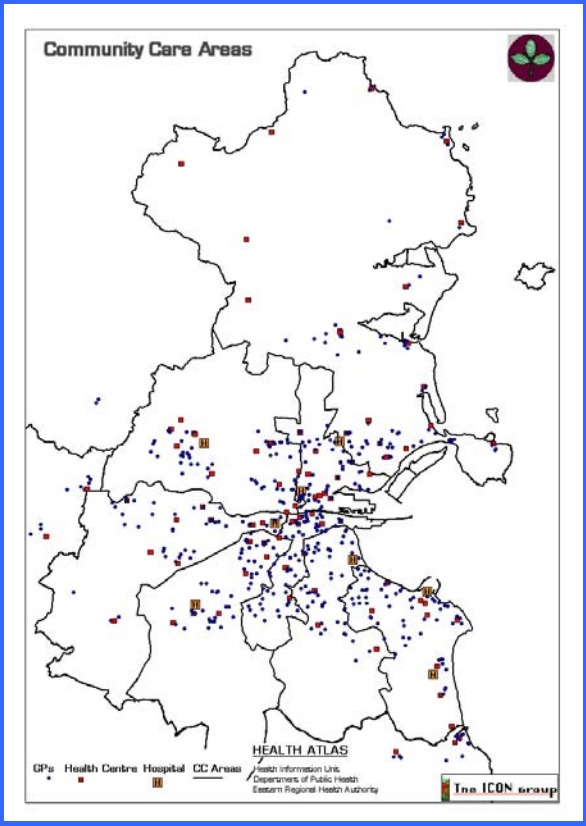
EASTERN REGIONAL HEALTH AUTHORITY

Údarás Réigiúnda Sláinte an Oirthir



Primary Care Strategy
Eastern Regional
Profiling Report
(Phase 1 of Rollout Plan)

April 2004
Phase One

Authors:
Dr Siobhan Jennings, Specialist in Public Health
Dr Howard Johnson, Specialist in Public Health
Ms Karen Burke, Service Planner – Primary Care

CONTENTS

1. Introduction

Background

The Primary Care Strategy - *A New Direction* sets out the importance of health and social needs assessment as one of the first steps in refocusing the primary care function in Ireland. Consequently, the Task Force and individual Health Boards/Authorities have devoted time to how macro and local health needs assessment may be carried out so as to enhance planning for improved health and reduction of inequalities.

Nationally, the CEOs established a group under the chairmanship of Dr Kevin Kelleher. A framework for a macro needs assessment was agreed and each board/Authority completed their macro needs assessment in early 2003. The national group are currently in the process of addressing the principals to be applied when carrying out a local needs assessments.

Within the Eastern Region the implementation of the Primary Care Strategy is being facilitated by the completion of a framework document – '*Primary Care Strategy: – Making it Happen'*. This agreed framework will put in place the specific actions required for the implementation of the vision for quality and invigorated primary care services for the people in the region as set out in the *Primary Care* Strategy as well as supporting the continued development of the three primary care implementation teams. Its overarching aim is to specify the agreed regional standards/actions needed to implement the strategy within the region as well as highlighting important milestones within the phased process for the delivery of continuous improvement to primary care services.

As part of the framework document a regional health needs assessment plan will be addressed and actioned. The actions associated with the needs assessment plan include a regional global needs assessment which as previously mentioned has been addressed as part the national global needs assessment process, a regionally-agreed guideline for local needs assessment which is currently being developed and thirdly a mapping and profiling exercise which will facilitate the development of a geographic plan to allow for the identification of further locations for the roll out of the *Primary Care Strategy*. It is this third action that will be addressed in this document.

Supporting documentation to facilitate needs assessments in the eastern region are: a) Global needs assessment, b) Mortality in the Eastern Region 1994-1998, analysis by Area Health Board, c) Listing of data availability by CCA, d) Eastern Region Local Needs Assessment Guideline Pack- *Stepping Forward*. Contact Dr Siobhan Jennings – Siobhan.Jennings@erha.ie regarding information on any of the above documents.

Definition

Needs assessment is the process of measuring health and social needs in the population, establishing the supply of health services (and other services) and planning to bridge any resulting gaps. It is not an end in itself but a means to using information in a systematic way to plan the future.

Aim of the proposed work

The aim of this work is to inform the process of defining the networks*, within which local teams* will be located, through the provision of spatial, population and service profiling within the region. This information, presented in the form of four options, will be used at local level to produce a plan for the evolution of networks over a set timeframe.

* Networks and teams are terms used in the Primary Care Strategy

Context

The development of a plan that would facilitate the identification of the location for the roll out of primary care teams and networks within the region was agreed by the regional CEO's group in December 2003. The agreed development plan consisted of three phases which were as followed:

Phase one: Mapping and profiling = December '03 – Mid April '04
Phase two: Local consultation = Mid April '04 – June '04
Phase three: Final report = July '04

A group representative of the three Area Boards, Dept of Public Health, the ERHA's Directorate of Planning & Commissioning (incorporating service planning and NDP management) and chaired by Dr S Jennings was brought together to discuss and evolve the processes that would be most beneficial.

This document sets out phase one of this process.

2. Methods and Results

Mapping

a) Mapping - Methods

The process of mapping primary care resources, administrative boundaries and the location of facilities involved a number of steps. Much of this work was done de novo with no database available. Large scale street maps of the city of Dublin and smaller scale maps of rural areas were provided to the AHBs by the Health Information Unit, Department of Public Health and the estimated location of GPs, health centres and existing partnership boundaries were manually marked on the maps with the help of local knowledge. Each AHB provided a database of the centres of practice (both main and other) of GPs and these were merged to create a regional database. For the purposes of unique identification, the GPs GMS number was used, and for non-GMS GPs a unique number within the AHB was derived. The unique building code of each practice location was added to the database where possible using GeoDirectory. A similar process was carried out for health centres and hospitals. Local authority boundaries were identified from maps supplied by Dublin City Council. The hard copy maps were digitally scanned on a commercial basis and all locations and boundaries were added to the database. The boundaries for community care areas, health centres and hospitals were based on district electoral division data developed

and retained by the Health Information Unit. Geographical Information Systems were then used to derive and plot the exact/best estimate grid coordinates of facilities and to plot the administrative boundaries.

To provide a background of local need, the demographic profile (2002 census) and mortality data (all-cause standardised mortality 1994-1998) at DED level were mapped.

b) Mapping - Results

In order to make decisions about location of networks and teams information on needs of the population and supply of services is important. It was agreed by the working group that maps with a structured layout would be helpful in informing the process resulting in a basic map with four options for boundary appraisal.

The basic map used in all options incorporates the boundaries of the CCA and pin points the location of health centers, hospitals and GPs. The options discussed and presented are

- Health centre boundaries,
- Current partnerships and development group boundaries with GPs and other groups,
- Local authority boundaries at local level.
- 6 general acute hospitals

Local discussion will influence the optimum selection of boundaries based on the above. DED should be used as the basic building block.

Maps showing boundary options and which profile need will be made available in the following format: a) A4 maps which will be part of this document and which will show details per Region and Dublin City; b) A3 maps which will show the same information plus close ups of each AHB in more detail and which accompany this document; and c) CDs which will also show the maps on pdf and PowerPoint (attached).

Profiling

a) Profiling - Methods

To enrich the process of identification of networks and teams it was agreed to present data on need and supply within populations. This process of profiling is presented here at CCA level. Note that much information is currently orientated towards county and regional level and not yet available systematically at local level. Data that is DED coded could be aggregated at, say, HC level but this would require customisation and interpretation. Also it is important to point out that there is a potential for over interpretation of data containing small numbers.

Indicators of need and supply are presented in a map or tabular format

***Indicators of need used are*:**

a) Total population within DEDs (Census 2002)
b) Deprivation presented as social class 5 and 6 as a proportion of the total from Census 2002 (table 1)
c) Mortality data for the aggregate years 1994-98 are available at CCA level in the categories: all cause, all cancers, all circulatory, IHD, cerebrovascular, respiratory and injuries/poisonings (table 2).

Indicators of supply used are

a) ERHA - Human Resources Census
Information relating to the provision of professional disciplines currently working within primary care per CCA was gathered. This data was provided using the ERHA Human Resources Census and reflects the number of whole time equilivants (WTE) in post at the end of December 2003. This data allows for the comparison of staffing ratios within CCAs. This work provides a framework for looking at equity of provision to match known inequity of need as evidence by a) socio-economic variations, b) mortality variations. Other factors to bear in mind are the current level of vacancies and staff shortages within certain professional sectors.

b) Health Centre Facilities Questionnaire
In identifying the indicators of supply information in relation to all health centres in the Eastern Region was gathered for the first time using a survey questionnaire (see appendix 2). Each CCA completed the questionnaire with analysis at regional level. Information was sought under 5 headings namely, Property Details, Transport, Activity, Care Group and Description.

b) Profiling - Results

Data presented should be looked at in conjunction with maps accompanying this document.

Indicators of need

a) Deprivation Social class is used to show the distribution of deprivation at CCA level. In the Irish social class scale there are 7 categories with SC 7 being the unknown category. Social class 1 & 2 comprise higher and lower professional and managerial staff whereas social class 5 & 6 incorporates semiskilled and unskilled staff. Table 1 presents the proportion in each of these two categories.

Table 1: The percentage social class breakdown by CCA (2002 Census)

Community Care Area	Social Class 1&2	Social Class 5&6
CCA 1	52%	7%
CCA 2	50%	7%
CCA 3	41%	11%
CCA 4	25%	16%
CCA 5	27%	17%
CCA 6	31%	15%
CCA 7	31%	13%
CCA 8	35%	14%
CCA 9	35%	15%
CCA 10	36%	15%

b) Mortality Mortality data is presented as Standardised Mortality Ratio (SMR) in order to facilitate comparison across populations of different age and gender. Table 2 outlines the SMRs for major causes of death with data in red indicating SMRs which are significantly higher than the region as a whole.

Table 2 shows Standardised Mortality Ratios (SMRs) by CCA

Community Care Area	ALL Cause	ALL Circulatory	IHD	ALL Cancers	ALL respiratory diseases	Injuries & Poisoning
	SMR	SMR	SMR	SMR	SMR	SMR
CCA1	86.3	87.7	85.2	88.1	81.8	85.8
CCA2	85.1	84.3	85.6	88.1	87.5	74.9
CCA3	107.1	107.6	101.1	105.1	110.1	96.0
CCA4	109.9	107.6	103.4	115.5	105.9	98.2
CCA5	107.6	110.4	109.0	104.1	109.9	105.2
CCA6	107.5	102.0	107.4	108.2	113.3	125.5
CCA7	109.2	108.9	112.4	110.0	103.3	114.9
CCA8	94.5	95.8	98.5	97.9	91.7	83.2
CCA9 (Kildare)	98.0	101.1	105.5	93.1	96.7	112.8
CCA10 (Wicklow)	98.9	101.1	95.4	87.4	109.6	108.3

c) Demography The accompanying maps show where the concentration of the populations within the region reside.

Indicators of supply

a) Human resources The data is presented as:

a) **Table 3** - a table of numbers of professional staff per CCA,. These numbers reflect WTEs in post in December 2003 and have been taken from the ERHA validated Human Resources Census. Changes to these numbers may have occurred in the intervening period.
b) **Table 4 –** a table of rates per 10,000 for the total population for nursing, occupational therapy and physiotherapy per CCA
c) **Table 5 -** a table of rates per 10,000 per population under 15 years for community dentists, social workers and speech and language therapists per CCA
d) **Figure 1 -** a graph of GPs, practice nurses and community pharmacists as a rate per10,000 population per AHB.

The rates presented facilitate comparison but no adjustment is made for social class/ deprivation. Local discussion needs to acknowledge this factor.

Table 3: Provision of professional disciplines in Primary Care per CCA (*Numbers (WTE) taken from ERHA Human Resources Census December 2003)*

CCA	Speech & Language Therapists	OTs	Public Health Nurses	RGN/ CPN	Community Dentist's	Social Workers	Physio's	Community Pharmacists	Practice Nurse	GPs
CCA 1	6.00	6.57	36.20	20.77	13.80	29.14	5.80	45		
CCA 2	12.76	7.61	30.21	19.87	0.00	42.76	5.70	34		
CCA 3	6.82	6.17	38.44	23.60	6.24	32.00	9.90	54		
CCA 4	7.00	6.30	43.78	15.66	17.89	51.87	5.48	34		
CCA 5	3.00	3.00	40.49	11.88	8.65	42.19	2.69	28		
CCA 6	10.00	13.00	48.19	34.00	11.80	72.44	2.86	42		
CCA 7	8.00	6.55	46.57	16.40	4.00	66.83	6.50	45		
CCA 8	12.24	9.91	49.79	29.41	16.50	38.45	8.57	56		
CCA 9	7.00	11.82	49.16	67.63	14.10	25.87	6.11	54		
CCA 10	5.50	5.67	33.05	19.04	8.37	22.18	4.55	31		
Total	78.32	76.60	415.88	258.26	101.35	423.73	58.16	423	206	781

Table 4: Provision of professional disciplines in Primary Care per CCA (RATES of 10,000 per total population)

Community Care Areas	Public Health Nursing *	RGN/CPN	Physiotherapists	Occupation Therapists
CCA1	2.8	1.6	0.5	0.5
CCA2	2.8	1.9	0.5	0.7
CCA3	2.9	1.8	0.7	0.5
CCA4	3.0	1.1	0.4	0.4
CCA5	3.2	0.9	0.2	0.2
CCA6	3.0	2.1	0.2	0.8
CCA7	3.8	1.3	0.5	0.5
CCA8	2.4	1.4	0.4	0.5
CCA9 (Kildare)	2.7	3.8	0.3	0.6
CCA10 (Wicklow)	3.3	1.9	0.4	0.6
Mean Average	3.0	1.8	0.45	0.53

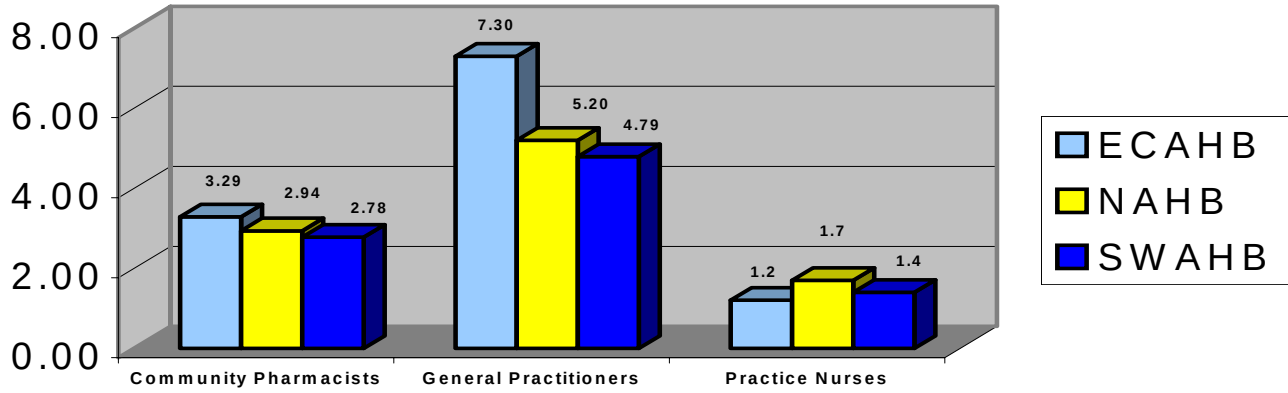
* These figures show that the average no. of PHN's per 10,000 population in the Eastern Region is 3.0 compared to an national average of 4.1 (Value for Money Audit -`2001)

Table 5: Provision of professional disciplines in Primary Care per CCA (Rates of 10,000 per population under 15 years)

Community Care Areas	Community Dentists	Social Workers	Speech & Language
CCA1	5.6	11.9	2.4
CCA2	0.0	[1]25.5	7.6[2]
CCA3	3.2	16.3	3.5
CCA4	5.9	17.2	2.3
CCA5	3.1	15.1	1.1
CCA6	3.7	22.8	3.2
CCA7	1.9	32.7	3.9
CCA8	3.8	8.8	2.8
CCA9 (Kildare)	3.3	6.1	1.6
CCA10 (Wicklow)	3.7	9.9	2.4
Mean Average for the Region	3.4	16.6	3.0

[1] CCA2 has regional responsibility for managing unaccompanied minors
[2] CCA2 Manages a Regional Speech & Language Unit

. Figure 1 – Shows the provision of General Practitioners and Community Pharmacists per Area Health Board (Rates per 10,000 population)



In the 1997 national survey of GPs there were 2427 GPs practicing in the country, a rate of 6.7 per 10,000

b) Health centres This survey was the first comprehensive study of health centre numbers and type of service provided. All health centres were counted including main and satellite centres. Local discussion should take this into account in decision making. The data is presented as two tables outlining the numbers of health centres in each CCA and the services provided from each centre. Table 6 shows the number of Health Centres currently offering services provided by the identified members of the primary care team as envisaged under the Primary Care Strategy.

Table 6: Shows the provision of services from Health Centres per CCA

CCA	CCA1	CCA2	CCA3	CCA4	CCA5	CCA6	CCA7	CCA8	CCA9	CCA10	Total
No. Of Health Centres	8	6	9	9	8	9	11	19	31	21	131
No. of services offered											
GP services	0	0	2	4	2	2	4	6	11	9	40
Home Help	1	0	4	3	4	3	6	5	3	8	37
Public Health Nurse Services	6	5	7	8	6	7	10	17	20	18	104
Social Work	1	0	2	3	0	3	3	3	5	5	25
Physio-therapist services	1	0	0	1	0	1	3	2	9	3	20
Occupational Therapy	1	0	1	1	0	2	1	1	1	4	12

Table 7: Shows the provision of services from Health Centres per CCA

CCA	CCA1	CCA2	CCA3	CCA4	CCA5	CCA6	CCA7	CCA8	CCA9	CCA10	Total
No. of health centres	8	6	9	9	8	9	11	19	31	21	131
No. services offered											
Chiropodist/ Podiatrist	0	0	1	1	0	0	0	1	14	3	20
Community Welfare	6	4	8	5	6	8	10	14	16	15	92
Dental	4	2	4	5	7	5	6	9	14	7	63
Dietary	2	0	0	4	0	0	0	0	0	0	6
Immunisation/Vaccination Services	2	4	3	8	2	5	3	5	13	5	50
A.M.O. Services	8	4	4	8	6	6	5	16	15	14	86
Psychiatric Services	0	0	1	1	1	3	3	7	6	7	29
Speech & Language	3	2	4	3	1	1	3	4	6	6	33
Methadone Maintenance	1	1	1	3	0	3	1	2	1	1	14
Other*	18	2	2	2	2	5	4	5	15	30	85

** Information available from General Managers*

3. Prioritising the rollout plan

In order to finalise the plan for where the locations for the roll out of the strategy will be, it will be necessary for the AHBs to prioritise which areas will be targeted for implementation earlier and which later in the timetable. This identification can be done using **1)** principals of prioritisation and **2)** a 'reality check' to ensure that what is envisaged is deliverable. To assist the AHBs the following principals have been identified and should be considered in their decision making process:

	Principals	Comment
1	Achieves health and social gain	May do so through reduction in mortality, increase in quality of life or an intervention which can be a proxy for outcome such as immunisation
2.	Address health inequalities	Need to target areas of high deprivation and/or mortality
3	Capability to implement	Need to examine state of readiness especially existing structures, human resource provision and collaborative arrangements. Notably the balance between quick wins and long term gains
4	Size of the population	Sometimes numbers of people rather than comparative rates of the problem have a major impact on need for services e.g elderly living alone, births
5	Balance between promoting health and preventing ill health and treating illness	Need to promote health such as increasing physical exercise as well as improve services.

4. Next steps

a) Consultative process: phase two

Having completed the process of mapping and profiling features of need and supply in the region, the Area Health Boards are now in a position to draw on this data as well as employing the principles of prioritisation. It has been agreed that each AHB will commence a consultative process with all relevant stakeholders and service providers in order to outline the location of further primary care networks (and possibly teams) within the region. Furthermore, it is agreed that the plan will indicate the priority order for the rollout of developments, the rationale underpinning the decision making and the timeframe. AHB representatives on the working group have agreed to take responsibility for ensuring that phase 2 of the process is carried out within the timeframe identified.

Local discussion will take place that will inform possible locations for primary care teams and networks. It is accepted that a degree of flexibility will be needed in finalising boundaries. It is agreed that this process of consultation and deliberation will deliver an agreed outline of network boundaries/locations by AHB by early July.

b) Final document: phase three

By July ’04 the AHBs will have completed their consultative process and be in a position together with the Authority to finalise the document that will provide the details and rationale, together with the methodology used for where the locations for the rollout of the Primary Care Strategy within the Eastern Region will be situated. The maps used to inform the process as well as the new maps showing the location of the potential primary care networks will accompany the final document.

c) Follow on

Having identified the location of networks and teams it would be important to further analyse the health needs and supply of these locations. It is envisaged that the tool kit to facilitate local needs assessment (*Stepping Forward)* will be available and used at this stage.

Tables

5. Appendices

a) Membership

Dr Siobhan Jennings, Specialist in Public Health Medicine, ERHA (Chair)

Ms Karen Burke, Service Planner, Primary Care, ERHA

Dr Howard Johnson, Specialist in Public Health Medicine, ERHA

Ms Pauline Bryan, Director of Primary Care and Acute Services, SWAHB

Ms Angela Kerrigan, Assistant CEO, NAHB

Ms Concepta de Brun, Manager Primary Care Unit, NAHB

Mr David Walsh, General Manager, CCA2, ECAHB

Ms Anita Behan, NDP office, ERHA

Dr A Staines, UCD Dept of Epidemiology and Public Health

b) Authors

This document was written by Dr Siobhan Jenning, Dr Howard Johnson and Ms Karen Burke

c) Acknowledgements

We are grateful to the Community Care Administrators for their contribution and assistance in the mapping and profiling process.

In particular we would like to thank the following:

Department of Public Health – Eugene Boyle, Ann Maher, Pat Dack, Brian O'Boyce, Derek Doyle (Health Information Unit) and Sinead Tiernan

NAHB – Brian O'Connor and Yvonne Milner

ECAHB – Andy Russell, Colin Cavanagh, Jackie Kelly, Maura Daly, John Keppel Helen Jordan and Mary Heaslip.

SWAHB – Anne O Connor, Siobhan Murphy and Valerie Whelan

Dublin City Council – Brendan Kenny, Assistant City Manager

ERHA – Olivia Magee and Geraldine Donoghue

Glossary

AHB	**Area Health Board**
CCA	**Community Care Area**
DED	**District Electoral Division**
ERHA	**Eastern Regional Health Authority**
GMS	**General Medical Services**
GP	**General Practitioner**
HC	**Health Centre**
NDP	**National Development Plan**
SMR	**Standardised Mortality Ratios**
WTE	**Whole Time Equivalent**