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EASTERN HEALTH BOARD

PROGRESS REPORT

ON

GOVERNMENT HEALTH STRATEGY

Shaping a healthier future

REGIONAL LIBRARY AND
INFORMATION SERVICE

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Section 1

Overall Programme for Implementation, Consultation and Restructuring

Introduction

In response to the Health Strategy, our Board has embarked upon a programme of briefing, consultation, restructuring and re-alignment towards the principles outlined in the Strategy document.

Not unlike other major organisations, the structure of our Board has traditionally been centralised and hierarchical. A process of decentralisation already initiated in recent years was given a new emphasis by the Health Strategy towards flattened management structures with greatly increased devolution of responsibility and accountability within the organisation. While initiatives taken have begun to move us in this direction, the changed structure cannot be finalised or made too definitive in the absence of clear knowledge of the ultimate organisational structure for the delivery of services in our Board's region.

In this section, we outline how the participation of local management and staff is being progressively developed through dissemination of information, consultation and devolution. Furthermore, cross-programme liaison to heighten effectiveness and cohesion in specific service areas has also been addressed. Multi-disciplinary review groups, in line with the key areas of action plans within the Health Strategy have been also instituted. To ensure that a multi-sectoral approach is maintained by our Board, various initiatives have been taken including heightened involvement with local Area Partnerships; these, and other initiatives, are discussed below. A clear customer focus has always been our goal and we are exploring even more effective methods for disseminating this mission to staff at all levels of our organisation. In this regard, we are heartened by positive responses to initiatives we have already undertaken and which are outlined later in this report. Our Board acknowledges that our key resource in meeting the targets of the Strategy is our staff. This section begins therefore with a discussion of the way in which communication of the Strategy's principles was undertaken with them.

Communication with staff

As a result of the launch of the Health Strategy in April 1994, briefing sessions were held at all staff levels within the region. These were extremely well received and helpful feedback and ideas were received. It was stressed during these sessions that the concepts and principles contained in the Strategy should be the signposts to the delivery of services for the future. It should be noted at this point that the initial enthusiasm with which the Health Strategy was greeted was coupled with a certain hesitancy on behalf of staff. This is as a result of uncertainty surrounding the organisation's future and how this will affect staff. Addressing this difficulty, and the preservation of staff morale, is a priority task in which our Board's new Communications Director will play an important role. The Health Strategy Co-Ordinator has also been designated to take responsibility for the programme of consultation and for staff liaison during the implementation.

Local management

It has been mentioned earlier that our Board had to proceed with some caution in relation to structures for decentralisation and devolution which are overdue and necessary. Notwithstanding this, some important steps have been taken to make the goals of the Strategy a reality, albeit tentatively. It is important that the organisation at all levels is appropriately structured to empower staff to take a proactive approach and to promote an atmosphere of participation and accountability. To achieve this, local management teams are being formed in a number of service units. These local management teams set clear objectives which assist them in being more responsible for their own areas of management. Increased responsibility for decisions on service delivery is being encouraged at this local level, in tandem with increased accountability for actions taken at local level. We are aware that our staff's training requirements are set to increase because of this and our Board is embarking on a process of helping staff to identify their own training needs in order to assist them undertake greater accountability and responsibility. Our newly evolved training strategy, discussed elsewhere in this document, will have a central role to play in this process.

One essential requirement of local management is that each person be given a clear understanding by senior management of major policy issues which not only affect their particular service but which also affect the wider service. This process

ensures that a clear understanding and context at local level for effective implementation of regional aims and policies for health and social gain.

Multi-disciplinary review groups

In addition to the local management teams discussed above, a number of special multi-disciplinary review groups have been established to review particular services with a view to the development of costed action plans for implementation for the years 1995-1997. These are in line with the key areas in the Health Strategy action plans. In addition, particular areas have been targeted for strategic management review and these are: the elderly; health promotion; child health; physical and sensory handicap; mental illness and mental handicap; food and medicine control; women's health and family planning; palliative care; child care and family support; travellers and the homeless.

Cross-programme cohesion

In order to maximise total service benefit in specific areas to the client, our Board has also implemented a strategy where one Programme Manager has taken overall responsibility for policy issues within particular service areas which are cross-programme. It is essential that there should be a unified cross-programme approach to the delivery of services for particular groups in order to ensure that an integrated and comprehensive range of services i.e. a "seamless" service is available to meet the varying needs of our clients and to ensure ease of access to the level of services most appropriate to these individual needs. Whilst the day to day provision of services for these client groups comes within the ambit of responsibility of each Programme Manager, an arrangement has also been introduced under which, for various key services such as services for the elderly, mental handicap, and children's services, which have a significant cross-programme content in their delivery, one of the Programme Managers has overall responsibility for leading and ensuring the development and implementation of policies and protocols, aimed at guaranteeing the provision of services which are accessible and appropriate to various needs.

To expedite and facilitate this new arrangement, each Programme Manager has nominated a senior manager within each of these important service areas. In order to develop paradigms for this more responsive and flexible approach to services, three areas have been identified initially: mental handicap, services for the elderly

and child care services. To date, this methodology has been shown to be effective and it is expected that measurable health and social gain in terms of accessibility, appropriateness, efficiency and cost effectiveness.

Partnership

Our Board has adopted a number of strategies in pursuing a closer partnership with local areas, service providers and with voluntary agencies. We have engaged in a number of such initiatives in order to both generate a more effective and involved response to need, while in other instances, the partnerships in question have the objective of securing increased accountability.

One of our primary responses to generating a more involved and effective response to need, was the recognition that our Board should take a pro-active approach to participation in Area Partnerships which have been established to address social and economic issues. The *National Development Plan* (1993) and the *Programme for Competitiveness and Work* (1994) call for the promotion of community-led initiatives in order to empower marginalised communities. Based on a "bottom-up" approach, these Partnerships involve assisting local disadvantaged communities to articulate their own problems and helping them to identify the means of addressing them. To achieve this objective, a full-time member of staff has been assigned to work with Area Partnerships and to co-ordinate the involvement of a number of our Board's staff who have been assigned to the Partnerships on a part-time basis. This initiative is addressed more fully in Section 3 of this report.

Another partnership initiative undertaken by our Board has been with general practitioners. In addition to the establishment of our Board's G.P. Unit, our Board is developing a number of pilot general practitioner model clinics. The model clinics have a two-fold partnership element: local district general practitioners co-operating in the provision of joint services, while at the same time, becoming partners of our Board in the provision of services. These will maximise opportunities to provide effective and efficient health care to patients and to deliver this care in appropriate, accessible and cost-effective settings. Many of these pilot schemes are located in population areas which experience marginalisation and social deprivation. The pilot services will operate in close partnership with our Board with the aim not only of improved health and social gain, but also of ensuring that improved information on practice activity, enhanced

data collection on morbidity, mortality, and uptake of essential preventative services is provided to us.

Consultation and initiatives leading to greater partnership with the voluntary sector are also taking place. These include developments which will bring about clearer standards of accountability and contracting arrangements. This is discussed further in Section 5.

Summary

Bearing in mind that steps towards restructuring must remain tentative in our region, it must also be recognised that the fruits of any programme of consultation and devolution of responsibility and accountability do not become apparent for some time. In the meantime however, it can be seen that the journey has begun. Our Board has not relied on a one-dimensional approach to the restructuring required as a result of the Health Strategy. Rather, a multi-faceted approach has been adopted to allow for maximum participation, local consultation and greater cohesion.

Section 2

Application of the Concepts of Health Gain and Social Gain:

Research Programmes

Introduction

Our Board acknowledges that the application of the concepts of health gain and social gain represents what is perhaps the greatest challenge contained in the Health Strategy. No longer will *volume* or *levels of activity* be used as yardsticks by which health services can be measured; now, greatly improved data collection and analysis must become the basis upon which management decisions are made, priorities are set, resources are allocated and upon which services are provided and reviewed. Underpinning this policy must be the principles outlined in the Health Strategy of equity, quality and accountability. There is no doubt that the re-orientation of our Board's services so that these criteria can be met, calls for a shift in organisational culture and in methods of operation. Nevertheless, we are confident that, pending decisions on the future structures and organisation of services in our Board's area, the initiatives already set in train will contribute significantly to meeting this challenge. Our new Department of Public Health will have an important role to play in these initiatives.

The Health Strategy document for effective health care in the 1990s, stresses the concepts of health gain and social gain. Both concepts underline the need for a demonstrable benefit to derive from interventions by the health or personal social services. In measuring gain, it is necessary to have an underlying concept of what may be considered gain. This cannot be achieved without agreed and clear objectives and comprehensive and accurate information on health needs and what interventions are most effective.

An established starting point is of importance. It is necessary to identify indicators as proxies by which to measure progress. Such indicators can be used to establish baseline data and to establish a starting point for demonstrating gain. Thus, before the gain/outcomes of health service can be measured, it is necessary to identify specific indicators on a service by service and intervention by intervention basis.

The quality of health care and health intervention is of prime importance to our Board. Quality may be viewed from different perspectives: that of the health care provider and that of the public, the potential user. Quality and gain can be considered in relation to:

- efficiency** of service
- effectiveness** of service
- equity** of service
- access** both in timeliness and geography
- appropriateness** relevant to need
- responsiveness**

Thus, it is appropriate to examine quality and gain in relation to: the structure, the process and the outcome, defined as the actual result/effect.

The aim of our Board is the development of an understanding of what is meant by health/social gain and to secure the commitment of all staff to the concept of meeting targets for improvement. Our Board's embryonic Department of Public Health has established a group which is currently seeking to identify priority areas for measurement of health gain, identify appropriate indicators, establish information systems to capture baseline data and to implement a monitoring system. The group is seeking to identify performance indicators appropriate to gain as outlined above, bearing in mind the need, particularly initially, for such indicators to be simple, controllable and to use available data.

Our Board's staff have already undertaken work which has the potential to contribute significantly to health and social gain. A report titled *Health Within the Eastern Health Board Region*, produced in 1994, reviewed, in broad terms, some aspects of health status within our Board's region. This report is the first public health report as such for our Board's area and further reports will follow on an annual basis. The report recorded baseline data relating to health status of the population, identified needs in relation to support information systems and established initial priorities for action. The report identified causes of early death, which were defined as before 65 years of age. When years of life lost through death up to the age of 65 years was examined for the Eastern Health Board region it was seen that the leading causes of death in males are: injury/poisoning (35.1%); ischaemic heart disease (22.8%); cancers (21.9%); respiratory disease (3.5%) and cerebro-vascular disease (3.3%).

The leading causes of years of life lost up to 65 years for females are: cancers (41.6%); injury/poisoning (19.8%); ischaemic heart disease (12.5%); respiratory disease (5%) and cerebro-vascular disease (4.9%).

In males, although circulatory disease and cancer contribute substantially to loss of years of life, other causes, such as accidents, are prominent. In females, cancer - particularly cancer of the breast and lung - is a major contributor to loss of life under 65 years. This report also highlights some important health issues which are: ischaemic heart disease, cancers, injury prevention, unintended pregnancies, infectious diseases and services for the elderly.

In addition, it notes that access to accurate, timely, complete and comprehensive information is essential. In relation to examining health status, the necessity to collect health data on a small geographical basis is stressed. In this regard, our Board has developed epidemiological and other information systems and these are being further developed.

It is recognised that it is important to develop a comprehensive information strategy to support the Health Strategy and to connect the many "islands" of health information which currently exist. Our Board is currently developing systems in this regard, with particular emphasis on information systems needed to support the public health function. Extension of access to analytic facilities to other users in our Board via use of menus will also be an important objective.

The foregoing are matters to which our Board's Department of Public Health will have particular regard when fully operational.

Health Promotion

Health promotion is a comprehensive term which includes strategies to promote personal health and well being both at an individual and at community level. It is a positive concept, implying more than the avoidance of illness. A central aspect of the Health Strategy is to reorient the health services towards a health promotion approach based on encouraging people to take responsibility for their own health and on providing the environmental support necessary to achieve this. Our Board is involved in a wide range of initiatives to promote health including: smoking prevention and cessation programmes; immunisation programmes; Health Promoting Schools; Health Promoting Hospitals; health promotion among travellers; Community Mothers Programme; promotion of sport and exercise; peer-

led nutrition intervention programme; accident prevention initiatives. Our Board also has a significant involvement in National Healthy Eating Week, National Health and Fitness Week and National Drugs Awareness Week.

Many of our Board's staff are actively involved in health promotion and health education activities as part of their day to day work. We want to continue to develop this approach rather than health promotion being seen by staff as the domain of specialists. We continue also, to develop links with many sectors and organisations in the promotion of health, notably Dublin Healthy Cities Project (discussed in Section 8 of this report), the Health Promotion Unit of the Department of Health, Department of Education/Cospoir, the Irish Cancer Society, the Irish Heart Foundation, local authorities, primary and post-primary schools, general practitioners, community groups and voluntary groups.

Our aim is to develop a comprehensive, effective and co-ordinated health promotion strategy involving staff at various levels, other sectors and the community at large. A review group on Health Promotion was set up in 1994 and their recommendations will be assisted by outside consultancy advice which will also take account of the Health Promotion Strategy to be published by the Department of Health.

Health Promoting Hospital

James Connolly Memorial Hospital in Blanchardstown is one of twenty pilot hospitals participating in a W.H.O. Europe initiative on health promoting hospitals. The aim of the project is to demonstrate the feasibility of the concept and to produce a wide variety of documented and evaluated experiences for concrete health promotion programmes in and by hospitals. The focus of the Health Promoting Hospital project is the development of health oriented perspectives, objectives and structures by hospitals. This recognises that, apart from their traditional role in curing illness, hospitals also have a potentially powerful influence on the health of patients, staff and the local community. A full-time project co-ordinator has been appointed together with leaders for a number of sub-projects covering areas such as smoking cessation, back injury prevention, cardio-pulmonary resuscitation, stress management and waste management. An important element of the project is participation by and empowerment of, patients and staff.

Evaluation criteria have been determined in advance and an independent evaluator has been appointed. The fruits of the evaluation will be shared with other hospitals within the network across Europe. Similarly, knowledge gained in those other hospitals regarding other aspects of health promotion will be shared with staff in James Connolly Memorial Hospital. Our Board is encouraging the development of a national network of Health Promoting Hospitals and along with the Health Promotion Unit of the Department of Health we hosted a national conference on the topic in April 1995 in order to launch a national network of health promoting hospitals. The response has been most encouraging and it is expected that following a meeting in June, 1995 at least 20 hospitals will form a national network.

Research and Review Documents

Service provision by our Board has been shaped by a number of elements. Research undertaken by our Board's staff - including specially commissioned research - has been significant and this will have even greater prominence as a result of the Health Strategy. Review reports have also been an important guiding force - both from our Board itself and the Department of Health - and from bodies such as the World Health Organisation. In addition, feedback from staff which is grounded in practice has also been a significant element in shaping the direction of service provision. Not all research needs to emanate from within one or more health boards; often it can be more cost-effective to utilise the fruits of published research undertaken elsewhere. Recent initiatives demonstrate the manner in which research can be utilised to help in the application of the concepts of health gain and social gain. Significant research and review reports undertaken by our Board are outlined below:

Patients 21 Days or More in an Acute Hospital Bed

This study identified the proportion and numbers of patients inappropriately occupying acute beds in Dublin hospitals, from among patients who had been 21 days or more in hospital. Factors were identified which were associated with patients who were inappropriately in an acute hospital bed and the study proposed ways of making more effective use of acute beds. The recommendations of this 1990 report are equally relevant today, particularly having regard to the renewed pressure for acute hospital beds in the Dublin region

A Study of the Functioning and Effectiveness of Out-Patient Departments in Dublin

This study critically analysed Out Patient Department process and included a patient satisfaction study and a general practitioner satisfaction study. Important recommendations were made in relation to: Out Patient Department information systems, management of Out Patient Departments, the processes and interfaces within the system and client facilities.

This Phase 1 report, completed in 1995, identified a number of improvements which can be made in relation to hospital Out Patient Department services, which would result in increased efficiency and gain. The report is also relevant to appropriateness and responsiveness. Proposals were made which would improve access and responsiveness by reducing waiting times. The findings and proposals in this report are included in our Board's action plan for this year.

Accidental Injury in Ireland: Priorities for Prevention

A prevention strategy in relation to accidental injury has significant potential in relation to both health and social gain. A report, *Accidental Injury in Ireland: Priorities for Prevention*, was recently completed by our Department of Public Health on behalf of the health boards' Chief Executive Officers. It identifies the factors associated with injuries and the areas which should be seen as priorities for prevention. The action needed and the suggested targets in relation to gain are also identified in the report and these will form the basis of a strategic plan aimed at reducing the numbers and impact of accidental injury over the coming years.

Series of Studies Relating to Disadvantaged Areas

- a) Behavioural risk factors among young adults in small areas with high mortality versus those in low mortality areas
- b) Socio-economic factors and mortality in small areas
- c) Small area analysis of low birth weight
- d) Small area mortality patterns

These research papers have contributed important health information baseline data for our Board. They relate socio-economic indicators to health indicators on a small area (District Electoral Division) basis. A significant correlation between standard mortality ratio and low birth weight per district electoral division and each

of the socio-economic factors is indicated. The best predictor of health status identified is the percentage population in social classes five and six. The percentage of the population in each district electoral division covered by a GMS card is also shown to be the best predictor of adverse health.

Health Promotion Initiative: Teenage Pregnancies

This primary prevention programme was targeted toward adolescents in a second level school in an area with a high proportion of teenage pregnancies. The objective was to alter the attitudes and behaviour of young people in relation to sexual activity with the aim of reducing the frequency of teen pregnancy. The programme addressed: decision-making skills; the development of self-esteem and the management of peer-pressure; the problems of alcohol misuse. The adverse health effects of early sexual activity were also covered. The importance of and the need for, taking responsibility were also highlighted.

Evaluation of the programme showed a large increase in knowledge among students and encouraging changes in attitude. As a result of the enthusiasm for this study within the pilot school, the programme was introduced in the school on an on-going basis. The Departments of Health and Education were informed of the programme and the findings of the study were made available to them. It is planned to extend this initiative to other schools in similar disadvantaged areas.

Drug Prescribing

An increased range of drug prescribing analysis is being developed which will include the use of symptomatic, specific and presumptive classification systems similar to those already developed in Belfast. This will provide pointers to areas of prescribing relating to individual general practitioners, where the quality of prescribing may be improved and scope for economies exist. Initial information available from this research has recently been provided to GP Unit doctors in support of their work relating to indicative drug budgets in general practice.

Prevention of Congenital Abnormalities

A project examining the role of vitamin B12 and Folic Acid in the aetiology of all congenital abnormalities is being undertaken by our Board in collaboration with Trinity College Biochemistry Department and the Health Research Board. The project is seeking to identify whether there is a relationship between low maternal

vitamin B12 and folic acid levels and a range of congenital abnormalities. Although still at an early stage, if this research demonstrates a relationship between these entities and other congenital abnormalities, an important potential for health and social gain would be identified.

Computerisation of General Practice

Pilot studies are underway aimed at computerising general practices. This project will provide morbidity and other data to our Board for epidemiological analysis. These GP Unit pilot projects may also identify areas where service efficiency and effectiveness can be enhanced.

Cardlink

This is an EU funded pilot project involving patient medical record data cards currently being led by our Board. Patients will be provided with "smart cards" containing essential administrative, clinical and prescribing information. It will allow the service provider to have ready access to appropriate information at the point of contact with health services, with the aim of increasing the quality of service, reducing unnecessary diagnostic investigations and ensuring a more effective response in emergency situations and in use of time. The potential benefits from this pilot project, if it is successful, are significant.

Review of Adequacy of Child Care and Family Support Services

Although undertaken as an annual requirement of the Child Care Act 1991, this Review, carried out in the latter half of 1994, grasped the Strategy's concepts of access, efficiency, equity, quality and accountability. It was also decided to extend the scope of the review to all child health services. A questionnaire was drawn up to evaluate the application of these concepts, and those of health and social gain within our Board's child care and child health services. Using this questionnaire, each manager was requested to conduct a self-audit of his/her service. The involvement of a large number of voluntary agencies which provide both residential and child psychiatry services, funded by our Board, was a crucial component of the Review. Important recommendations were made in the health and social spheres - particularly in relation to the more effective allocation of resources to areas of greatest need. The reshaping of the child care services, in line with these recommendations, will be the focus of action in the future.

Female Drug Users and Service Provision

This study, which studied forty female drug users, enabled them to identify their own service needs. It demonstrated clearly that it was their role as parents which was the primary motivating factor in the women becoming drug free. In addition, the needs identified by the women included principally support in parenting and the need for work preparation and skills training. Furthermore, also as a result of this study, a special skills and work training initiative is being established to meet the stated social needs of this group. In-built evaluation criteria for assessing health and social gain will be an essential part of this project and such criteria are currently being devised. As a result of this study, our Board was confirmed in its plans to establish a special project to support such parents in an inner-city area which has acutely experienced debilitation due to drugs. This initiative was also confirmed by a study undertaken by our Board on the problems faced by the carers of drug misusers. This study identified a great need among women, who had lost adult children to drug misuse or AIDS, for support in rearing their grandchildren.

Review of Speech and Language Therapy Services

Speech and language therapy services were reviewed by a working group which issued its findings in 1994. The review group studied a wide range of literature and reports in relation to speech and language therapy, in addition to reviewing relevant existing health board data and material. Submissions were invited from organisations employing therapists within the region and from their training college and professional body. The group also undertook research, by means of a detailed questionnaire, into our Board's speech and language therapy service. In addition, information was also sought from therapists who had left our Board's service in recent years. The group's recommendations will be implemented as quickly as required resources can be secured. Some recommendations were concerned with improving access to the service for clients; others specified the adoption within the region of objective criteria and standardised assessments, objective monitoring and efficient management of waiting lists.

Strategic Management Initiative in Community Welfare Service

Our Board's Superintendent Community Welfare Officers have undertaken to examine their management role with a view to taking a more proactive rather than reactive approach to the management of the service.

The object of the initiative is to develop the organisational structure and the management systems, processes and style of the service so that the goals of increased customer responsiveness and satisfaction - together with the optimal use of resources - can be achieved. Obviously, the uncertainty regarding the role of our Board in the provision of this service in the future will have to be taken into account.

Community Based Stroke Care Service

Published research has demonstrated clearly that "well-organised stroke rehabilitation services are cost effective: the patient's independence is increased, so there is less need for therapists and hospital stays are shorter. The challenge is to institute community-based disability services that not only improve stroke outcome but also help other patients with neurological disability. Based upon this research, our Board has undertaken the establishment of a community based Stroke Care Service at Baggot Street Community Hospital. Planning is at an advanced stage with an expected commencement date in late 1995. This service will aim to assist the patient to return to full and active participation in normal daily living as soon as possible, resulting also in more effective use of resources. The anticipated health and social gain accruing to the patients will be monitored.

Services for the Elderly

Our Board adopted a policy on Services for the Elderly in 1989 in response to *The Years Ahead* report. The primary objectives are to maintain elderly people in dignity and independence in their own home; to restore those elderly people who become ill or dependent to independence at home and to encourage and support the care of the elderly in their own community by family, neighbours and voluntary bodies in every way possible.

Following a detailed review of progress in service development since 1990 and of current needs our Board has recently adopted a report, *Review of Services for the Elderly* which incorporates a four year action plan (1995-1998). This report, having taken the latest available demographic information and the projected increase in the elderly population in our Board's area into consideration, acknowledges the urgent need to:

- (a) extend the number of community Ward Teams to two per community care area by 1996
- (b) develop nine Community Units as part of our Board's immediate to long term strategy in the development of services for the elderly on a phased basis.

As envisaged by the 1989 policy report, the Community Units will ideally be built in two modules of 25 places each, to reflect a size and economy of scale which will enhance the quality of life of our residents. Our Board is of the view that this approach will result in a responsive humane service and that small community based units will have the best chance of achieving close integration with community services and acute general hospital based services.

The Units will be part of a spectrum of services designed to support elderly people at home or to care for them when for medical or nursing reasons they cannot remain at home. A range of services will be provided in the catchment area of the Units for elderly people themselves and will also support their carers through provision of respite/intermittent care, day care and extended nursing care. The Units will also cater for elderly people who require nursing care or rehabilitation after acute illness but who do not need the services of an acute hospital and are too ill to return home. The Units will also accommodate confused elderly persons, following appropriate medical assessment.

Home Care for Psychiatric Patients

No one exact model of community care was prescribed in the policy document *Planning for the Future*. Therefore development programmes were in effect pioneering, requiring re-orientation of goals in the context of experience gained. Whilst the development of a community model was the overall philosophy, service teams were facilitated in developing their own ethos within the overall policy structure to allow continuous development and comparison of ideas and models of care. In parallel with these developments, staff have been involved in a variety of pilot and research initiatives aimed at evaluating service outcomes and quality of care and particularly focusing on health and social gain.

A project in Clondalkin was developed as a pilot study in the West Dublin Area and compared a traditional community psychiatric service with an innovative home care service model. The research investigated the feasibility of running a comprehensive community psychiatric service and the effectiveness of such a

service as measured by the following outcomes: clinical; family-burden; patient, relative and GP satisfaction with the service; economic; and change in hospital use. The research showed that a well resourced home support programme gave a highly acceptable service to the patient population, that those patients enjoyed a high level of personal self esteem and that the programme was highly regarded by the carers and primary care providers. As a result of this research the Clondalkin Project was validated and the model of care has been established in Kildare and North County Dublin. Further services will be developed in Areas 4 & 5 in the current year. The evaluation of the service model is continuing in the North County and Kildare.

Psychiatry of Old Age

The first psychiatry of old age service was established in Dublin in 1989 in the North Inner City. The service operates on a multi-disciplinary model led by a consultant psychiatrist and is based on the principle of domiciliary assessment and support services. Management of the patient is community based wherever possible. Community psychiatric nurses play a key role in supporting patients and carers and they monitor patients so that needs can be met as they arise and crises avoided.

Previous research on elderly acute hospital in-patients referred to the service confirmed the need for immediate and close liaison between acute hospital and community personnel in the appropriate placement of patients. Research conducted in 1994 assessed how services in day hospitals were meeting clients' needs. The study found that a day hospital provides a satisfactory process of care for patients, with a low usage of in-patient beds.

Feedback from professionals working in the field of psychiatry of old age in James Connolly Memorial Hospital highlighted the need for further support services for both elderly dementia patients and their carers, in addition to day care and home help provision. This feedback demonstrated that little other respite or support was available, especially at weekends or in the evenings. To meet this need, a sitting service has been introduced, with student volunteer sitters relieving the carers of the patients so that they could have some respite at times when other supports were not available. This respite allows the carer to attend carer support groups or to engage in recreation of their own choosing. An induction programme was arranged for the volunteers and at the end of the study period, significant beneficial outcomes were achieved for all concerned: students, carers and patients alike.

Supported Community Accommodation

Supported Community Accommodation is an integral part of a modern comprehensive community based psychiatric service. In our Board's area we provide 678 places in hostels with ranging support levels (high, medium & low support). This accommodation, as well as meeting on-going service requirements, is also used to relocate long-stay patients from institutional care. The development of supported accommodation has been validated by a number of research and study projects which have confirmed the appropriateness of this accommodation as a model of care and demonstrated an overall improvement to clients in terms of health and social gain. The first such study examined the outcomes for the discharged group investigated. It showed that the patient group, although severely disabled, preferred living in the community. It also confirmed that well planned discharges with comprehensive aftercare do not result in clients becoming homeless or lost to follow-up, nor indeed do they suffer a higher mortality rate. Patients discharged to hostel accommodation were reviewed in 1994. The review found that the group audited enjoyed an improved quality of lifestyle outside the hospital environment and the policy of de-institutionalisation was fully endorsed by them. The review highlighted the need for social integration with the local community which it found is not guaranteed by physical integration. It also found that community residences are not operated as "mini-institutions" but rather as warm, home-like settings where residents are treated as individuals and their need for privacy and freedom respected. A further evaluation of high support hostels is under way at present. This evaluation is concentrating on high support hostels as a service component with particular emphasis on meeting the needs of high dependency patients.

Parenting Skills Project

Recognising the current pressures on family life and in order to promote health gain within families, our Board's Psychology Department has developed a Parenting Skills Training Programme. The programme involves courses for parents in community-based venues with the objectives of promoting positive mental health and well being in both parents and children; resolving current problem behaviours and the prevention of future ones; and enhancing greater harmony within the home. The programme has been expanded on a partnership basis with the National Rehabilitation Board and courses were adapted to meet the needs of parents of children with physical disabilities. Evaluation procedures were integral to the programme from the outset. Health gain has been demonstrated by a

significant improvement on measures of the mental health status of parents, a reduction of emotional and behavioural problems in children and an improvement in the attitude of parents towards their children. Social gain was shown by increased parental confidence, increased social competence in parents, the establishment of ongoing social support networks and the empowerment of parents in becoming active in their community.

As a result of the success of the programme to date, it is proposed to strengthen and expand the programme with additional staffing resources subject to the necessary finances coming on-stream in the context of Child Care Development Funds.

Summary

Our Board is committed to the concept of greatly improved data collection, monitoring and evaluation in the pursuit of health gain and social gain as the research and review activity outlined above demonstrates. It is recognised that the application of these concepts throughout our Board's services will require modification in methods of planning and operation. The attendant costs of this are also acknowledged. Nevertheless, the value of the ideals and the benefits to be derived from the approach are appreciated and, as summarised above, have already informed service delivery in our region.

Section 3

Health Development Sectors: *Identification and Organisation*

Introduction

As is recognised by the Health Strategy document, the achievement of equity must be addressed in a multi-dimensional way and the selection by our Board of Health Development Sectors reflects many facets of need. Central to our Board's approach in this regard is the motivation toward achieving greater equity in the drive towards health and social gain in certain disadvantaged groups with low health status.

Three distinct strategies have been adopted by our Board in undertaking this task. The first of these are our initiatives towards populations whose access to, or participation in, the health services called for greater equity. This sector includes drug misusers, disadvantaged mothers, the homeless, travellers and adult victims of child sexual abuse. Other populations also discussed in this section include the young chronic sick, those in need of palliative care and those whose need for residential detoxification services has hitherto been unmet. Because of the health and social difficulties which some women in certain situations may undergo, our Board has identified them as a priority health development sector and a number of initiatives are being undertaken in this regard which are outlined in this section. Secondly, although the forces which create social disadvantage lie outside the direct control of our Board, initiatives have been developed in disadvantaged, defined geographic areas or communities. In order to increase health and social gain in these communities, such initiatives include Local Area Partnerships, community development projects and nutrition intervention projects. Thirdly, all these strategies are underpinned by our Board's epidemiological information systems and this section begins with a discussion of these.

Inequalities in Health

A marked gradient by social class in relation to mortality and morbidity is the rule rather than the exception in many international epidemiological studies, with those

in the lower socio-economic groups faring worse in relation to health status. Thus, it is important to have in place health information systems which can identify the significant variation in health needs in geographical population sectors. District electoral divisions (DEDs) have been shown to be a useful geographical unit for collecting information.

A number of recent reports, including the Health Strategy document, have emphasised the importance of collecting health data on a local or small geographical area basis. To compare mortality at local level with the rest of the population, data must be adjusted for age differences. A standardised mortality ratio (SMR) can usefully be used as an indicator of health at DED level or for comparison of mortality from specific causes.

Our Board has been to the fore in developing a methodology for an Epidemiological Health Information System (E.I.S.) which allows for a range of selected health indices, including SMRs, to be monitored on a DED basis. Using this epidemiological information system, work undertaken in our Board's area has included a study of mortality patterns in small geographical areas of Dublin city and county which identified areas of higher than expected mortality. The association between mortality in small geographical areas and socio-economic indicators has been demonstrated. The prevalence of behavioural risk factors for premature mortality such as smoking, lack of exercise and unhealthy eating, have been related to areas of high and low mortality, showing that areas with high mortality have the highest lifestyle risk factors. The association between low birth weight and social class, male unemployment and GMS card coverage has also been shown.

Of great importance in determining need and identifying those at risk are changing social, environmental and economic circumstances. Many factors influence health, including diet and nutrition, prevalence of disease including chronic disease, lifestyles, emotional and behavioural disorders, stress, level and length of time in education, housing standards and social inequalities and unemployment. Systems have been developed in different countries which use selected factors as an indicator of health needs. Our Board's Epidemiological Information System has been used to show that a GMS card is an indicator of material deprivation and consequently, it is a very good indicator of health need. The system also allows for the mapping of "black-spots" over a range of health indices allowing for the

identification of areas of health need, the targeting of specific groups for intervention and the evaluation of gain in relation to intervention. In addition, the system has been applied to investigate alleged environmentally related disease clusters.

The Department of Public Health intends to further develop the Epidemiological Information System and to extend its coverage to all of our Board's region.

Health and Social Gain Initiatives for Disadvantaged Population Groups

A number of initiatives, specifically targeted at disadvantaged groups and districts have been undertaken by our Board in order to increase health and social gain for these populations and areas. Important sectors identified by our Board include those whose participation in, or access to, the health services has been inequitable until now. These are addressed below:

Women's Health

There has been a widespread view in recent years that there should be greater encouragement to women, particularly disadvantaged women, to increase their uptake of health care and preventive services. Because of these health and social difficulties which some women in certain situations may undergo, our Board has identified them as a priority health development sector and a number of initiatives are being undertaken in this regard.

Among the initiatives directed primarily towards supporting women in their role as mothers, our Board's Community Mothers Programme has been shown to increase the self-esteem and confidence of the Community Mothers themselves. Other initiatives are directed at improving the parenting skills of women and at improving their employment prospects. Our Board is also actively involved in education projects, Homestart and Homemakers projects. Many of these developments are detailed elsewhere in this report.

Maternity hospitals in Dublin, in addition to providing the traditional range of inpatient and outpatient services, are in varying degrees involved in the process of broadening services to focus on the wider health needs of women. Our Board supports each maternity hospital in providing outreach outpatient clinics in our

Board's area. Linkages with maternity hospitals are detailed elsewhere in this report. An evaluation of the adequacy of the services currently being provided by maternity hospitals, general practitioners and the voluntary organisations is currently under way. Once this survey is completed, any areas of need which are identified will be addressed.

Family planning and other support services are also provided by our Board in association with Accord (formerly the Catholic Marriage Advisory Council), the Irish Family Planning Association and NAOMI (the National Association of the Ovulation Method of Ireland). The Dublin Well Woman Centre has developed a wide range of services: contraceptive advice, pregnancy testing, preventative health care, menopause services, pre-menstrual syndrome advice, infection testing, an infertility unit and counselling over a wide range of topics. These services have been centre-city based and are in heavy demand. However, only 10% of their clients to date are in the medical card category. To improve the access of this group to women's health services, two pilot projects are being established in Coolock and Tallaght/Clondalkin areas for the provision of a comprehensive range of services for women. In Coolock, the proposed project will involve a number of general practitioners practising in an agreed area and the Dublin Well Woman Centre. The proposed Tallaght/Clondalkin project will involve a number of general practitioners practising in an agreed area and the Irish Family Planning Association. These projects will be the subject of evaluation and audit to measure the impact on both health and social gain of the women in the areas concerned and the cost effectiveness of the service.

Our Board has also developed services for sex workers, providing preventive health care, screening for sexually transmissible diseases, contraceptive advice and counselling.

While a wide range of services exists, improved take-up among vulnerable groups is the objective of our Board. This may partly be a problem of accessibility but also relates to awareness and motivation and issues which should be addressed in a wider policy context. The adequacy of present arrangements for cervical screening and breast screening are other issues which need to be addressed. Our Board has already undertaken preliminary work on the development of a wider women's health policy and the publication of the proposed national policy document is awaited.

Community Mothers Programme

The Community Mothers Programme harnesses the skills of experienced volunteer local mothers in disadvantaged areas to give support and encouragement to first time parents in rearing their children. The programme stresses the inherent skills of parents and seeks to encourage the parent's own problem solving skills. Having evaluated the pilot project which demonstrated important health and social gains for the children of mothers receiving the programme, our Board has extended the programme throughout the region with particular emphasis on provision in areas of highest deprivation. Parent and toddler groups, facilitated by Community Mothers, have evolved from the programme in a number of areas along with ante-natal visiting and support groups for breast feeding mothers. Home visits and developmental initiatives with the Travelling community are also taking place.

Women and Children subject to Family Violence

A major priority for developing women's health services is the need to expand services for women who are the victims of domestic violence. Our Board already provides a range of services in the Dublin area, including refuge accommodation, either operated directly or grant- aided through voluntary organisations. There is a need to co-ordinate services more effectively with other agencies. In this regard, our Board has joined with the Dublin housing authorities and the voluntary sector in developing a structure which will oversee and monitor the implementation of all services available for homeless persons, including families affected by violence. To assist in drawing up an action plan, including the provision of refuges and social work and support services for abused women and their children, our Board is participating in a research study commissioned by Women's Aid. Some of the main areas included in this research are the prevalence and incidence of domestic violence, the type of injuries occurring and how the response of the support services can be made more effective. The recent Review of Adequacy of Child Care and Family Support Services which incorporated the work of both directly-managed refuges, found that a high standard of social and health care was provided for the children of these families during their stay.

Travellers

The inequitable health and social status of the travelling community has been well documented in the past showing that it is significantly unfavourable when

compared with that of the settled community. While many of the factors which give rise to these problems - such as poor living conditions - are outside the direct control of the health services, there is nevertheless considerable scope for improvement in the health status of travellers. Our Board continues to develop its policy of attaching high priority to measures in order to redress this inequity.

Travellers' access to health care has been improved by the provision of a Mobile Clinic which attends both permanent and temporary sites in the Dublin area. The Mobile Clinic places an emphasis upon child care, health promotion and vaccination. The work of this clinic is supported by the development of a computerised child health records system which facilitates easy exchange of information within our Board's area.

A simplified procedure for processing medical cards for travellers is being piloted in the Tallaght/Clondalkin area and will extend to other areas of our Board in 1995.

The "Shared Rearing" Project is an important initiative which recruits traveller families as foster families for traveller children who have been taken into care. A fostering network among traveller families is being developed to provide emergency, short and long term placement of children with traveller families. This project allows care to be delivered to traveller children in the most appropriate setting and is culturally acceptable to traveller families. Our Board also funds nursery school provision for traveller children in order to provide compensatory social gain programmes and to increase the children's preparedness for later school attendance.

With special funding from the Department of Health, our Board, in association with Pavee Point, will continue to pilot a peer-led health promotion intervention programme for travellers on five sites in the Finglas area. Eight traveller women have been recruited to deliver the programme to sixty traveller families. The project will establish a model of traveller participation in the promotion of health and will develop the skills of traveller women in providing community based health services. It will also encourage dialogue between travellers and health service providers in the area and allow an invaluable insight for our Board into travellers' perceptions of health, disease and care needs. Evaluation of the initiative at the end of 1995 will help in shaping service organisation, content and delivery.

Teenage and Non-Marital Births

Many studies indicate that babies born to teenagers and single mothers are relatively disadvantaged in beginning life when compared with those born to married women in their mid-twenties and early thirties. Such disadvantages range from medical to social problems. A detailed analysis of teenage births in Community Care Area 8 revealed, like other studies, that babies born to teenage mothers were significantly more likely to be premature and that teenage mothers were less likely to breast feed. It was also identified that while pregnancies in this group occurred in all sections of society, there was a predominance among lower socio-economic groups.

Arising from this, a prevention programme was piloted. The objective was to alter the attitudes and behaviour of young people in relation to sexual activity with the aim of reducing the frequency of teenage pregnancy. Evaluation of the programme showed encouraging changes of attitude and knowledge. The extension of this programme to two other areas will commence in 1995.

Adults Victims of Child Sexual Abuse

Following reviews of services in our Board's area, it became clear that there was an un-met need for a specialist service to deal with the large number of referrals of adults who experienced sexual abuse as children. Due to their childhood experiences, this group was continuing to experience impaired mental health status. In order to address this need, and in partnership with the Rape Crisis Centre our Board established a specialist service, focusing upon north Dublin, Tallaght, Clondalkin and Kildare, with the Rape Crisis Centre providing the service in the south city and in Wicklow. Two counsellors are assigned to each of the locations and additional funding approved for 1995 will improve access for clients wishing to avail of the service. The service aims to offer an extensive therapeutic service to female and male adult victims of child sexual abuse and to enhance understanding and knowledge of the effects of sexual abuse within the community.

In addition, information, training and support will be offered to other professionals working in the area of sexual abuse. Liaison between the service and other relevant agencies will also be encouraged.

Homeless Adults

Research carried out over the last two years among the residents of the direct access hostels and low-standard accommodation in Dublin's inner city and by independent audit of homeless persons presenting at the Assessment Unit, St Brendan's Hospital, show that there is considerable mobility among persons using such accommodation. It was also shown that there is considerable morbidity among this population and very often a dual diagnosis of alcohol addiction/substance abuse with underlying psychiatric disorder. Both studies show that there are two new distinct areas which require development: a focused service for homeless females and the need to provide services for increasing numbers of young adults. The necessity for a more integrated approach to the problem of homelessness was also highlighted linking the specialised psychiatric programme for the homeless with each of the catchment area services. A focused alcoholism programme together with a case work service for the more dependant persons among the homeless is also a requirement. In addition, the importance of training and support for staff in the direct access hostels was also seen as important. The implementation of these recommendations is discussed below.

To date, our Board provides a specialist psychiatric programme for the homeless based at St Brendan's Hospital, the key components of which are: admission unit; day centre; high support hostel; rehabilitation programme; supervised group home and an outreach programme. Future development plans include the transfer of the day programme to two sites in the city centre which will provide more appropriate settings for the day service and which will facilitate the closure of the existing day centre at St Brendan's. It is also intended to re-orient the services at the assessment unit to provide a base for the homeless programme including a crisis outreach and intervention service/respite care for both males and females. Case workers will be deployed who will have responsibility for vulnerable homeless persons and they will respond to needs in all direct access hostels. A training programme for the staff in direct access hostels will be put in place to enable them to deal more effectively with residents who present with challenging and anti-social behaviour. Special support services are planned for this group.

We are also reviewing the particular needs of a group of homeless adults with drug addiction problems, some of whom may be H.I.V. positive.

Drug Misuse/H.I.V. Services

Over the past year, our Board's methadone maintenance programmes operating from three satellite clinics have consolidated their efforts to achieve health gain for drug misusers. In common with evidence in other countries, attenders at the methadone programmes have begun to stabilise and are beginning to consider other options such as detoxification. This will be facilitated by the opening of our Board's own detoxification unit which is discussed below. The third round of Soilese rehabilitation programmes for stable and former drug users is about to commence. This will be availed of by attenders at our clinics. HIV prevention continues to expand and over the past year, a further 300 new attenders availed of our Board's needle exchange and counselling programme. This measure has been shown in other countries to be one of the most effective in limiting the spread of HIV amongst injecting drug users. Needle exchange is now available in nine locations throughout the city. An active Hepatitis B immunisation programme is offered to all attenders at our Board's prevention outlets. Amongst the beneficiaries are intravenous drug users, homosexual men and prostitutes. A range of support services to victims of AIDS is provided and kept under review.

Social gain is being achieved by our Board's methadone maintenance programme. Much of the crime in Dublin is publicly attributed to drugs and to the need to fund illicit drug habits by means of theft. An indirect benefit to society from the maximum number of intravenous drug users entering the formal health care sector is that drug related crime amongst this group will decrease significantly. Thus, health treatment services for drug users increase social gain both at an individual and community level.

The average age of patients attending our Board's methadone programme is 28 years and the average length of time for their opiate habit is eight years. Methadone has only been available to this cohort for the past two years. Thus, a health service is now being provided to a marginalised group which was without an adequate health service response for many years before our Board became involved in the provision of such services. The development of two further satellite clinics and a mobile clinic is included in our Board's action plan for 1995.

In order to explore ways of achieving health and social gain for the carers of drug misusers, these carers were the focus of a study undertaken by our Board in late 1994. A central recommendation of this study was that social gain for this group could be improved by providing support for them in rearing not only their children,

but also the grandchildren whom they must rear as a result of bereavement due to AIDS. Our Board was confirmed in its plans to provide a dedicated family support service for this group, and now that staff and premises have been identified, the launch of this project is imminent.

Equity of Access: Residential Detoxification Services

The need to provide more equitable access to patients requiring residential detoxification services in the west and south side of the city is acutely evident. Current provision of these beds is confined to Dublin's north side through the ten beds at Beaumont Hospital. In order to ensure more equal access to this vital treatment and the resultant health and social gain, a unit in Cherry Orchard Hospital is being adapted for use as a Detoxification Unit. This will provide fifteen residential detoxification and rehabilitation places and it is hoped that the unit will begin to receive admissions in mid 1995. The equipment and revenue costs associated with this development are the subject of on-going discussions with the Department of Health.

Health and Social Gain Initiatives: Populations in Defined Geographic Areas

The effects of unemployment and poor housing have critically adverse impacts on the health and social status of individuals and communities with incidences of mortality and morbidity being relatively higher in these areas. While these adverse factors lie outside the direct control of our Board, we have actively participated in a number of initiatives to help to address these issues and to work towards achieving health and social gain among the disadvantaged. Community development initiatives are supported by our Board and examples of just some of these are given below:

Local Area Partnerships

In order to generate a more effective and involved response to local needs, it was decided to take a pro-active approach to our participation in Area Partnerships which have been established to address social and economic issues. Based on a "bottom-up" approach, these Partnerships involve assisting local disadvantaged communities to articulate their own problems and helping them to identify the means of addressing them.. To achieve this objective, a full-time member of staff has been assigned to work with the thirteen Area Partnerships in our Board's

region and to co-ordinate the involvement of a number of our Board's staff who have been assigned to the Partnerships on a part-time basis. Alongside this process it is seen as vital that statutory agencies are open to listening to criticism or suggestions which may be made about service improvement and creation. In the light of these suggestions and in conjunction with the resources of other agencies, our plans can be modified and enhanced to take account of local requirements. Through this process, our Board is more likely to maintain a consumer focus and to be more in touch with the emerging needs of the community. Notwithstanding this, the principal objective of Area Partnerships remains clear: the importance of supporting community development initiatives in order to help disadvantaged areas to enhance their own potential.

GP Unit: General Practitioner Services In Disadvantaged Areas

Our Board's GP Unit has initiated a vaccination scheme involving general practitioners in seeking to reach those children who may have missed vaccination at the appropriate age. Furthermore, an additional developmental paediatric examination, undertaken by general practitioners, has been implemented to cover the most deprived areas of our Board's region. Our Board is also involved in a number of general practice pilot projects aimed at enhancing general practice and extending the range of services provided. The emphasis is on establishing such pilot projects in deprived areas.

Ballymun Task Force on Community Services

The Ballymun area of Dublin has experienced many of the difficulties associated with areas of high unemployment coupled with high-density housing. Nevertheless, the community of Ballymun has been active on its own behalf in attempting to address these problems and our Board has played a key role in supporting this through the Community Services Task Force there which is a representative grouping of community-based voluntary and statutory agencies such as our Board and the Departments of Social Welfare, Education and Justice. The aims of the Task Force are to promote cohesiveness and co-ordination within community services provided to Ballymun so that there will be greater efficiency and effectiveness of service provision and to assist and support the work of voluntary groups in the area through revised and improved policies. Consumer research has recently been carried out into the community's views of the services provided by the local health centre. The findings of this study are currently being analysed.

Whitefriar Street/Eastern Health Board Project

This project is an example of an inner city community education project which uses the community education model as a vehicle for achieving health and social gain. A Public Health Nurse has been seconded to co-ordinate the undertaking. The target group of the initiative are those wishing to avail of "second chance" education or those who do not normally participate in adult learning or community development opportunities. Personal development courses are offered with "follow-on" options in a number of topics. The project also provides ongoing training in administration skills, community development and leadership skills. Co-operation between the community, statutory and voluntary organisations is a central feature of the initiative. The ultimate aim of the project is that local people will take over its management and develop it according to their own needs.

Blanchardstown Nutrition Intervention Project

Studies in the 1980s have shown a strong association between premature mortality and preventable behavioural risk factors such as inappropriate diet in socio-economically deprived areas of Dublin. In order to address this, our Board, with special funding from the Department of Health, initiated a pilot, peer-led intervention project in the greater Blanchardstown areas. In this project, a Community Nutritionist was appointed who identified and trained local people in healthy nutrition practices and facilitation skills. Those who were trained in this way now run similar courses for others in the community, targeting women aged 25-44.

A formal evaluation was undertaken in December 1994 among the group of trainers which showed increased knowledge and awareness coupled with positive behavioural changes. To date, informal evaluation among their trainees shows similar beneficial outcomes, including a decrease in fat consumption and increased fibre intake.

Health and Social Gain Initiatives for Defined Hospital Populations

Equity of Access: Palliative Care

Hitherto, the only in-patient palliative care unit in Dublin has been based in the south side of the city and access to the service has been consequently impeded for those living on the north side. St Francis Hospice, Raheny has been providing

palliative services on a day-care basis and it is now intended to extend this by providing a 19 bed in-patient facility for the terminally ill. Our Board has been advised by the Department of Health that £300,000 is being made available in 1995 to St Francis Hospice for the provision of an in-patient facility. Discussions will now be required to determine the quantum of in-patient service that can be delivered in 1995 within the funding being made available. In addition, our Board's G.P. Unit have been involved in developing and organising a Palliative Care Training Programme for general practitioners. Our Board also makes a special payment to general practitioners involved in providing terminal care in the community.

Equity of Access: Young Chronic Disabled People

There is an accepted need to develop additional services for young chronic disabled persons in the region. This group represents a sector whose needs are being inappropriately met, often in acute hospitals. To meet this need, our Board proposes to develop two 25 bed units in the region.

The first of these units will be provided by upgrading and extending a vacant unit in Cherry Orchard Hospital. In addition to residential and respite care, it is also intended to facilitate day attenders at the unit. Planning for this unit is progressing satisfactorily and the target date for completion is the end of 1995. This will ensure the unit is operational in time to allow for the transfer of young chronic disabled persons from acute hospitals before the onset of the increased demand for acute hospital beds associated with the winter months. The key requirement for the successful implementation of this development will be the availability of the requisite revenue and equipment funding from the Department of Health.

Summary

The principle of equity has been fundamental in the identification by our Board of health development sectors. As demonstrated above, resources are being targeted towards groups with low health status or inequitable access in order to give them priority in the development of services. In doing this, a variety of approaches has been adopted and the knowledge gained from these different initiatives will allow us to replicate successful services and initiatives elsewhere in our region.

Section 4

Linkages Between Service Areas

Introduction

It has long been acknowledged that current health care systems have tended towards compartmentalisation, particularly as between hospital and community services this has allowed little flexibility for ensuring the most appropriate response to patient needs. It has been noted also that general practitioners have traditionally remained independent of other community systems; also, services for the elderly have demonstrated poor integration between hospital and community services. The formation of better linkages is a key element of the Health Strategy and our Board has taken a number of steps to significantly improve linkages between general practitioners and other health services and to develop linkages between hospitals and community services with particular reference to services for the elderly.

Co-Ordination of Services for the Elderly

The need to ensure the required linkages in services for the elderly is a key feature of the Health Strategy. In line with the recommendation of *The Years Ahead* and our Board's response *Services for the Elderly - A Policy Document*, the co-ordination of services across the Board in recent years was further enhanced by the establishment of Area Care Teams. These cross programme teams were established in each Community Care Area with the following multi-disciplinary representation which includes physicians, psychiatrists, public health nurses, community welfare officers, general practitioners, the local authority and representatives of voluntary organisations. The main function of the Teams is to ensure that the needs of the elderly are identified and to ensure that these needs are met and that any compartmentalised problems are overcome. A Co-ordinator of Services for the Elderly has been assigned in each community care area to ensure that services delivered in the area including that of the District Care Unit are delivered in a cohesive and effective manner.

Following the establishment of Community Ward Teams to provide high level support to dependent elderly persons in each community care area, it became apparent that the previous arrangement, under which a liaison Public Health Nurse acted as a link person with each acute general hospital, was no longer sufficient and that a broader and more inter-active linkage arrangement was required between personnel in hospitals and Community Ward Teams. Following consultation with the hospitals a Liaison Committee of key personnel has been set up with each hospital to facilitate the early discharge of elderly to supported care at the appropriate level.

The avoidance, where possible, of inappropriate admissions of elderly persons to acute hospitals is another important objective of the Community Ward Teams. They provide levels of medical, nursing and para-medical care appropriate to the dependency needs of individual patients in their own homes following G.P. or Public Health Nurse referral. The G.P. retains clinical responsibility for the patient and is invited to attend case conferences.

The specialist Psychiatry of Old Age service works closely with the Community Care services including the Community Ward Teams. There is a hospital component to this service which is totally integrated with the community services and with the nursing home services.

Co-ordinators of Services for the Elderly at community care area level have proven to be effective in developing and maintaining linkages between services in the community and hospital and nursing home services. At regional level, cross-programme linkages and overall co-ordination between services in the different community care areas is the responsibility of an overall Co-ordinator of Services for the Elderly who works with a nominated senior person from each of the three service programmes and reports to the designated Programme Manager who has overall responsibility for the policy direction and quality of response of our Board's services for the elderly. The Regional Co-ordinator of Services for the Elderly has the responsibility of ensuring the provision of the most comprehensive and appropriate services response to needs unrestricted by programme or service boundaries.

Linkages with General Practitioners

Our Board's General Practitioner Unit continues its efforts to improve linkages between general practitioners and other health services, particularly hospitals.

General practitioners are now represented on the therapeutic committees of many major hospitals as a result of these initiatives. The Unit is encouraging the development of joint protocols between hospital consultants and general practitioners and it is hoped to involve general practitioners in selected hospital procedures. Our Board has developed direct access by general practitioners for their patients to certain services provided at our Board's three directly-managed hospitals. Services which can be directly accessed include radiology, pathology, physiotherapy, dietetics, endoscopy, routine and stress ECG and day hospital services.

Our Board is working with a representative group of the various interests involved, with the aim of exploiting the unique opportunity presented by the development of a new acute hospital in Tallaght. A project group has been established and it will be seeking to agree arrangements which will significantly improve the linkages between general practitioners, hospitals and community services in the catchment area of the new hospital. It is proposed that this should include appropriate G.P. involvement in some of the hospital services.

Accident and Emergency Services

It is recognised that the general practitioner plays a key role in the provision of Accident and Emergency services relating particularly to the prevention of inappropriate attendances at the casualty departments of acute general hospitals. It is important that strong lines of communication and co-operation are established between the acute general hospitals and the general practitioners in their catchment areas. With this in mind, our Board has supported both financially and with technical advice, a research project involving general practitioners working in the Accident and Emergency Department of St James's Hospital. In this project, general practitioners treated selected groups of patients following their assessment by triage nurse triage. This study found that more favourable outcomes resulted for the group seen by the general practitioners, when compared with that seen by Accident and Emergency doctors. General practitioners referred fewer patients for investigation, or for a second opinion or for an Out Patient Department appointment. They also sent more patients home or back to their own family doctor for follow-up. Preliminary results from a patient satisfaction questionnaire administered immediately after treatment, and again one month later, suggested no difference in outcome between the overall group of patients treated by both methods.

It is envisaged that this involvement of general practitioners will, in the longer term, result in a more efficient service provision at Accident and Emergency Departments. A more efficient and more appropriate use of Out Patient Departments is also anticipated, along with greater linkages between the hospital and general practitioners involved. Having evaluated the outcome of this research to date, our Board is proposing to extend this project to the Accident and Emergency Department of James Connolly Memorial Hospital.

Our Board has co-ordinating responsibility for the Dublin Accident and Emergency Service and in this regard has on-going consultation with each of the six major acute Dublin hospitals. This involves regular meetings with management personnel of the hospitals concerned. A twice daily report on the Accident and Emergency activity in each hospital, as well as bed availability at that moment is received by our Board for constant monitoring. The co-ordination of hospital response in the event of a major accident is also the responsibility of our Board and involves us in constant on-going communication.

Acute Hospital Bed Co-ordination

Parallel to our Board's co-ordination of the Accident and Emergency service is the task of monitoring the effective bed utilization in the acute hospitals. Critical to this task is the accurate return by the hospitals of the number of persons occupying acute beds who have been assessed as being in need of long term care. This information is supplied on a fortnightly basis. Our Board also receives details of patients who have been medically discharged but who are unable to return home for other reasons. This information allows our Board to respond to service needs in long term care more effectively. Equally important is the facility which this system allows for the provision of the necessary care in the most appropriate setting. Central to the process is the multi-disciplinary Liaison Committee which meets regularly to assess problems of bed utilization for elderly people to ensure their effective use. This committee was discussed earlier in this Section.

Co-ordination of Hospital Services in Dublin South East/East Wicklow

A network of co-ordinated and complementary hospital services is required for the south eastern area of our region. To this end, our Board is involved in discussions with management of St Vincent's Hospital, St Michael's Hospital, the National Maternity Hospital to develop, with St Columcille's Hospital, a system of inter-linked services in that area. Target services for inclusion are anaesthetics, surgery,

obstetrics/gynaecology, radiology and pathology. This will allow for the more effective and efficient use of facilities and services at all hospitals involved.

Naas General Hospital/Tallaght Hospital Links

In the future development of Naas General Hospital our Board has been particularly conscious of the complementary role Naas General Hospital will have with the new Tallaght Hospital. This will ensure a co-ordinated approach to the provision of general medical and surgical services, including regional specialities, to the wider catchment area of both hospitals. To ensure this co-ordination, our Board has already developed linkages with the MANCH group of hospitals in anticipation of the transfer of services from the MANCH group to the new hospital at Tallaght. Current linkages between Naas General Hospital and the MANCH group include geriatrics, orthopaedics, anaesthetics, and more recently, radiology.

Co-ordination of Services between James Connolly Memorial Hospital and others

Close liaison is maintained with the other five major Dublin hospitals and in particular Beaumont and Mater Hospitals in the provision of Accident and Emergency Services. Discussions have been entered into with the objective of involving local general practitioners in the hospital's Accident and Emergency Department. James Connolly Memorial Hospital management has developed close working relationships with the Mater and Beaumont Hospital Managements in the context of the overall development of hospital services in the wider catchment area of Dublin north City and County, particularly in service areas such as plastic surgery, E.N.T., ophthalmology etc.

Maternity Hospitals and Community Linkages

In consultation with the three Dublin maternity hospitals, our Board has developed and extended the number of community ante-natal clinics throughout the region. This facilitates closer working relationships between hospital and the community. It also allows the service to be delivered to patients in the most appropriate setting and facilitates ease of access especially for those whose uptake of ante-natal care has been low or delayed to later stages of pregnancy.

A Public Health Nurse has been appointed as a Liaison Nurse to each of the Dublin maternity hospitals. This is an important linkage between hospital and

community settings: early notification is provided by the Liaison Nurse to Public Health Nurses in the community regarding babies who are being discharged with special physical needs or in situations where there may be concerns regarding the

mother's ability to manage the care of her newborn baby. In this way, the health and social status of both mother and baby is ensured through an immediate visit by the Public Health Nurse on the day of discharge from hospital.

A Combined Ante-Natal Care Programme is offered to pregnant women in our Board's region. Through this, women may attend their general practitioner for routine ante-natal checks, attending the maternity hospital only at specified times during the pregnancy or if the general practitioner has concerns regarding the health of mother or baby. This programme not only provides access to care at the location which is most convenient for the mother, but it ensures that hospital and general practitioner services remain linked in a cost-effective and efficient manner.

Linkages in the Psychiatric Service with Hospitals and Voluntary Agencies

Important changes have taken place in recent years in the delivery of psychiatry services. No longer are these services seen as remote and confined solely to psychiatric hospitals. Now, services are increasingly located in the community or in general hospital settings. Strong links already exist within the psychiatric service between our Board and hospitals and voluntary organisations. These linkages ensure that services are both readily accessible to the patient and are delivered in an environment which may be perceived as less threatening or stigmatising by them. In-patient services for four Community Care Areas are provided in acute units in the following general hospitals: Mater Hospital, St. James's, James Connolly Memorial, and Naas General Hospital. Our Board is also working towards the commissioning of further acute psychiatric units in Beaumont Hospital, St. Vincent's, Elm Park, Tallaght Hospital and James Connolly Memorial Hospital.

Sessional commitments are undertaken by our Board's psychiatrists in the three Dublin children's hospitals, in two maternity hospitals and at the Meath and St Vincent's, Elm Park. Integration of services is a feature also of the work of St. Vincent's Hospital, Fairview and the Mater Hospital with our Board's community services in Area 7, with associated rotation of staff at all levels. Fifty per cent of nursing staff in the psychiatric unit at the Mater Hospital are seconded from the Eastern Health Board. Our Board is establishing similar linkages in Areas 1 and 2

in partnership with the Hospitaller Order of St. John of God and St. Vincent's Hospital, Elm Park in the provision of old age psychiatric services and with St. Vincent's Hospital in the delivery of general psychiatric services. This development involves major restructuring of services in Area 2 and our Board's integration with the above agencies.

Linkages between the Psychiatric and Primary Care Services

The development of a modern, community based psychiatric service has involved close linkages with general practitioners and other primary care services. In order to develop these linkages further in the current year, a review of out-patient services in both hospital programmes is being undertaken with particular regard to their interface with general practitioners. In future, it is intended that the hospital consultant and multi-disciplinary team will become more involved in providing a liaison service to the general practitioner with members of the multi-disciplinary team being deployed to provide professional support to individuals and groups. Our Board's G.P. Unit will be very much involved in these developments.

Linkages between the Psychiatric and Forensic Services

Our Board is actively forging intersectoral links in the provision of services in psychiatry and forensics through discussion with the Department of Justice with regard to meeting the psychiatric requirements of the Prison Services. The package under the consideration will have components from our Board's Forensic Psychiatry, Substance Abuse and General Psychiatry Services. Our Board is also involved with the Prison Service in the provision of specialist training for Prison Officers in skills such as first aid treatment, response to emergency situations and dealing with psychiatric conditions in a controlled environment. The course is highly practical and aims to equip officers with new skills in the performance of their activities.

Linkages in the provision of Special Education

Our Board, in co-operation with the Department of Education, is involved in the provision of special education in four schools attached to the Child Psychiatric Services. The transfer of the Ballyowen Meadows School to Beechpark, Stillorgan was achieved in co-operation with the Department of Education. Arrangements are progressing to transfer a second school to this site. Fostering a policy of integration for children with special needs is strengthened by these linkages,

preventing the isolation of this group, thus ensuring that the health and social gain of the children is achieved.

Linkages between Providers of STD Clinic Services

Services for patients with STD, being based in hospitals are now seen as too compartmentalised and remote from those in need of the services of STD clinics. In order to broaden the reach of this service, our Board in consultation with representatives from St James's Hospital and the Mater Hospital, is currently reviewing the STD service in the Dublin area. The purpose of this linkage is to consider the extension of treatment locations beyond those which already exist. Locations being considered for the newly extended service are university campuses and prisons where data shows there is large and growing demand. This linkage will also examine the need for an expanded contact-tracer service, and the standardisation of clinical protocols. Structured linkages between the paediatric and adult services are also being provided so that a whole-family approach is taken in treating families with HIV/AIDS. The appointment of a further consultant in GUM/ID is also being considered in order to expand STD treatment even further into community and to reduce the compartmentalisation which exists in the existing service.

Summary

In line with the Health Strategy, our Board has prioritised the co-ordination of services for the elderly. Important linkages have been formed, preventing the compartmentalisation of services and ensuring the provision of integrated services and greater flexibility. Similar initiatives should ensure the smooth linkage of general practitioners with hospital and community services. Hospital services themselves are also being co-ordinated by our Board to the maximum possible extent under the present structural arrangements. All of these developments have called for an ability to adapt and co-operate in both professional and administrative staff in all sectors. The positive experiences of our Board in this regard augur well for future such developments.

Section 5

Consultations and Discussions with the Voluntary Sector

Introduction

The significant contribution by voluntary agencies and their support and provision of services is fully recognised by our Board. In the light of the Health Strategy particular attention is being given towards the further development and strengthening of links with all service providers and establishing partnerships - including explicit contracts- with major providers. This is undertaken with a view to the provision of a quality service which is responsive, efficient and cost-effective manner. There is no formal framework or procedural guidelines for the relationship between the statutory and voluntary agencies to ensure that they complement each other. Reporting relationships and standards of accountability appropriate to the provision of publicly funded services, are in the process of being laid down as a result of the Health Strategy.

A contracting process has been initiated within our Board on a pilot basis and it is intended to apply this eventually to all agencies in receipt of funding. The nature of the contract defines the quantity, quality and cost of services to be provided, together with protocols governing the linkages between our board and the relevant agency's services. The initial contract process involves setting out a specification of our Board's service objectives and determining how the agency can fulfil our requirements. The question of integration and fit of these services with our Board's own directly managed facilities is also reviewed.

The contract sets out the following details:-

- classification and volume of activity expected
- cost profile of services
- records
- monthly reporting requirements
- insurance
- quality assurance issues

- staffing - number and qualifications
- annual financial statements

The first such contract is currently in the process of being finalised with the Hospitaller Order of St. John of God in respect of the Cluainn Mhuire service. This contract was negotiated by a team consisting of finance and service personnel from both organisations. The second contract will be concluded with St. Patrick's Hospital and initial negotiations have already begun in this regard.

This process of developing explicit service agreements will need specialist resources in the finance function to be involved, initially, in specifying contracts and then subsequently in monitoring performance, including reviews of the efficiency and effectiveness achieved in the contracts. It is proposed that a Management Accountant be assigned to lead this function who will progress the contracting process throughout our Board's services. This post will work closely with service managers and develop good working relationships throughout the voluntary sector. It is suggested that an appointment be considered as a matter of priority to enable the rapid implementation of contracting within our Board's region.

It must be noted at this point however, that pending final clarification of the eventual structure planned for our Board's area, coupled with the proposed new funding arrangements, the scope for developing significant new relationships with voluntary agencies has of necessity been limited.

Mental Handicap Services

Mental Handicap Services for the Eastern Health Board region have been developing satisfactorily under the auspices of our Board's Central Planning Committee for Mental Handicap. This is a representative body consisting of the Executive Heads of all the major service providers in the field of mental handicap, including the Eastern Health Board. A representative of the Section 65 Organisations is also included. The committee is chaired by the Programme Manager, Special Hospital Care and resourced by the Special Hospital Care Programme. The committee co-ordinates development plans for mental handicap services in the region. All interests involved in the Committee contribute to the establishment of agreed priority requirements, particularly in the area of un-met

needs, resulting in a unified and co-ordinated approach to service planning and delivery.

Mental Health and Mental Illness

Recent reports, including the Commission on Health Funding and the Health Strategy itself, highlight the need for contractual arrangements to be entered into between the statutory and the voluntary organisations. For many years psychiatric services for catchment areas 1 and 3 have been provided on an agency basis by the Hospitaller Order of St John of God and St Patrick's Hospital respectively. Discussions have been in progress on developing these arrangements on a formal contract basis. This development has been warmly welcomed by both the Order of St John of God and the management of St Patrick's and it is expected that formal contracts will be in place within the next three months.

The voluntary organisations in the field of advocacy and support for mental health sufferers and their families are an intrinsic part of the overall service and work very closely with our Board's professional and service managers. Three officers of our Board are seconded as Development Officers to the Mental Health Association on an ongoing basis.

Our Board is represented on the management of many of the voluntary agencies working in support services for mental health and mental illness. Our Board is represented on the board of Gheel - a limited company providing services for persons with autism. Likewise, our Board's officers are involved on the boards of Sunbeam House, Fingal Workshop, the Mental Health Association and the Schizophrenia Association.

It is hoped that these existing fora for consultation and discussion will provide a firm foundation for the proposed statutory framework which will recognise the roles and responsibilities of both our Board and the voluntary agencies with whom we have already developed partnerships.

As is highlighted in the Health Strategy, voluntary organisations have a particular role to play in the identification of service needs. Joint ventures have now been developed with voluntary agencies as a result of such identification. These joint ventures have brought our Board into closer partnerships with voluntary agencies such as Friends of Newcastle Hospital; the Schizophrenia Association; Bradog

Trust and St Brendan's Mental Health Association. Developments such as sheltered housing schemes, hostels and day centres have resulted from the efforts of these partnerships. The development of sheltered accommodation is a major resource for particularly vulnerable groups for whom placement elsewhere can be difficult. Such accommodation and support services are now provided also in partnership with the Salvation Army and the Dublin Central Mission who provide the residential component with our Board providing clinical back-up and support.

The willingness of voluntary agencies to fund raise in order to meet needs which they have identified must be recognised and many facilities and extra resources are provided as a result of fund-raising by voluntary agencies.

Children

Residential Care

Historically, voluntary organisations have been pre-eminent in identifying and meeting the needs of children in Ireland and they have had a major role to play in this area, particularly in the development of residential care. Our Board has been working closely with them in the evolution of residential care services from large orphanages to small family-type units, often based in local communities. Forty five such services are funded by our Board, the majority of which are directly managed by voluntary agencies.

In the past year, the thrust of our Board's involvement with this sector focuses upon aligning it more closely to meet the current needs of children and helping our Board meet its obligations towards these children. This includes ensuring greater accountability on behalf of these organisations and will also involve our Board working in closer partnership with them. In advance of the requirement of the Child Care Act that health boards undertake inspections of children's homes, our Board has appointed a Head Social Worker to undertake a review of all children's homes in our region. This has initiated the process of ensuring closer partnership and greater accountability. The review is an exhaustive exploration of the very many facets which impinge upon the quality of care which children in residential homes are receiving. More than half of the homes in our region have already been reviewed, a preliminary report has been made and the process is continuing. Upon its completion, the recommendations of the review will be implemented. These

recommendations will include the ways in which our Board can support and facilitate these agencies in carrying out their difficult task.

Aftercare

Research has shown that young people leaving care experience difficulties in establishing independent living arrangements and in coping with the general complexities of modern life. This group is usually over-represented among the numbers of homeless and out of home young people, thus impairing their health and social status. As a result of consultations and discussions with the major voluntary organisations in the field, our Board has funded the establishment of a range of aftercare initiatives to redress this situation. Such projects include supported semi-independent living flats and the employment of outreach workers to maintain contact with and support young people who have left care. The successful establishment of these aftercare schemes represent the future direction of discussion and collaboration with voluntary organisations in the identification and meeting of social needs.

Day Support for Vulnerable Children and Adolescents

Consultation and discussion carried out by our Board with the voluntary sector has recently identified a need for day support services for adolescents who are vulnerable as a result of the erosion of their links with family, school and community. In order to meet this need, our Board is engaged in discussion with the Daughters of Charity regarding the development of a day support service which will provide education continuance, vocational training and social skills development.

In conjunction with Focus Point, our Board has recently identified the need for support for small children whose families are living in bed and breakfast accommodation. A nursery which caters for fifteen of this pre-school age group is funded by our Board and directly managed by Focus Point. This service provides a stable and stimulating environment for this group and allows time for their parents to enable them undertake visits unencumbered to our Board's Resettlement Officers, local authorities, and other support services for homeless families.

Child and Adolescent Psychiatry

Although responsibility for the provision of services in child and adolescent psychiatry rests with our Board, major elements of that service are provided by voluntary agencies: the Mater Child and Family Service and the Hospitaller Order of St. John of God at Orwell Road. In some districts of our Board's region, the service provided by the Hospitaller Order of St. John of God is funded directly by the Department of Health. In order to bring cohesion to these arrangements, our Board has in 1994? formed a Central Co-Ordination Committee which meets on a monthly basis. The senior managers of both these voluntary agencies attend, along with the senior manager of our Board's own service. The Committee is chaired by the Programme Manager, Special Hospital Care, and is establishing a co-ordinated approach to the planning, development and delivery of the services.

Services for Physically Handicapped and Elderly People

Voluntary organisations have historically been an integral part of services for people with a physical handicap and they continue to play an important role. Our Board is conscious of the significant contribution which voluntary bodies have made to the development of services this group. Our Board sees a strengthened and co-ordinated voluntary sector continuing to play an important role in the provision of these services in the future. To this end, there are regular discussions and consultations between officers of our Board and all of the voluntary and indeed private concerns involved in the care of physically handicapped and the elderly e.g. Cheshire Homes, MS Care Foundation, private nursing homes, voluntary religious and charitable homes, etc. Many of these organisations are grant-aided by our Board and our Board is represented on the Boards of Management of some of the voluntary organisations involved e.g. Cheshire Homes.

Peamount Hospital

Following a strategic management review by the Board of Peamount Hospital and recent discussions with our Board at senior officer level, it has been agreed to renew joint discussions on a restructuring of services to meet our Board's priority needs. It has also been agreed to develop these discussions into an agreed model service contract.

Summary

Our Board has begun the process of implementing arrangements for contracting and greater accountability with voluntary organisations in our region. While recognising the autonomy and flexibility which such agencies bring, and the important role they play in the identification of service needs, there can be no doubt that the new arrangements which are being put in place will provide for even closer partnership in the future.

Section 6

Quality Initiatives

Introduction

The drive towards quality is undertaken in order to ensure that our Board's services are equitable, efficient, effective, relevant and socially acceptable to our customers at all times and these concepts underpin quality initiatives in our region. In assessing and improving quality, two dimensions must carry equal weight: technical quality and the importance of customer satisfaction i.e. the customer's own perception of the quality of the services he or she is receiving. Included in this aspect of the quality dimension is the "internal" customer, thus ensuring that both user and end user of our Board's services are included in our analysis. Each of these aspects is addressed below: our Board's Customer Service initiative along with an example of end-user satisfaction, and these are detailed along with technical quality initiatives which are taking place, such as clinical audit.

Quality Assurance

Quality has always been an implicit issue in the provision of health care but it is now becoming more explicit as the role of audit in health care is evolving. In purchasing and providing health care, three issues are central: quality, volume and cost. This does not mean that improving quality of service will necessarily have resource implications. Quality can often be improved without increased cost by effective management. Our Board is committed to achieving a high standard of quality by implementing various initiatives at different levels of the organisation. Progress towards the defined quality state will be monitored by audit initiatives on an on-going basis.

Action taken by our Board in relation to quality to date include: training for staff, the establishment of a Customer Service Department, the inclusion of both a patient and GP satisfaction audit in the recent hospital out-patient department study, a review of the adequacy of the child care and family support service and the inclusion of a patient consultation satisfaction questionnaire in one of the GP pilot projects.

A quality assurance programme in the area of continuous care and rehabilitation of patients has been introduced in St. Columcille's Hospital. It is assisted by the use of 'Monitor' which is a recognised quality assistance tool developed to audit all aspects of Nursing care, including direct nursing intervention, patient satisfaction, patient safety and work management. The information gathered gives a picture of the patient care on a particular ward and shows where strength and weaknesses lie, and assists management in resolving these weaknesses. It is our intention to develop this programme in other hospitals in the coming months.

Customer Service Department

Our Board has established a Customer Service Department whose aim is to identify with people's problems and to show people that "we care." This includes a central facility staffed by specially trained personnel who deal with any questions, problems, complaints or requests for information regarding any of our Board's health and personal social services. Of course the concept of customer satisfaction is not confined to this one facility and quality initiatives and the impetus towards achieving customer satisfaction has spread to other areas of our Board's services.

The Customer Service Department continues to improve the standard and quality of service to all Health Board customers by providing comprehensive information and advice on all health and personal social services and other related services in a customer friendly way. Ease of access is ensured by the provision of a freephone service. A mechanism is provided in the Department where complaints and problems can be dealt with efficiently and in a non-conflict environment. The Department's staff are also involved in projects such as the production of information leaflets, exhibitions etc. to ensure that the health and personal social services become more accessible to the customer. It is also seen as vital to advertise the existence of the Department to help ensure that customers are aware of it and can therefore benefit from its services.

The Department has achieved its aims by ensuring that each customer receives the most comprehensive advice, information and help, thus eliminating any confusion, problems or delays they might encounter in obtaining services. The staff of the Department ensure that each complaint or problem is dealt with and resolved without the customer feeling intimidated by procedures and systems. In order to audit the effectiveness of the service provided by the Department an analysis is

being carried out using quantitative measures to determine levels of customer satisfaction with the service.

On-going customer service training for staff is a priority. The Customer Service Department plays a key role in promoting a customer service ethos throughout our Board; advice and training is given to all departments regarding possible improvements in services to ensure that the customer receives the highest possible standard of service at all times.

Arrangements are under discussion with the Department of Social Welfare on an initiative to decentralise the Customer Service activities to the Tallaght area. This new service will open shortly. The benefit to customers will derive from considerably reduced time and effort needed to avail of services from either organisation. It is proposed to avail of further opportunities to extend the service along similar lines.

Customer Facilities

Our objective when providing services is to ensure that the service provided is accessible and is delivered in pleasant surroundings, in an efficient and cost-effective manner. The programme of upgrading and refurbishing of premises currently in process will meet this objective. Satisfactory progress is being made in relation to the provision of eight new health centres at Carnew, Athy, Celbridge, Swords, Bray, Howth, Deansrath and Fortunestown and the upgrading of others. Our Board has also prioritised the improvement of accommodation and staffing for the delivery of the Registration of Births, Deaths and Marriages service. Discussions are ongoing with the Office of Public Works relating to acquiring additional accommodation in Joyce House.

Our Board has upgraded and refurbished 15 dental clinics in 1994 at a cost of £0.235m. It is planned that more clinics will be refurbished in 1995. These requirements will be placed in order of priority and a planned approach will be taken to the upgrading in 1995.

Primary Nursing

Primary nursing is a system of organising care so that one nurse is responsible for all the nursing care of a patient from admission to discharge and a pilot primary nursing project is currently being undertaken at St. Columcille's Hospital. In July

1994, St. Joseph's Unit for the Elderly was launched as a Nursing Development Unit. The key characteristics of St. Columcille's Nursing Development Unit are as follows:-

Primary nursing involves a clearly identified clinical nursing leader who has day to day responsibility and authority for clinical practice in the unit. A philosophy of care is developed collectively and is underpinned by a shared vision of high quality nursing practice espousing the values of equity and equality in care. Nursing staff and patients work in a partnership which ensures that patients receive the care most appropriate to their needs. Staff accept change as a way of life and take a proactive, dynamic, challenging and planned approach to the management of change. Nursing Development Unit nurses experiment constantly to improve practice and to develop themselves. All nursing staff within the unit have ownership of the on-going development of clinical nursing practice. Staff are encouraged to develop research-based practice. In the past year, a number of specific research projects have been undertaken and the findings of these projects are being made available to relevant groups for their information and consideration.

This innovative pilot project has acted as a stimulus for similar development elsewhere and a number of workshops have been held to promote the concept; these were attended by other hospitals and health boards. The unit at St Columcille's is now part of the European wide networks of Nursing Development projects sponsored by TENDA (The European Nursing Development Agency). Our Board is appointing a full-time Nursing Development Officer whose brief is to extend the concept of primary nursing throughout other hospitals in our Board's region. St. Mary's Hospital, which cares for the elderly and young physically disabled people is also establishing a Nursing Development Unit in a female long-stay ward. This unit was recently altered to provide a more therapeutic environment for staff and residents, introducing a climate of change which will now enable the unit to be established as a Nursing Development Unit

Consumer Satisfaction in Hospitals

It has been recognised by service industries generally that consumer satisfaction through quality service is the key to business success. There has been a growing awareness in recent years that the health service, including hospital service, needs to be more quality conscious and that central to this is the need to be aware of and responsive to the consumer by regarding the patient as a whole person with a wide

range of needs and expectations. Because of these changing requirements for our hospital service, a study has been carried out at St Columcille's Hospital regarding the levels of consumer satisfaction there. This study not only elicited the views of hospital patients, but discussed the findings with hospital management to determine what changes might be made. As a result of this study, the Orthopaedic Department was reviewed and re-organised which resulted in substantial reductions in waiting times for patients; open visiting was introduced and showers and facilities were upgraded. In order to maintain the impetus of the study, St Columcille's Hospital established Quality Circles to set quality standards which are being audited every six months. In addition, two staff members were nominated to examine complaints -not only in a reactive, but also in a pro-active manner.

Each of the three acute general hospitals directly managed by our Board, adheres to the principles set out in the Charter of Rights for hospital patients. In addition, a detailed patient handbook is distributed to patients on admission, which provides information relating to the hospital and the services available. The handbook also gives specific information on admission procedures, care of personal property and an outline of normal hospital routines. Enclosed with the handbook is a questionnaire to be completed by the patient regarding the care received and patients are invited to put forward suggestions for the possible improvement of service delivery. Formal and informal systems are in place in each of our Board's three acute general hospitals to monitor the level of consumer satisfaction; as in all quality management systems, the analysis of this helps to monitor the level of quality and consumer satisfaction. Furthermore, patients and their relatives are encouraged to discuss all aspects of their care with staff during their stay in hospital.

The three hospitals are also in the process of drawing up a questionnaire to be given to out-patients to enable ongoing feedback on customer satisfaction in relation to waiting times, communications and services provided.

Customer Satisfaction with Child Health Community Nursing Service

In order to ensure that the Child Health Community Nursing Services are customer oriented and in line with the emphasis placed by the Health Strategy upon the importance of customer feedback in the delivery of services, our Board is initiating a pilot study to measure consumer satisfaction with these services. This study is

being undertaken in conjunction with the Institute of Community Nursing. The aims of the project are to examine how existing services are meeting the needs of the consumers and to evaluate the perceived performance of the Public Health Nurse in her role as advisor and source of support. The perception of the consumer of the role of the nurse will also be evaluated along with the level of satisfaction with local child health services among user groups. As a result of this study, it will be demonstrated how professional performance can be enhanced, providing information which will assist in the planning of future services.

Hospital Patient Information Bureau

A well-developed patient information system leads to the development of a sense of personal responsibility for health and greater awareness of the health care process. Patient information systems must therefore become an integral part of this process. In order to heighten customer satisfaction, a Patient Information Bureau is planned for St Columcille's Hospital. By being accessible to all patients, visitors and staff, this Bureau will help to generate a flow of information between both patients and staff. In this way, not only can patients be given full information, but staff can be kept in touch with the information needs of their patients. It should be noted at this point that information regarding medical, paramedical and nursing care remains the task of the relevant staff involved. Because high levels of information reduce anxiety, the provision of help and support for patients' unanswered questions, complaints and suggestions is shown to increase health and social gain for the patients. An active collaboration between patient and hospital contributes to an improved recovery and shorter admissions. The Bureau will also have an advocacy role and can act as a mediator between staff members and patient, should a break down in communication occur. The feedback from the patients, given to the hospital via the Bureau will provide invaluable data for quality monitoring.

Quality-of-Life Initiatives at James Connolly Memorial Hospital

The objective of the Health Promoting Hospital initiative at James Connolly Memorial Hospital is to improve both the quality of life of patients and staff and to increase the quality of care received at the hospital. The Health Promoting Hospital endeavours to incorporate the concept, values and standards of health promotion in the organisational culture and structure of the hospital.

A smoke awareness programme is an integral part of the programme and the reduction in patient and staff exposure to environmental tobacco smoke has been brought about by the establishment of a smoke-free hospital. In order to help the hospital population achieve a better quality of life, a support group has been also established for those who wish to stop smoking. Recognising that stress has a major role in diminishing quality of life, a stress management programme is being piloted in one ward. Initial feedback has been positive and early evaluation has indicated that patients have found the support of benefit. Environmental quality is ensured by the introduction of a comprehensive waste management plan for the hospital. Along with the improvement of environmental quality, the project has created a greater awareness of environmental issues. A safer environment for both patients and staff has been secured by initiatives such as ergonomic improvements and alterations and improved staff training in handling and lifting techniques. Training in cardio-pulmonary resuscitation has improved the quality of care in emergency resuscitation procedures at both basic and advanced levels. This project also incorporates an educational component on coronary heart disease. Elements of the training have now been extended from the hospital into the wider community. As discussed in Section 2 of this document, this project is being comprehensively evaluated.

Quality of Catering in the Psychiatric and Mental Handicap Services

The rehabilitation and social skills development of psychiatric and mental handicap patients in the community has been targeted by our Board with the development of self catering in our training centres, day centres and high support hostels. Traditionally, cooked food was supplied to these centres from the institutional kitchens. This development is a further dimension to these centres and has enhanced the therapeutic community orientation in high support hostels. The catering development programme is supported by catering officers assigned to the community to provide professional expertise in developing and evaluating the standards of catering, training programmes, food preparation and hygiene,

budgeting and purchasing, menu planning and staff training. Benefits to patients in terms of health gain and social gain have been enormous and the development has confirmed the efficacy of a client-led and client-centred service.

Evaluation of Effectiveness and Quality

Examples of measures which are in use in our Board's Acute General Hospitals to assess effectiveness and quality of services are clinical audit, casemix analysis, primary nursing/care planning and consumer satisfaction ratings. These measures apply equally in assessing the effectiveness and quality in the other sub-programs of Services for the Ill and Dependent Elderly and for the Young Chronic Disabled Persons.

Clinical Audit

Clinical Audit is being developed in all of the three acute General Hospitals to carry out systematic critical analysis of the quality of medical care including procedures used for diagnosis and treatment, the use of resources and the resultant health and social gain for the patient. It will identify opportunities to effect improvements in quality of medical care for the patient, efficient and effective use of resources and medical training and continuing education.

A research project on clinical audit in general surgery has been carried out at James Connolly Memorial Hospital in conjunction with the Royal College of Surgeons in Ireland, Beaumont Hospital and Our Lady of Lourdes Hospital, Drogheda. The objectives of the project were to adapt, test and evaluate a computerised audit instrument for the assessment of process and outcome of surgery and to assess the quality of care. The ability of the hospitals to effect realistic computerised audit of surgical care was also assessed. Comparable categories of patients across surgical teams and hospitals were also examined.

In Naas General Hospital, discussions between the surgical and medical consultants and the hospital manager are taking place in order to develop clinical audit at that hospital. The development of clinical audit at St Columcille's Hospital will be fully implemented in 1995. Our Board's Computer Department is introducing a computerised system to facilitate the assessment of process, outcome, standard of care and resource implications of the different outcomes for comparable categories of patients.

Quality Assurance in Hospitals: Infection Control

Hospital acquired infection has been a matter of serious concern and nowadays, hospitals are using infection control as a quality assurance marker in order to make

hospitalisation safer and more cost effective. Our Board's Matrons' Group has undertaken a study of infection control in hospitals. As a result of this study, our Board is appointing an Infection Control Sister to Cherry Orchard Hospital and to James Connolly Memorial Hospital at Blanchardstown. These Sisters will review the effectiveness of current control measures, advise on policies and procedures, advise on appropriate response to infection and organise relevant education for health care staff. The service will also heighten the awareness of the use of environmentally friendly products, improve the quality of patient care and lead to cost effective use of scarce resources. As the service develops, it is intended that all health care workers will be informed of new developments based on research findings thus preventing the use of outdated, time consuming and ritualistic practices.

Quality Audits in Child Care

Our Board's Review of Adequacy of Child Care and Family Support Services in 1994 selected a number of indicators by which managers involved in these services were requested to undertake a self-audit of the service for which they were responsible. One of the indicators of quality which the Review employed was liaison with universities and third level colleges. This indicator was employed since such contact, whether in the form of accepting students on placement or by acting as visiting lecturer, ensures the maintenance of quality standards of professional work. In this way, excellent cross-fertilisation takes place: new ideas from current practice are brought to our Board by the students, while they in turn bring back to the colleges the real concerns of the workplace thus ensuring that the training which our future employees receives is relevant.

The Review commented very favourably on the university/work co-operation which the audit revealed. Throughout the child care and family support services, very high levels of co-operation were revealed and students were accepted on placement by all teams involved in: public health nursing, social work, residential care and in the family refuges. In turn, managers of these services act as guest lecturers in the Royal College of Surgeons, Trinity College, University College, Dublin, Dublin Institute of Technology and in the major maternity and general hospitals. The Review was satisfied therefore that these close links are helping to ensure quality standards of work in our Board's child care and family support services.

Summary

Through a range of clinical and other quality measures and audits our Board is ensuring that the technical quality of the services we provide is of the highest possible standards. The customer care element of quality is of equal important to us: our Customer Service Department, and customer information initiatives ensure that, within available resources the priority of quality customer care is paramount.

Section 7

Programme for Training, Education and Development

Introduction

Our Board adheres to the philosophy outlined in the Health Strategy that “services will stand or fall on the contribution of the staff who provide them”. In order to maximise this contribution, and to develop our staff to meet the challenges brought by the Health Strategy, our Board has developed a comprehensive approach to training which is two fold. The first element to our approach involves training for our staff to enable them to adopt a strategic approach to the management of change. In this regard, our Board is engaging a company of training consultants to assist in conducting a Training Needs Analysis which is the first step in delivering a strategic approach to staff training and development. Crucial to this analysis is our training needs in management, business and strategic development. The other aspect of our Board's training plan is the provision of technical training so that our staff's development is ensured to enable them to continue to provide the highest possible standards of quality service to our clients. Underlying our Board's approach to training is a well-grounded philosophy which underpins our approach and this, along with the other elements outlined here are addressed below.

Training Strategy

The Training Needs Analysis mentioned earlier will involve our Board in undergoing a programme to assess the strengths and weaknesses of our current training and staff development approach. This analysis identifies a strategic approach to training and examines a variety of approaches in order to devise a Training and Development Action Plan based on this evaluation. Our Board's managers are central to this process and will be involved in the diagnosis of training needs in the following areas: business objectives; operational needs and individual training and development needs..

Staff Training and Development

Our Board encourages staff to pursue third level courses of study through financial assistance schemes, paid study and examination leave and sponsorship schemes. This facility ensures the personal and career development of our staff, thereby maximising follow-on benefits for the organisation and the health and social gain of the staff members involved. Similar objectives regarding health and social gain underpin the Career and Personnel Development courses for many different grades and disciplines which have been also been organised by our Board. Throughout, equity is ensured by providing equal access to training and development opportunities across all staff disciplines and by the standardisation of procedures regarding staff release, financial support etc. The quality of our training initiatives is provided by the incorporation of specific learning objectives in training design. There is a commitment to ensuring that the training processes and programmes chosen should match the organisational learning objectives and the learning needs of the participants.

Our Board is also committed to the concept of accountability in staff training and development through the establishment of clear targets and objectives for training programmes and a systematic process of evaluation of outcomes including that of value for money.

On-going in-service training for our staff remains a feature of our training programme and includes participation in the Management Development Course for health board managers which is organised in conjunction with the I.P.A.. For Community Welfare Officers, a Diploma in Continuing Education has been organised by our Board in conjunction with St. Patrick's College, Maynooth. Local education committees also organise in-service training on a regular basis. Other in-service initiatives undertaken by our Board are addressed below.

Nurse Training and Development

Our Board continues to provide training and education programmes for undergraduate students, post registration students and students from the major general hospitals. Our Board, through a Central Training Department, in co-operation with the Nurse Training Schools and education committees of our

Board's hospitals, are committed to the improvement and development of training and education programmes. Major initiatives were taken in the psychiatric nursing service to equip nurses with skills appropriate to the delivery of a modern psychiatric service - post-graduate programmes were developed and are in place in the following areas: family counselling; behavioural therapy; challenging behaviour; rehabilitation; child and adolescent psychiatry and mental handicap. These courses are approved by An Bord Altranais. Other initiatives include discussions with third level colleges regarding their input to pre-registration nurse training programmes. The development of a comprehensive continuing education programme for nurses is underway and will be in place before the end of 1995. Formal accreditation has been sought and received for certain educational and training programmes. In-service education and development for nurses includes a Management Development Course for Ward Sisters and a Certificate course in Patient Lifting and Manual Handling Techniques .

Ambulance Service Training

Our Board has plans in hand to recruit an in-service instructor who will be dedicated to meeting the requirements of our Board's Ambulance Services. This will facilitate the introduction of an induction programme for new staff, refresher in-service training and the standard patient report form as recommended in the Ambulance Review Report.

Child Care and Family Support Services

The Review of Adequacy of Child Care and Family Support Services noted the range of relevant external training which is undertaken by our Board's professionals working in Child Care and Family Support. Formal academic training which was discussed includes: Diploma in Child Protection and Welfare; Diploma in Addiction Studies; Family Therapy and the Diploma in Adult and Community Education. A wide range of other courses were also attended including: breastfeeding, bereavement counselling, research skills, neonatal nursing, HIV/AIDS, working with sexually abused children and psychotherapy. Our Board is convinced that access to such training ensures high levels of skills and the maintenance of our focus on our staff's own development. The Review also evaluated very positively the feedback received regularly regarding the in-service training courses offered to our social work staff in courtroom skills. Our social work staff are committed to the retention of children with their own families where possible, or to voluntary agreements being reached if children must come

into care. Nevertheless, there are very many situations where action must be taken through the courts in order to protect the safety and welfare of children in our Board's region and this requires particular skills in writing reports for court, in the giving of evidence and in coping with cross-examination. The courses which have been offered in the past year in courtroom skills have trained our staff in these skills and, as noted above, our staff have acknowledged the positive benefits which have accrued.

Post Graduate Training in Psychiatry and Clinical Psychology

Our Board's psychiatric services are accredited for post-graduate training in psychiatry leading to the M.R.C. Psy. and higher training as Senior Registrar for consultant appointments. Our Board's training programmes are now being integrated with similar programmes based at the Mater Hospital, St. Patrick's Hospital and St. Vincent's Hospital, Elm Park. We anticipate that when fully rationalised, there will be four training programmes in the eastern region incorporating all the agencies involved in the provision of mental health services and the three medical schools.

Our Board is involved with the Hospitaller Order of St. John of God and Trinity College Dublin, in a post graduate training programme in clinical psychology. The programme is managed by a joint committee with representatives from our Board's Department of Psychology, the Hospitaller Order of St. John of God and Trinity College.

Staff Health, Safety and Welfare

Our Board is committed to ensuring the safety, health and welfare of our staff and this area is now an integral part of all in-service training programmes. A staff counsellor has been appointed who is available to all our Board's staff; the service is confidential and is readily accessible to those who wish to avail of it.

At an early stage the need for a manual handling programme was identified in order to provide health and social gain for both our staff and the people in their care. A number of staff were selected with a view to having trained instructors in each location to provide in-service training for all staff in need of this skill. There are now over fifty manual handling instructors throughout our Board's region.

Training in the handling and management of potentially violent patients and clients has recently been identified as a training need among some of our staff members. To meet this need, our Board has specially trained a number of staff in the Central Mental Hospital as instructors in control and restraint. These instructors are actively engaged in training programmes in our Board. At the request of other Health Boards, they are also released to provide training for staff in other regions.

In addition, in response to concerns about the level of violence to which some of our Board's staff are exposed, the Health Promotion Committee in Area 8 has organised a series of "Violence at Work" workshops for front-line health care staff. The workshops were held under the direction of a senior clinical psychologist and addressed issues such as protective strategies and responses. Arising from the workshops, a package of measures to minimise violence at work is planned which will become a blueprint for all of our Board's staff.

Workshops on Service Review Techniques

Reference is made elsewhere in Section 1 of this report to work already carried out by a number of multi-disciplinary service review groups. It is proposed to develop this process further incorporating the provision of a number of training workshops this year for staff involved.

Summary

Our Board is undertaking a systematic approach to the identification of our training needs to assist us in meeting the challenges of the Health Strategy. This, aligned to the existing range of in-service and external formal academic study which is undertaken already and allocated in an equitable manner, will help to ensure that the appropriate skills and expertise are developed within our staff.

Section 8

Intersectoral Activities

Introduction

As is acknowledged by the Health Strategy, many of the factors which affect health lie outside the immediate control of bodies such as our Board. This is not to say that we cannot be of influence and it is our task to encourage the retention of a health and social gain focus in the deliberations of other agencies. To this end, our Board has engaged in a number of initiatives which ensure that such a focus is retained in discussions on key public policy areas which impact upon the health of the population of our region.

Dublin Healthy Cities Project

Intersectoral co-operation is an important principle of the World Health Organisation's Healthy Cities Project, which is aimed at promoting health according to the principles of *Health for All*. The Project is striving to enhance the physical, mental, social and environmental well-being of the people living and working in the cities of Europe. It is doing this by helping to change structures, develop new working relationships and build new ways of tackling health issues in cities. Through the Healthy Cities Project, cities are being challenged to create visibility for health at the local level and to put health high on the social and political agenda. In order to do this, the health consequences of multiple factors in the city need to be recognised and the co-operation between key city sectors needs to be facilitated. The principles of the *Health for All* strategy of equity, health promotion, participating community, intersectoral action and an emphasis on primary health care are those which guide the Healthy Cities Project.

Our Board participates in this project along with the four Dublin local authorities the Health Promotion Unit of the Department of Health. The Dublin Healthy Cities Project has initiated a process whereby our Board and the other participating agencies are formulating an intersectoral health plan for Dublin. For this purpose, seven key areas have been identified for action and strategies are being drawn up

in relation to each: smoking, alcohol, nutrition, active living, urban ecology, housing and accidents. Our Board is leading the smoking and alcohol groups and along with the Health Promotion Unit, is leading the nutrition group.

The second phase of implementation of the Project's objectives is to produce a health profile of each participating city. A health profile is a document which brings together key information on health in a summary form which includes interpretation and analysis of that information. The main function of the profile is to stimulate action that will improve health. Intersectoral co-operation is a key to the compilation of a health profile in order to ensure that all sections of the community have a sense of interest, participation and ownership of the project. In some cities, difficulties have been experienced in securing this intersectoral co-operation, often due to the compartmentalisation of responsibilities which can occur. Because of this, informing the public, policy makers and politicians about health and its determinants underpins the process of strengthening projects in cities. A systematic appraisal of health status and of the local determinants of health are the keys to ensuring that all relevant groups in the city have a true understanding of all the concepts and issues involved.

The City Health Profile therefore, will be the ideal means to bring together a wide range of health information to inform the different groups about health. It will summarise health information and identify health determinants and will provide a focus for intersectoral action and help provide the means to ensure accountability for health in the widest number of sectors.

Our Board is also participating in a W.H.O. expert group on city health indicators and city health plans.

Regional Authorities

The Local Government Act 1991 provided for the establishment of Regional Authorities and the creation of three new County Councils also highlighted the need for a co-ordinating mechanism for the Dublin region.

Dublin Regional Authority

The Dublin region experiences infrastructural, economic and social difficulties which require a co-ordinated response. The Dublin Regional Authority was established in 1993 to provide this mechanism. The function of the Authority is to

co-ordinate public policy in the following areas: strategic planning for the region; maximising of E.U. funding; public services policies; co-ordination of regional development in economics, social development, arts, culture and heritage, community development, poverty and marginalisation; global and local environmental concerns. Our Board's representation on the Operational Committee of the Dublin Regional Authority ensures that issues concerning the health and social gain of much of the population of our Board's region remains to the fore of these deliberations in these areas. A presentation was made recently to the Operational Committee in this regard.

Mid-East Regional Authority

Our Board's representation on the Operational Committee of the Mid-East Regional Authority also ensures that issues concerning health and social gain are included in the deliberations of this Authority. The function of the Authority is to promote co-ordination of the provision of public services in the region and to review the overall needs and development requirements of the region. In particular, the Mid-East Regional Authority is obliged to have regard for the need for co-ordination with the Dublin metropolitan area and its hinterland. The Authority has decided to incorporate all these needs in the format of a *Regional Socio-Economic Development Strategy*; this review will provide the framework for the future development of the region. Our Board will have an input to this review.

Eastern Regional Co-ordinating Committee on Drug Misuse

The problem of drug misuse is an area where intersectoral co-operation is vital since action required spans very many agencies and disciplines. In order to bring about a co-ordinated and cohesive approach to the issue, the Eastern Regional Co-ordinating Committee on Drug Misuse has recently been established, the purpose of which is to further develop strategies for prevention, intervention, treatment and rehabilitation in our Board's region. Membership of the Committee includes not only officers of our Board, but also representatives from the Department of Education including the Youth Affairs Section; the Garda Síochána; the Prison Service; the Probation and Welfare Service; FAS; voluntary drug treatment agencies and the Dublin Healthy Cities Project.

The Committee will monitor the effectiveness of current policies and advise on any policy changes considered necessary and will maintain and monitor an up-to-date information data base. An intersectoral approach is being taken in reviewing

the existing responses of all statutory and voluntary agencies. The Committee will also work to ensure that a co-ordinated action plan is in place and that its aims and objectives are continuously reviewed in line with changing needs. Appropriate areas of research are being identified aimed at improving effectiveness of existing responses. Regular reports will be made to the National Co-ordinating Committee on Drug Misuse.

Child Care Advisory Committee

Our Board has established a Child Care Advisory Committee in accordance with the Child Care Act 1991. This intersectoral committee has representatives not only of our Board but also from the Departments of Education, Gardai Síochána and the Probation and Welfare Service along with representatives from the universities and the voluntary sector. While having the shared focus of children, this committee also has the advantage of bringing different perspectives together and helping to keep the need for health and social gain for children to the fore of the discussion. This committee has already produced two reports for our Board concerning both early childhood intervention and adolescents. In both of these areas, intersectoral dialogue and co-operation is seen as crucial.

Summary

Our Board is pro-active in the development of intersectoral initiatives in order to promote a focus upon health and social gain in public policy deliberations. These initiatives span the activities of many government departments and state agencies, encouraging them to appreciate the health and social significance of their actions.

Section 9

Business Planning and Management Information Systems

Introduction

The Department of Health strategy document places a requirement on all health agencies providing services to take direct responsibility for the achievement of agreed objectives. Our Board has formulated policies and service plans which give a visible expression to our objectives and the means of their achievement. This service planning process has allowed us to identify priorities in terms of the health needs of our area which will guide future decisions about the allocation of resources within our Board. Thus the resource allocation process within our Board is becoming closely aligned with identified service objectives.

Following on from this process of service planning there is a need firstly to have in place relevant structures which are clearly focused and drive our services towards our objectives. The following paragraphs outline the case for developing a management information framework which will support business planning and performance evaluation functions in our Board together with the information technology needed to support it.

Integrated Business Planning and Performance Review

We have already recognised the need for a cohesive approach in relation to policy issues governing the delivery of services for particular groups. As referred to in earlier chapters each Programme Manager has taken overall responsibility for leading and ensuring the development and implementation of policies and protocols aimed at guaranteeing the provision of services which are accessible and appropriate to certain special need groups - Elderly, Mental Handicap and Children's services.

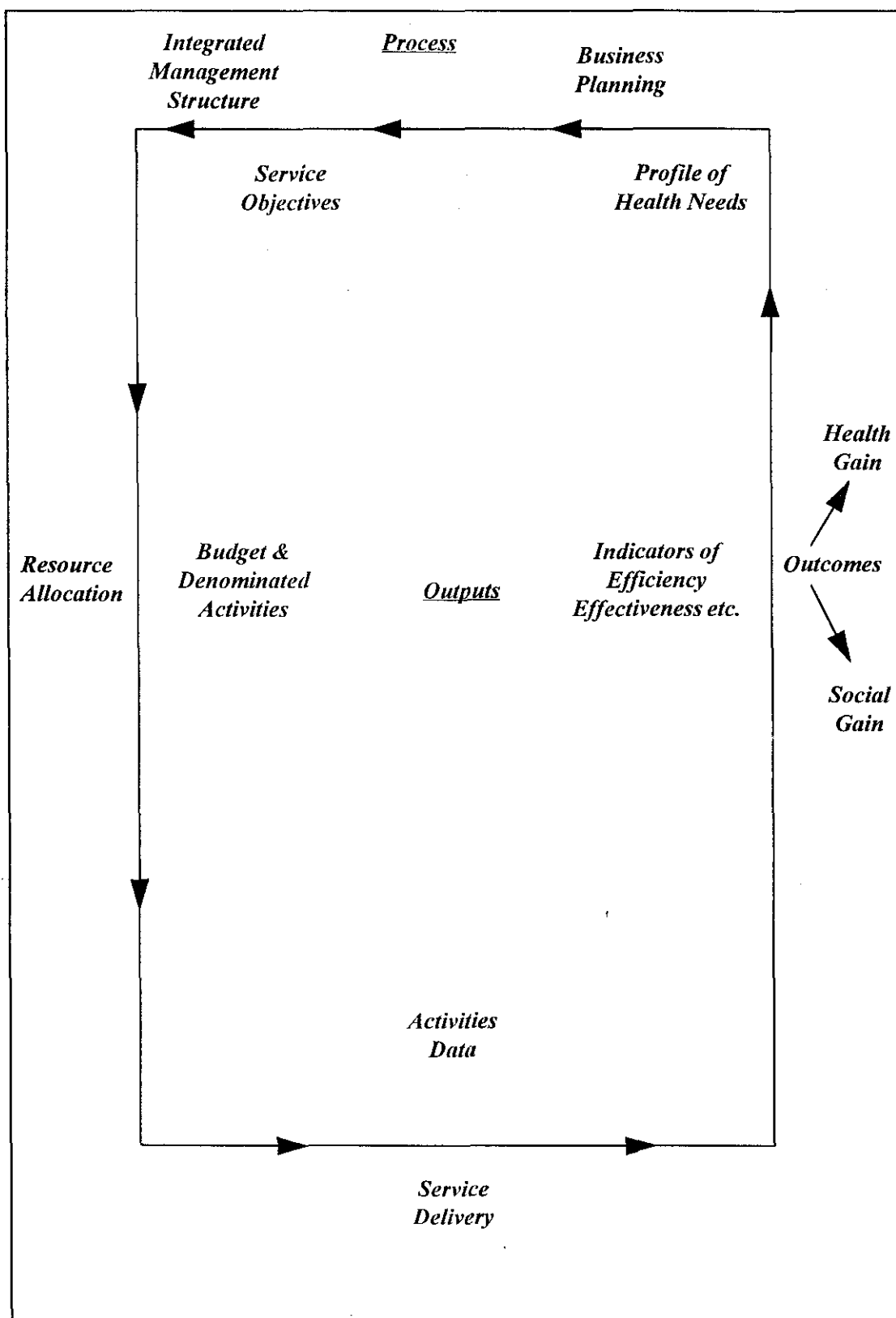
A key aspect of an integrated planning management and service delivery framework is an effective performance review and evaluation process. We have identified a multiplicity of service objectives but, in the absence of a systemised and comprehensive performance measurement system, we are impeded in

assessing to what extent our goals of health and social gain are being achieved. In a number of instances the output of our services may be imprecise and not easily quantifiable and they have therefore tended to be evaluated largely on the basis of inputs consumed.

The process of business planning now needs to be supported by a significant investment in management information systems to improve the process of planning, service management and performance review. To date, our information systems have consisted largely of separate financial and service systems which have tended to operate in isolation of each other and were designed to support short term budget and service objectives respectively. Our goal now is to develop an integrated management information framework which will be clearly aligned with our Board's service objectives. This framework will facilitate effective business planning in both the short and long term, help us direct resources to identified priority service needs, and monitor not only the cost but the outputs of our services and the outcomes in terms of health and social gain. The following diagram represents the information paradigm envisaged: *[Please See Overleaf]*

Figure 'I'

Management Control Paradigm



This paradigm sets out a framework for overall development of management control systems within our Board. The processes described in the paradigm reflect an integrated approach to the planning, management and service delivery functions of our Board together with the output of each stage of these processes.

The outer portion of the paradigm begins with a profile of health needs, which guides the Business Planning process. This planning process defines the service objectives together with the relative priority of each objective in the context of resources available. The achievement of these objectives is the focus of the Management Structure which integrates the service objectives into the Resource Allocation process. The level of resource allocation determines the volume of Service Delivery, which produces activity data which in turn produces various indicators leading to outcomes which are described in terms of health and social gain.

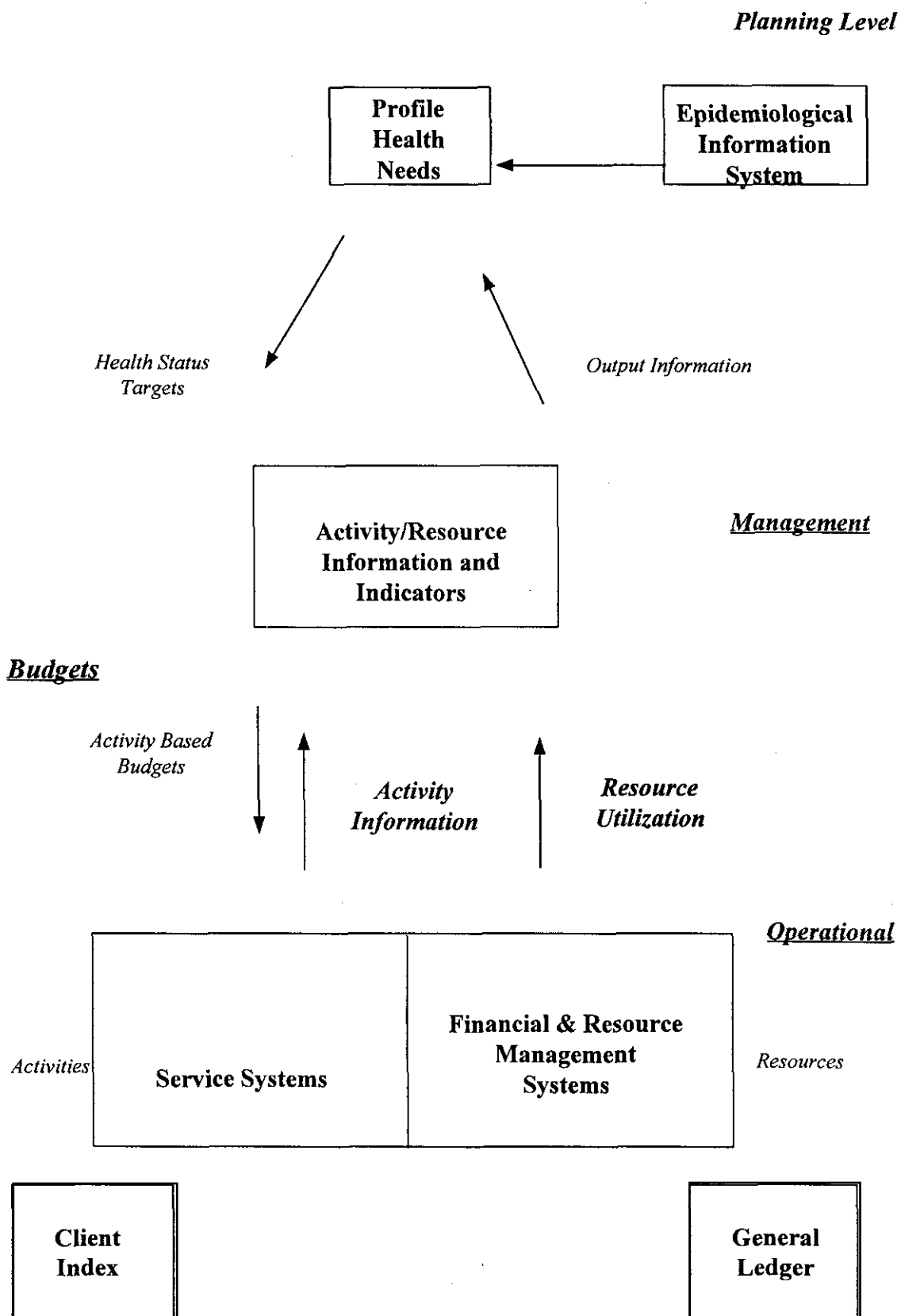
The inner portion of the paradigm sets out the outputs from each stage, viz., Health Needs, Service Objectives, Budgets, Activity Data and various indicators of efficiency, effectiveness etc. Comprehensive information on all aspects of our services, together with facilities for critical analysis of what is being done and how it is being done will be needed to support the whole process leading to outcomes in terms of health and social gain.

In line with the Health Strategy principles our information systems must focus on the patient/client at both the level of the individual and collectively in terms of local area and regional populations. This patient/client focus will facilitate a more effective co-ordination of services within our Board's area, help track patient movements through the system, analyse referral patterns, and provide total activity/patient costs across a wide range of services within the proposed new organisational structures.

A suggested Information Systems framework is set out in *Figure 'II'*

Figure 'II'

Information Systems Framework



The Information Systems Framework sets out to integrate activity and resource data into a comprehensive Management Information System. This strategy is designed to link existing isolated islands of technology into a cohesive framework which is aligned with service objectives. The strategy protects existing investments in Information Technology and facilitates a multisectoral service approach. The key development is at the Management level of the pyramid where activity and resource information is combined for both budget and performance appraisal functions. In order to achieve this objective, it is necessary to identify the gaps in our existing information systems and to focus attention on the strategic system development issues at each level of the pyramid. These matters are dealt with in the following paragraphs:

Operational Level

The operational level is concerned with capturing client, activity and resource information. Currently all financial information is co-ordinated through the General Ledger System which accumulates details of expenditure and income from an array of individual feeder system [Payroll, Accounts Payable, etc.]. The information is allocated to cost centre level and summarised for management information purposes. The General Ledger acts as a co-ordinating mechanism for all financial resources consumed within the organisation. No such co-ordinating mechanism exists at the service level. Individual service systems [HIS, CCIS, SWIS, etc.] operate independently of each other and there is a need to have a co-ordinating mechanism which is equivalent to the General Ledger. This co-ordination can be achieved by developing a common Client Index for all service level systems. This Client Index represents the major priority to facilitate the integration of activity information into a total management information system.

Strategic Development - Client Index

The objective of the Client Index is to link all our Board's patient and client based applications to a common Central Index. The Central Index will also ultimately facilitate the development of linkages to other health agency databases in the region. The index is designed to capture activity information which will, in summary form, be transferred to the Management Level Systems. At this level, activity and associated resource information will be combined. The design of this index has already been completed and the funding priority for 1995 is the acquisition of software and hardware platforms together with the

consultancy/programming activities necessary to implement the index on a pilot basis. It is anticipated that a pilot project linking our Board's Community Care Information System, James Connolly Memorial Hospital, St James's Hospital and the Child Care System can be completed before the end of 1996. During 1997 all other service systems can be linked to the common client index.

Management Level

At the Management Level, details of activities and resources must be combined with each other so that relevant cost and activity information will be available to service managers. At this level also information relevant to senior management to review performance against business plans across all responsibility centres must be provided. This combining function is most effectively carried out by a management information system which is flexible enough to link with both the General Ledger, Client Index and other individual service systems.

A further function of the management information system is the production of various indicators including efficiency and other key requirements achieved in the use of resources. This approach facilitates the measurement of activity against the level of resources being used. Our existing systems largely focus on financial performance. The proposed management information system will provide the tools necessary for a more comprehensive evaluation of costs and activities, help us to focus on areas where output indicators show that there is less than optimal efficiency being achieved and facilitate comparison between different service provider options.

Strategic Development - Management Information System

The management information system can be tailored specifically to individual manager specifications and can easily be adapted to accommodate different mixes of cost/activity information. Our Board already utilises a number of modules of the SAS Information System. Currently the technical feasibility of linking the SAS Management Information System to our General Ledger and Client Index is being evaluated. Preliminary reports indicate that a high level of technical compatibility exists between these systems. It is anticipated that this evaluation process can be completed by July/August 1995 and that our Board can commence implementation during Autumn 1995 subject to resource availability. It is proposed initially to utilise the details held on the individual service plans to conduct an experiment to assess optimal activity/resource matching arrangements. Based on this experiment

our Board will define a framework for tailoring management information for the different needs of individual service, senior management and business planning functions. A significant level of external consultancy will be needed to progress this project. It is anticipated that a budget of approximately £150,000 will be needed in 1995 to cover consultancy and system enhancements costs.

Relevant Pilot Studies

A number of pilot studies have been undertaken within our Board to assimilate cost and activity information. In the case of Naas Hospital Laboratory, the total costs of providing this service, approximately £500,000 in 1992 was aligned with the volumes and range of pathology services during that year. The outcome of the study was a costed profile of the range of activities undertaken in the Laboratory which will enable management to focus more clearly on both the workload and efficiency achieved in the Laboratory.

A similar study was undertaken in regard to Fostering Care services. The results of this project were inconclusive due mainly to the lack of information about the activities of the Social Work Service. This information deficit is now being addressed through the development of a computerised case load management system. It is proposed to extend the range of such pilot studies to encompass a cross section of all activity within our Board. The outcome of these studies will form the basis of an activity based budgeting and costing approach for service planning and review.

Planning Level

Currently our Board has a comprehensive Epidemiological Information System which analyses demographic, disease and prescribing information on a small area level basis. This system has recently been augmented by developing a linkage to our Board's Geographic Information System which enables us to plot trends and statistical information on area maps. It is now necessary to augment this data with activity and output information which will then enable us to model different scenarios of resource and activity information to assess the outcomes on the health status of the population which we serve.

Strategic Development - Integrated EIS

The objective of this system is to develop a linkage between the Management and Epidemiological Information Systems to construct an operational model of factors influencing the health status of our catchment population. The model will utilise information from internal and external sources to track relevant health status indicators. It is also planned that this model will function as a testbed to examine the effects of different scenarios of resource and activity levels on health status indicators, thus giving alternative options within our business planning function. It is important that the proposed computerisation of General Practice within our Board's area is expedited to ensure that comprehensive epidemiological data is available at individual community and area level. It is envisaged that the work programme of the new Department of Public Health should co-ordinate the specification of the information needed. The output of the model will be a health planning utility which will help to rationally allocate resources to areas of priority need and provide a basis for measurement of outcomes of services within our Board. The work already completed by the Health Information Unit will form the nucleus of the new integrated EIS. It is envisaged that a specialist in Public Health together with a health economist resource will be needed to design this system.

Developments in Information Technology

Our Board, has traditionally taken advantage of leading edge technologies to provide relevant and cost effective solutions to our information needs. Major advances have taken place in the fields of hardware and communications in recent years which we have harnessed to improve the effectiveness of our information systems. The momentum of change is rapidly increasing and our strategy envisages taking on board new developments once they are proven. The development of distributed systems offer the potential for applications and information to be integrated across diverse and physically separated systems bridging different hardware and software environments. These systems promise to maximise the use of networked resources, services and databases, ultimately leading to minimisation of cost. These types of systems are particularly relevant to our integrated management information strategy, especially with the availability of greatly increased computing power on the desktop coupled with modern communication technology. Our Board has already developed a significant array of Wide Area and Local Area networks where information is passed automatically from one computer application to another. These developments can be extended further to provide effective linkages between primary and secondary care providers

which will facilitate a seamless integration between these services at local level. Telemedicine represents the next logical stage for augmenting these linkages. Telemedicine will facilitate a sharing of expert consultation across a wide range of specialities. The availability of Telemedicine can assure availability of the most appropriate experts for any particular question which may arise. The mixed medical information exchanges of images and interpretative reports combined with facilities for video conferences have already made their appearance and it is part of our Board's strategy to harness these developments for the most effective levels of patient care within our region. Our Board is examining a proposal to link primary care clinics with a centralised specialist expertise in the area of dermatology. A General Practitioner may hold a special clinic which is linked by a Video conference facility to Hume Street Hospital.

Our overall strategy for information technology is based on the new distributed open architectures of the client-server type which involves the use of multiple and interconnected networks, facilitating a new manner of co-operation between health care providers, managers and experts. Similarly our communications strategy envisages taking advantage of ISDN/ATM services, whether public or private to provide the necessary linkages for voice data and image transfer between these groups to enhance shared usage of information to improve the Health and Social Gain of our client population. Our Board's detailed Information Technology Strategy sets out a comprehensive schedule of costed projects which underline the attainment of our business planning and management information objectives.
