- All service users, including those with problem drug use issues, need to be treated equally, fairly and at a human level. This facility must espouse to the key principles outlined in the National Health Strategy which emphasises equity, people-centredness, quality and accountability.
- Access to medical cards for those in receipt of drug treatment requires immediate attention. Clarity is required in terms of criteria for eligibility and entitlement. While these criteria may be clear to service providers (i.e. that eligibility and entitlement is based on means), this is not as clear for some service users, particularly those with problem drug use issues.
- Increased numbers of GMS GPs within the inner city, and specifically within this facility is critical to the delivery of appropriate primary care services not just for those with specific health concerns, but for all population groups.
- An appropriate addiction service must consider the person in a holistic sense rather than treating them solely on the basis of their drug use. The service needs to be grounded in the broader determinants of health and also take account of the person's social and family circumstances and respond accordingly.

- Family support services need to respond to the needs of families who have been bereaved through drug use. Support of those taking care of children is particularly important in this regard e.g. grandparents, single parent families and surviving parents with HIV/Aids.
- In the provision of appropriate addiction services and other related services (e.g. sexual health, mental health etc) this facility should pay particular attention to issues of discretion, privacy and confidentiality. The physical layout of the building should allow people to easily access their required services without compromising their privacy.
- Training for all staff engaging with the public should include anti-discriminatory protocols and policies to ensure that everyone is treated in an equitable, fair and consistent manner within the facility.
- A spacious, comfortable waiting area with tea and coffee facilities and a TV and magazines is important to enable people to pass the time comfortably while waiting for their appointments. Within the waiting area, a staff member should be available to discretely direct people to their required service and to deal with any general queries and concerns.
- An appropriate process should be in place within the facility to allow for complaints to be processed efficiently. This service may be linked to the information or community welfare service.

3.9 People who are homeless

The issues of homelessness has particular impacts on people's health and wellbeing. This has been well documented in the literature and, specifically, in a study by O'Carroll et al (2005), which included a review of international literature and a review of 144 records of homeless people requiring health care. This research highlighted the following:

- Living homeless exposes people to extreme health risks.
- Health and housing are inextricably linked. The current accommodation and care options are severely inadequate.
- There are homeless people with extreme healthcare needs for whom no appropriate care/accommodation options currently exist.
- Homeless people have higher morality and morbidity rates, yet have decreased access to primary health care services.

A subsequent study by O'Carroll & O'Reilly (published in 2008) also highlighted that while Irish society was experiencing growth in the economy and reducing absolute poverty, the situation for homeless people as measured by duration of homelessness, morbidity patterns, self-assessed health and risk behaviours worsened. The demographic shift towards a younger population and more women has resulted in large numbers of children living in homelessness. Additionally, access to services has not improved. Furthermore, drug abuse now supersedes alcohol as the main addiction and the morbidity profile of homeless people in Dublin is consistent with a drug using population. It should be noted that a recent evaluation of the Safetynet Methadone Programme Pilot at the Dublin Simon Emergency Shelter, published in July 2008, provides valuable insights into appropriate and relevant delivery of a drug treatment service to the homeless by using the Methadone Protocol, based on legislation, policy and guidance. (Geraghty, C. Harkin, K & O'Reilly, F. (2008).

Many of the issues raised in these studies were also highlighted in the consultation meeting with people who are homeless in the NEIC.

Health needs identified:

The consultation highlighted the following health needs in relation to homelessness:

- **Physical health needs:** i.e. normal health care and general health screening as per the rest of the population and acute physical health needs, including respiratory disorders, HIV, hepatitis, skin conditions (mainly related to injecting drug use), trauma and infectious or parasitic diseases.
- **General ill health** as a result of poor self-care including poor diet and nutrition, lack of exercise, disturbed sleep patterns and additional health problems associated with homelessness.
- **Mental and emotional health**: The impact of homelessness on mental and emotional health is significant and mental health problems experienced by this population include panic attacks, chronic anxiety, depression, psychiatric illness and schizophrenia. Dual diagnosis (mental health problems coupled with an addiction) is frequently an issue (O'Carroll et al 2006).
- **Suitable accommodation,** including accommodation for those with extreme health care needs and who may not be able to live independently

- **Drug and alcohol misuse** impact significantly on the health of people who are homeless. This impact increases in the case of dual diagnosis as already referred to above.
- **Personal safety:** The issue of violence was significant. Many homeless people are banned from homeless accommodation as a result of violence. Furthermore, violent behaviour can be exacerbated by alcoholism and poly drug use

Experience of current service provision

Significant challenges exist for those who are homeless in relation to accessing and using health services. This is primarily due to the fact that medical services have been designed for the needs of the housed community and are not user-friendly for homeless people. The group involved in the consultation did not have a great deal to say in terms of their experience of current service provision apart from the fact that the location of primary health care facilities can be a barrier unless the facility is centrally located in the community. Furthermore, dental health services were difficult to access and accessing medical assistance for conditions which affect mobility pose particular challenges. The D Doc service was also commented on and some people expressed the view that they found it difficult to describe their symptoms over the phone and that it would be easier for them if they could do this face to face. On a positive note, the service provided by the public health nurses was positively commented on.

Irish studies, cited by O'Carroll et al (2006), have demonstrated that between 25.6% and 46.6% of homeless people do not have a medical card and, therefore, do not have access to primary care services. As a result, a high percentage of homeless people are not accessing primary care and consequently, have higher attendances at A&E, higher inappropriate attendance at A&E, higher admission rates and longer in-patient stays in hospital compared to housed people.

Gelberg (1990), also cited by O'Carroll et al (2006), identified a range of additional barriers for homeless people in accessing health care as follows:

- Competing needs – basic needs for food, shelter, and income take precedence over health care;
- Psychological distress and disabling mental illness means that homeless people are least able to obtain services when most in need;

- Social conditions of street life affect compliance with medical care.
- Personal avoidance of authorities or bad experiences with authorities in the past e.g. undocumented immigrants fear medical providers will call immigration authorities, homeless women with children may fear child protection service workers, drug users or ex-convicts may fear the police.

Health and social services required in the new primary health care facility:

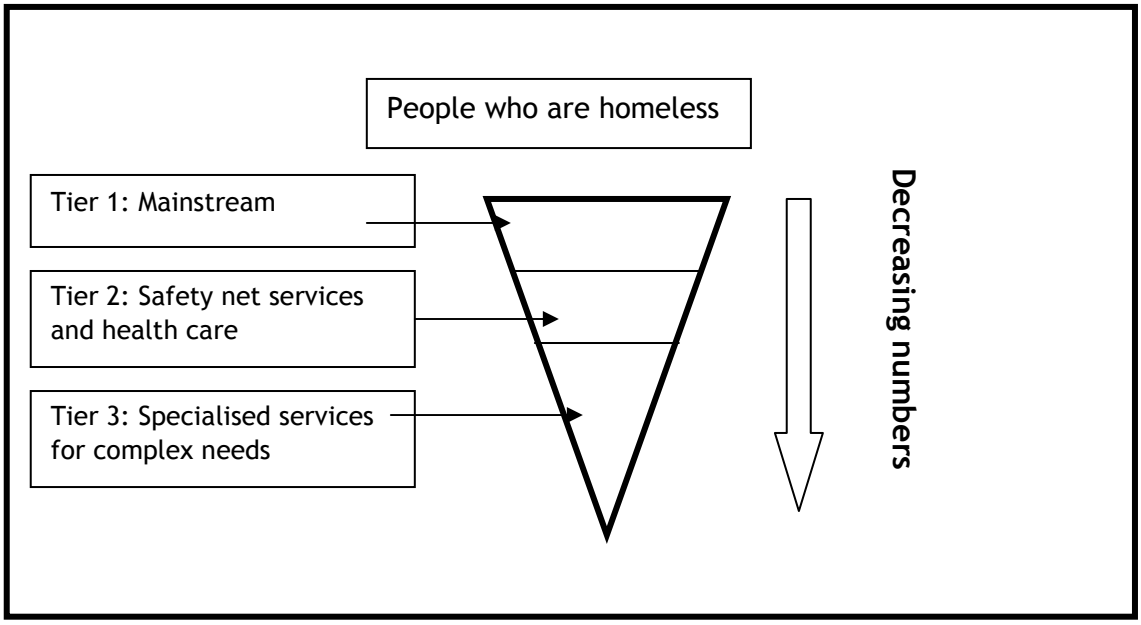
- Core primary care services e.g. GPs, PHNs, practice nurses, social worker, occupational therapist and physiotherapist.
- Access to a chiropodist and community welfare officer through the Primary Care Network.
- Sexual health services including STI screening, contraception, advice and information on sexual health.
- Specialist health services for those with HIV/Aids.
- Mental health services including counselling and support - a general counsellor for all kinds of issues.
- Health information which would be basic, easy to understand and user-friendly.
- Outreach services which would deliver basic medical care at centralised locations e.g. hostels, centres for the homeless etc. This group stressed the importance of 'bringing the service to them'. Community health workers could play a significant role in linking with homeless people in the community, highlighting the services available to them and assisting with aftercare support. Additionally, community health workers could network with specific homeless agencies and projects in the community.
- Minor injury clinic – to deal with minor emergencies e.g. stitching, x-rays etc.

Recommendations on making this facility more 'user friendly' for those who are homeless:

- Longer opening hours as well as weekend opening;
- User-friendly and efficient appointments system with limited waiting times;
- A more efficient queuing system with a ticket machine (similar to the Tax Office).
- Bright, comfortable waiting area with magazines, board games, TV and radio and a vending machine providing snacks and teas/coffees;

- Options on accessing male and female health professionals as appropriate;
- Clear signage with symbols;
- Homeless people deserve to be treated with respect and in the same manner as the rest of the population.

In addition to these recommendations, it is worth highlighting the recommendations made by O'Carroll et all (2006) in relation to the development of a comprehensive model of health care services more appropriate to the needs of homeless people. O'Carroll et al recommend a three-tier model which focuses on the provision of more appropriate care for homeless people at primary care level as follows:



- **Tier 1:** Improving and maintaining access to mainstream services e.g. primary care services, maintenance of medical cards and tracking mechanisms.
- **Tier 2:** Safety net services and health care in hostels e.g. "bringing the service to us".
- **Tier 3:** Specialised services e.g. an intermediate care centre, treatment services for alcohol and drugs, long-term in-patient facility with medical care and an increased range of care accommodation options for homeless people with complex medical, psychological and social problems.

3.10 People with disabilities

Health needs identified and the experience of current service provision:
While it was not possible to facilitate a consultation meeting with people who are disabled, this consultation process did identify the wide-ranging issues that relate to those living with disabilities. A review of literature produced by the National Disability Authority (NDA) clearly identifies the health and service needs for those living with disability. The NDA has produced several strategic and policy documents which highlight the needs and experiences of those with disabilities in terms of health care. Generally, those with disabilities have particular difficulties accessing health services and GPs. Some health services demonstrate a lack of disability awareness, disabled people have little or no input into health service planning and there are inadequate complaints procedures within health services.

Men with disabilities experience a high rate of poverty and social exclusion. People with disabilities are at double the risk of poverty than the non-disabled population. In turn, poverty is a key predictor of poor health. People with disabilities frequently experience physical, attitudinal, communication and information barriers to availing of mainstream health services. As men are less likely in general to avail of heath services, disabled men are likely to be additionally disadvantaged in relation to general and specialist health care.

The NDA's publication 'The Experience of People with Disabilities in Accessing Health Services in Ireland: Do inequalities exist?' (2005) highlighted the substantial and wide-ranging health impacts of disability. These include:

1. Greater risk as a consequence of having a reduced income due to exclusion from the labour force and being caught in the 'benefits trap'
2. The additional costs of being disabled;
3. Increased incidence of other disabling conditions and illnesses:
4. Lack of access to acute, rehabilitative and population health services;
5. Experience of a range of barriers to accessing care (financial, physical, organisational, transport, communication, informational including the inadequate knowledge and attitudes of health care providers;
6. Experience of un-coordinated and fragmented provision, exacerbated by the involvement of multiple health and social providers;

7. Limited provision due to the focus of health services on the individual's impairment rather than the health issue or condition.

In 2005, the NDA published a research report from NUI Galway looking at inadequacies and inequalities for people with disabilities accessing health services. This research found that people who are particularly disadvantaged in the use of health services include those with intellectual disabilities, people with disabilities who also have mental health needs and people who are deaf.

Health service requirements and recommendations on how health services should be developed and delivered to meet the needs of people with disabilities:

Clearly, those with disabilities require the same level of health service delivery as other population groups in the community. The core primary care services identified throughout this report pertain to those living with disabilities. However, there are unique issues to be considered in how services are developed and delivered to meet the needs of people with disabilities. The NDA, through wide-ranging consultation with people with disabilities and their families and carers recommends the following in this regard:

- Disability services should be re-oriented from age-restricted, single-impairment client groups to a holistic, life course approach to provision, supporting access to integrated, co-ordinated services for people with disabilities throughout their life course.
- The development of a 'passport' for people with disabilities to assist their movement through and between health services, and other related services.
- The development of life course service planning based on independent needs assessment that delivers appropriate and adequate early intervention. Furthermore, planning must anticipate service needs and support integrated and co-ordinated strategies to meet the needs of those who are disabled.
- The development of a research programme that identifies policy and service provision issues for people with disabilities over the life course and at key transition stages.
- The comprehensive introduction of disability / equality proofing in disability services and across the health system is required.

- Health information must be accessible to people with disabilities, in accordance with the Disability Act 2005.

The NDA suggests that the current reform programme in health, on foot of 'Quality and Fairness, A Health System for You' (2001), provides opportunities to:

- Introduce routine health service mapping;
- Develop management information systems;
- Resource effective participation mechanisms so that people with disabilities are decision-makers at all levels of health care;
- Ensuring equitable provision;
- Mainstream non-health functions;
- Implementing standards and systems of inspection;
- Build networks for sharing good practice and building collaboration;
- Promote equality proofing of health care policies and provision;
- Promote and provide disability awareness training for health professionals of every discipline is desirable.

In conclusion;

This section has provided a complete overview of the findings of the community consultation process in the NEIC across a broad range of population groups and special interest groups. The key themes and associated recommendations which have emerged from this consultation process have been presented at the start of the report in the Executive Summary together with a 'model' for the new primary health care facility which is informed by the recommendations and suggested services highlighted in this section.

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APPENDIX 1: Literature review - setting the context

A comprehensive literature review was undertaken in order to set the context for the community consultation in the NEIC. This section provides an overview of key literature in this regard. Initially, information on the profile and demographics of the NEIC is provided. The literature review then addresses key issues relating to poverty and health inequalities and the determinants of health. It clearly sets out the links between poverty and ill health, including equity of access to health services. It identifies key national policy and strategy documents which highlight approaches for addressing health inequalities. This section then focuses on the importance of community participation in health service planning and sets out the principles and approaches for facilitating community involvement and participation in health service planning.

North East Inner City profile and demographics:

The North East Inner City (geographical area covered by ICON) is comprised of ten electoral divisions in the centre of Dublin. The area is bounded to the south by the River Liffey, to the east by the sea, to the north by the River Tolka and Clonliffe Road, and to the west by Dorset Street and East Arran Street.

(Integrated Services Initiative, Common Goals Unmet Needs. 1997:13)

Essentially this includes the Dublin 1 area, the southerly part of Dublin 3 (Ballybough and Northstrand), and very small parts of Dublin 7.

There are a total of ten DEDs as follows:

- Ballybough A
- Ballybough B
- Mountjoy A
- Mountjoy B
- North City
- North Dock A
- North Dock B
- North Dock C
- Rotunda A
- Rotunda B

POPULATION OF NORTH EAST INNER CITY, 1966-2006

The population of the area had been dropping significantly from the 1960s up until 1991 when it started to rise again. This coincided with rebuilding in these communities. From 2001 to 2006 the population rose in eight of the ten DEDs, and fell, very slightly in two. Overall the population has increased by 10% since 2002.

Breakdown of population by DED –North East Inner City (1966 – 2006)

(Source: Census of Population, Small Area Population Statistics 2007)

District Electoral Division	1966	1971	1981	1991	1996	2002	2006	% de/ increase from 02-06
Ballybough A	6,039	5,145	4,969	3,581	3,570	3,368	3624	**7.6%**[1]
Ballybough B	3,926	3,380	2,460	2,466	2,571	3,009	3215	**6.8%**
Mountjoy A	7,957	6,442	3,690	2,983	3,108	3,242	3760	**15.9%**
Mountjoy B	3,345	2,902	2,102	1,657	1,994	2,725	3446	**26.5%**
North City	2,966	2,311	927	819	2,391	3,942	3867	**-1.9%**
North Dock A	2,237	2,032	1,593	1,222	1,188	1,287	1200	**-6.7%**
North Dock B	6,244	5,637	4,258	3,503	3,655	3,628	3690	**1.7%**
North Dock C	5,067	4,366	2,659	2,324	2,411	3,568	4179	**17%**
Rotunda A	4,982	4,172	2,597	1,837	2,522	4,199	4672	**11.3%**
Rotunda B	1,775	1,886	1,273	896	1,122	1,752	2137	**21.9%**
Total NEIC	**44,538**	**38,273**	**26,528**	**21,288**	**24,532**	**30,720**	**33790**	**10%**

** All percentages have been rounded off to the nearest decimal point or nearest percentage therefore there will be small errors if cumulatives are calculated.*

POPULATION BY NATIONALITY

One of the significant changes in recent years is the increase in the non-Irish population living in the inner city communities. Based on the information provided, 61% of the population in the ICON area is now Irish, with the remaining 39% from the rest of the world, including 1.6% from the UK, 6% from Poland, 1% Lithuanian, 8.6% from the rest of the EU and 17% from the rest of the world. (almost 4% did not state where they were from).

Breakdown of population by nationality
(Source: Census of Population, Small Area Population Statistics 2007)

Nationality	Irish	UK	Polish	Lithuanian	Other EU 25	Rest of World	Not stated	Total	% not Irish
Ballybough A	2,962	44	120	23	140	203	84	3,576	17%
Ballybough B	1,994	33	234	37	198	382	40	2,918	32%
Mountjoy A	1,914	47	265	31	276	546	251	3,330	43%
Mountjoy B	1,493	55	373	78	430	795	84	3,308	55%
North City	1,212	55	162	31	436	887	124	2,907	58%
North Dock A	979	19	40	14	37	80	14	1,183	17%
North Dock B	3,020	61	78	42	177	161	55	3,594	16%
North Dock C	2,384	89	168	30	309	641	288	3,909	39%
Rotunda A	1,947	65	326	52	373	1,141	161	4,065	52%
Rotunda B	900	49	140	31	290	551	95	2,056	56%
Dublin City	406,916	8,310	10,736	2,637	17,567	34,739	10,650	491,555	17%

** All percentages have been rounded off to the nearest decimal point or nearest percentage therefore there will be small errors if cumulatives are calculated.*

It is envisaged that the overall population of the NEIC will continue to grow over the coming years. This must be taken into account when planning health services, and particularly primary health care services for this geographical area. This is critical in order to ensure that services will continue to be developed on the basis of the community's needs and as the community grows, so too does its health and service needs.

Poverty and health inequalities:

Health inequalities arise when lower socio-economic groups experience poorer health and a greater prevalence of health problems than those in higher socio-economic groups. Such inequalities are considered to be unnecessary, unfair and avoidable (Combat Poverty Agency, 2005). For example, the all-cause mortality rate, on the island of Ireland, in the lowest occupational class is 100-200% higher than in the highest occupational group (Balanda and Wilde 2001).

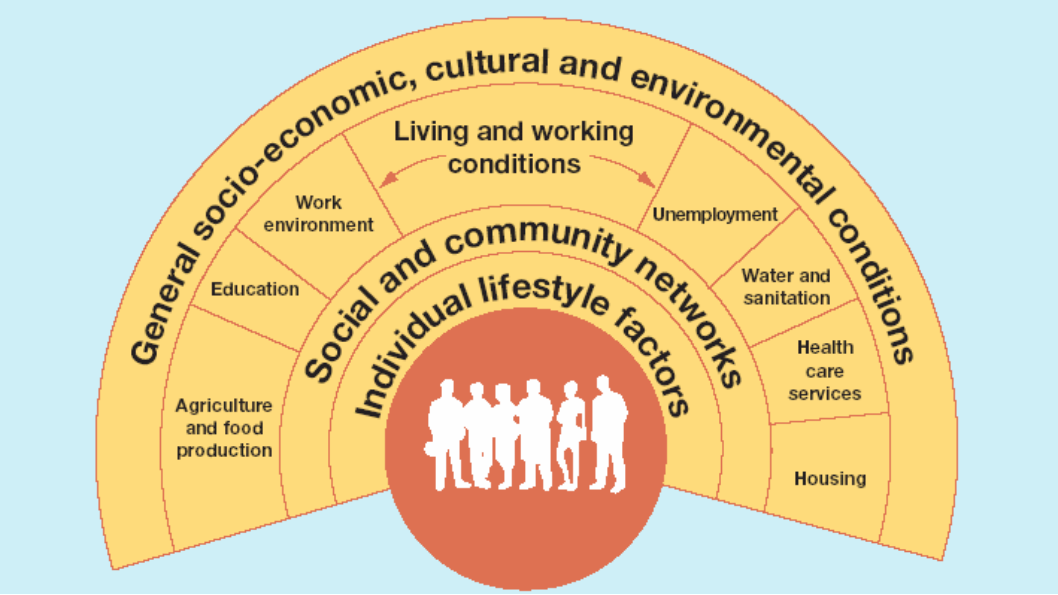
Over recent years, considerable progress has been made at international, national and regional level in terms of identifying the significance of the broader social and environmental factors and inequalities impacting on health. These factors have been central to the way in which national health-related policies and strategies have developed. Specifically these include the National Health Strategy and the Primary Health Care Strategy, both launched in 2001, the Traveller Health Strategy

(2002-2006) and the National Anti-Poverty Strategy and Health (2002-2007). Additionally, much has been researched and written in relation to the links between poverty and ill health and the ways in which poverty impacts negatively on health. Specifically, key Combat Poverty Agency publications are important in this regard.

Determinants of Health:

Each of these significant Government health documents acknowledges the broader determinants of health. These recognise that there are a myriad of social, political, educational and environmental impacts on the health of individuals as well as living and working conditions and individual genetic and lifestyle factors. The Dahlgren & Whitehead model of the Determinants of Health (1998), presented in Figure 3 below, has become a widely recognised model to describe the range of influences on health.

Figure 3: Dahlgren & Whitehead (1998). Determinants of Health.



Poverty and ill health – the links:

Much research has been conducted into the links between poverty and ill health. Some of the most significant research has been summarised by Ruth Barrington (2004) in her discussion paper *"Poverty is Bad for Your Health" on behalf of the Combat Poverty Agency*. This paper indicates some significant findings, as follows, which have also been highlighted anecdotally and through the community consultation process in the NEIC:

- The scale of the differences in death rates between those in the lowest and highest socio-economic groups appears to be greater in Ireland than in other European countries. Even on the island of Ireland, the difference in mortality rates between the groups at each end of the social spectrum appears to be greater in the South than in the North of Ireland;
- Those on low incomes tend to have lower levels of education than those with higher incomes. Many receive little more than primary education. Those who only have primary education have much fewer job opportunities than those with secondary or tertiary education.
- Those from disadvantaged backgrounds are more likely to be unemployed or to have experienced unemployment in the past. If they are working, they tend to work in jobs that are less secure and that offer little control or reward for effort. They in turn are more dependent on income support and public services for everyday necessities.
- Low income is also associated with less control over individual lifestyle factors that affect health. The diet of those in the lowest socio-economic groups is likely to include insufficient fruit and vegetables. They are more likely to smoke, more likely to be medicated and less likely to exercise regularly than people with higher incomes. They are more likely to be single parents, and if women, to have had a child during their teenage years. They are more likely to be exposed to environmental pollutants, both at work and where they live.
- In relation to housing, they are more likely to experience overcrowding and to have to live with the insecurity of private rented accommodation rather than the security of being owner-occupiers. They are at higher risk of dying during the winter as a result of inadequate heating in their homes and difficulties in accessing health services.
- Those on low incomes experience more exclusion or alienation from society than those who are better off. They are less likely to vote or take part in community or voluntary activities. If they are members of minority ethnic groups, they may experience discrimination and aggression. They are more likely to be the victims of crime and intimidation. They are less likely to see a medical specialist when ill and have to wait longer for hospital treatment.
- The cumulative impact of the stress associated with living on low incomes for individuals has a significant impact on health. There is increasing

evidence that the strain of living on a low income manifests itself in biological changes in the body. Symptoms include depression, increased susceptibility to infection, diabetes and a harmful pattern of cholesterol and fats in the blood, high blood pressure and the risks of heart attack and stroke. If the stress associated with living on a low income is added to the damage caused by high levels of smoking and poor diet, it is not too difficult to explain why poor people experience more ill health and die younger than the better off.

- One of the consequences of the struggle with life that people on low incomes experience is that they do not attach as high a priority to good health as those who are better off. (Ruth Barrington, 2004)

Equity of access to health services:

The issue of equity of access to health services has a further considerable impact on health status and is inextricably linked with poverty and health inequalities. Equity of access to health services is set out as one of the four principles of the National Health Strategy and is also contained in the Primary Health Care Strategy. Equity is concerned with creating equal opportunities for health and bringing health differentials down to the lowest level possible. The requirement for equitable access to health services in terms of timeliness, waiting lists, physical accessibility and access to information was highlighted throughout this consultative process. Support for the development of a comprehensive, holistic, integrated and accessible primary health care service was identified as fundamental to improving the health of people who are living in poverty or experiencing social exclusion (Burke, 2002).

Generally, most media attention focuses on access to hospitals; however, most people's first point of contact with the health services is at primary health care level. Cosgrave, (2003) reports that in 2001, access without charge to primary health care was 31%, i.e. access by medical card holders. The elderly and large families are viewed as those most disadvantaged by the current income guidelines. However, certain preventative screening services e.g. cervical smear tests are not available without charge through GPs, even for persons with a medical card.

An IPH study (2001) found that, in relation to organisational and operational matters, inequity in access can also arise from the way in which services are

organised and operated. This includes the geographic distribution, for example, there is considerable variation in GPs services and in access to other particular services. It highlights the impact of transport on access to health services, which can be particularly inhibiting for the elderly and less able bodied and for parents of young children and can act as a disincentive to uptake of services.

Cosgrove (2003) also highlights that there are particular access problems for some groups. The attitudes of the local community can also be a significant factor affecting access for drug users and people who are mentally ill, as proposals regarding the location of services for these groups are often met with strong opposition. St Vincent de Paul's reference to the health needs of multi-disadvantaged groups in the community is quoted i.e. those with multiple disadvantages which include;

- Refugees and asylum seekers
- People with physical disabilities
- People with intellectual disabilities
- Homeless people
- Drug users
- Ex-Prisoners
- Travellers

The range of issues discussed above all has significance for the health and well-being of those living in the NEIC. The broader determinants on the health, as outlined in Dahlgren and Whitehead's model, each impact to varying degrees on the population groups living in the area from childhood to adulthood to older people. The links between poverty and ill health are particularly relevant as the NEIC is designated as a disadvantaged area. The issues pertaining to access to health services are a reality for the people of the NEIC where they have experienced inadequate levels of service delivery and have experienced inequity in accessing services over the years. These issues, which in turn have prompted this community consultation process, are further explored in Section 3, which presents the findings from the consultation.

Addressing health inequalities:

In acknowledging the model of the broader determinants of health (Dahlgren & Whitehead, 1998), it is also critical to recognise that a multi-faceted approach to addressing health issues is required. Health and health inequalities must be addressed at a range of different levels including individual, social, political, educational and environmental levels, as well as at the level of health service delivery. In espousing to this model of health, the most significant policy and strategy documents in Ireland to date have acknowledged the importance of working with communities to address health inequalities and health needs.

The National Health Strategy, Quality and Fairness – a Health System for You (2001) focuses on a whole-system approach to addressing health in Ireland. It identifies overall national goals to guide activity and planning in the health system over a 7-10 year period. It also describes how the Government, the Minister and the Department of Health and Children will:

- work with everyone in the health system who has a role to play in improving health and engage with the wider community to improve health;
- evaluate services so that resources are used to best effect;
- reform the way we plan and deliver services within the system;
- modernise and expand health and personal social services through focused investment;
- support the development and contribution of people who work in the health system.

The vision of the future of the health system in Ireland is described in the National Health Strategy as;

"A health system that supports and empowers you, your family and community to achieve your full health potential…A health system that is there when you need it, that is fair and that you can trust…A health system that encourages you to have your say, listens to you, ensures that your views are taken into account".

Guiding the development and implementation of the National Health Strategy are the principles of equity, people-centredness, quality and accountability.

The Primary Health Care Strategy - Primary Care – A New Direction (2001) is of particular significance in setting the context for this consultation process. It is the Government's response to some of the major deficiencies in the current primary care system. This strategy outlines a new approach which shifts the emphasis from over-reliance on acute services such as hospitals to one-stop-shops where patients can access GPs, nurses, physiotherapists, chiropodists, social workers and home helps at community level. Wider networks of health and social care professionals will also work with a number of primary care teams. The approach brings a wide range of service providers together in primary care teams, with the aim that integrated services can be delivered in the community in the most appropriate and accessible way.

The National Anti-Poverty Strategy – Building an Inclusive Society (2002) was informed by a comprehensive consultation process involving a broad range of statutory, voluntary and community stakeholders. The consultation process highlighted a range of themes, relating to the previous discussion on poverty and ill health. These, as summarised by Cosgrove (2003) include;

- The need for a social model of health and social determinants of health;
- The impact of poverty and social exclusion on health is stressed;
- The provision of good quality affordable and social housing and accommodation is an essential factor influencing peoples health;
- The provision of transport for marginalised communities is essential in order to access services;
- Participation in decision making, particularly of the socially excluded is a critical factor for developing effective health and other public services
- Community development can play a significant role in supporting people who are living in poverty and experiencing social exclusion as a key tool for developing healthier citizens and communities
- Co-ordination of services and policies;
- Equitable access to health and personal social services;
- A comprehensive integrated accessible primary care service;
- The importance of an information and research base for target setting, monitoring and reviewing is stressed.

Furthermore, this strategy includes an overall objective for health as follows:

> *"…to reduce the inequalities that exist in the health of the population by making health and health inequalities central to public policy, by improving access to health and personal social services for people who are poor or socially excluded and by improving the information and research base in relation to health status and service access to these groups".*

Its key target is *"to reduce the gap in premature mortality between the lowest and highest socio-economic groups by at least 10% for circulatory diseases, for cancers and for injuries and poisonings by 2007"* (Dept. of Social, Community & Family Affairs, 2002).

Cosgrove (2003) has aptly summarised the key themes emerging from these national policy documents as being particularly relevant to community-based approaches to addressing health inequalities. These are:

- **Equity** - the recent health policies refer to equity and fairness as a principle underlying how health services will be delivered;
- **People having a say** - the involvement of the consumer is emphasised throughout, whether through costumer panels, community involvement in primary health care units or the partnership and peer-led approaches to Traveller health;
- **Culturally appropriate services for particular groups** - the Traveller Health Strategy, the National Health Strategy and the Primary Health Care Strategy each refer to the need to provide training for staff and to re-orientate services to ensure that health services are delivered in culturally appropriate ways;
- **Primary health care** - providing services locally in an accessible way, which will take the pressure off specialist and secondary health services is emphasised;
- **Community development approaches to health** addressing the health needs of marginalised groups;
- **Tackling inequalities in health** is an important aspect of all the national health policies outlined.

Community participation in health service planning:

One of the key objectives of The National Health Strategy 2001: *Quality and Fairness – A Health System for You* is ensuring that the patient is at the centre of the health services. Making provision for the participation of the community in decisions about the delivery of health and personal social services is one of the key actions identified to support this objective. This objective and action is reflected in the Primary Care Strategy, which commits to community participation: Recommendation 19 of the Primary Care Strategy states that:

> *"Mechanisms for active community involvement in primary care teams will be established. Community participation in primary care will be strengthened by encouraging and facilitating the involvement of local community and voluntary groups in the planning and delivery of primary care services. Consumer panels will be convened at regular intervals in each health board. At local level, primary care teams will be encouraged to ensure user participation in service planning and delivery. Consumers will also have an input to needs assessments initiated by individual health boards. A greater input from the community and voluntary sector will enhance the advocacy of primary care teams in ensuring that local and national social environmental health issues, which influence health, are identified and addressed."* (DoHC 2002)

In 2002, following the publication of the Primary Care Strategy, the National Primary Care Steering Group formed the Community Involvement and Health sub-group. The overall objectives of this sub-group were:

- to define community involvement in health;
- to research and review approaches used to effectively engage communities;
- to show the added value of community involvement in health.

This document suggests that the aims of community involvement in health are to set up a process whereby the community defines its own health needs, works out how these needs can best be met and collectively decides on a course of action to achieve the desired outcomes. Community participation is recognised as being important for a number of different reasons and offers a range of benefits to individuals, communities, organisations and society as a whole. Community participation can achieve a more democratic solution; develop a culture of participation; empower people; mobilise resources and energy; result in the development of holistic and integrated approaches/services; ensure the ownership

and sustainability of programmes; result in better decisions and more effective and efficient services and improve health outcomes.

Community involvement does not occur in a vacuum but is dependent on a number of key values and principles. These are as follows:

Values of community participation:

- **Social Justice**: enabling people to claim their human rights, meet their needs and have greater control over the decision-making processes which affect their lives.
- **Participation**: facilitating democratic involvement by people in the issues which affect their lives based on full citizenship, autonomy and shared power, skills, knowledge and experience.
- **Equality:** challenging the attitudes of individuals and the practices of institutions and society, which discriminate against and marginalise people.
- **Learning:** recognise the skills, knowledge and expertise that people contribute and develop by taking action to tackle social, economic, political and environmental problems.
- **Co-operation:** working together to identify and implement action, based on mutual respect of diverse cultures and contributions.

In May 2008, the Minister for Health & Children, Ms Mary Harney, TD, and the CEO of the HSE, Professor Brendan Drumm launched the National Strategy for Service User Involvement in the Irish Health Service. Consisting of seven goals, the Strategy strives to build on current good practice in involving service users (i.e. patients, their families, and voluntary and community organisations) across the country.

The goals identified by the Strategy are:

- Develop a Patients Charter and service quality guarantees that patients can expect when they use the health services;
- Patients will be enabled to become more involved in their own health care and decisions and choices affecting their health;
- Children, young people and the socially excluded groups will be specifically listened to identify their needs in accessing health services;

- A systematic approach that evaluates current mechanisms for involving users will be adopted and the best approaches will be implemented in al parts of the country;
- Commitment to and leadership for this strategy will be evident from involvement of user groups in all health care planning and the success of this will be evaluated each year;
- Primary care team development will be achieved in dialogue with the local community. Community care services will listen to users and their families and hospitals will develop consumer panels to ensure that patients' views inform the running of our hospital system;
- Training and support to ensure the successful implementation of the strategy will be provided to HSE staff.

Conclusions:

In conclusion, a review and exploration of the literature pertaining to identifying and addressing health inequalities within communities identifies many extremely important learnings for the NEIC community and the ICON Health Action Forum. The broader determinants of health, presented in the Dahlgren and Whitehead Model (1998) are of significant relevance to those living in the NEIC. Social, economic, political, educational, environmental, living and working conditions and individual genetic and lifestyle factors all impact, mainly negatively, on the lives of those living in the NEIC community.

Issues relating to equity of access to health services are extremely relevant for the community with very poor or little access to relevant and much needed services for all life stages. Many of those experiencing difficulty in accessing services suffer from multiple disadvantage and include refugees and asylum seekers, people with physical and intellectual disabilities, homeless people and drug users.

In terms of addressing health inequalities in a real and meaningful way, the literature presents a sound rationale for engagement and involvement of the community at all stages. A community development approach to health, underpinned by the values and principles of community development and participation, is the most effective way forward in terms of health service planning. A strong evidence base exists, developed by the health service itself, for the involvement of the community in the planning, development and delivery of primary health care services. This evidence and rationale is particularly relevant

for the HSE, the people of the NEIC and the Health Action Forum as they move forward in partnership to plan and deliver a needs-based primary health care service for the NEIC.

Appendix 2: Breakdown of participants involved in the community consultation process.

Group	Total	No of Males	No of Females
FOCUS GROUPS			
• Young people	8	6	2
• Parents	2	1	1
• Men	*		
• Women	*		
• Older people	20	6	14
• People with problem drug use	8	5	3
• Residents	5	1	4
• People who are homeless	6	3	3
• People with disabilities	*		
• Minority ethnic communities	8	4	4
• Expert Panel	14	3	11
• Individual Interviews	14	4	10
Total number involved in this consultation	**85**	**33**	**52**

* Despite numerous attempts by ICON to access these population groups through local representative organisations, it proved difficult with these population groups. However, the following points should be noted:

- While the number of parents participating in the parents' focus group was very small, many of the participants in other focus groups were also parents and contributed accordingly.
- While it was not possible to consult directly with a specific group of men or women, all of those who engaged in the remaining focus groups brought both perspectives to the consultation. Additionally, the report drew on existing research and other relevant consultation findings in this regard.
- With regard to people with disabilities, again, it was not possible to convene a focus group. However, once again relevant research was referenced in the report.
- Finally, the limited scope of this consultation process validates the need for a more extensive in-depth needs assessment process which should include a door-to-door survey of all households in the NEIC as well as further focus groups and interviews.