

**NATIONAL COUNCIL  
FOR THE ELDERLY**

**CO-ORDINATING  
SERVICES FOR THE  
ELDERLY AT  
LOCAL LEVEL:  
SWIMMING AGAINST  
THE TIDE**

**A REPORT ON TWO  
PILOT PROJECTS**

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## NATIONAL COUNCIL FOR THE ELDERLY

The National Council for the Elderly was established in January 1990 in succession to the National Council for the Aged which began in June, 1981. The terms of reference of the Council are:

*To advise the Minister for Health on all aspects of ageing and the welfare of the elderly, either on its own initiative or at the request of the Minister, and in particular on*

- *measures to promote the health of the elderly,*
- *the implementation of the recommendations of the report, The Years Ahead — A Policy for the Elderly,*
- *methods of ensuring co-ordination between public bodies at national and local level in the planning and provision of services for the elderly,*
- *ways of encouraging greater partnership between statutory and voluntary bodies in providing services for the elderly,*
- *meeting the needs of the most vulnerable elderly,*
- *ways of encouraging positive attitudes to life after 65 years and the process of ageing,*
- *ways of encouraging greater participation by elderly people in the life of the community,*
- *models of good practice in the care of the elderly, and*
- *action, based on research, required to plan and develop services for the elderly*

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CO-ORDINATING SERVICES FOR THE ELDERLY AT  
LOCAL LEVEL: SWIMMING AGAINST THE TIDE



# **CO-ORDINATING SERVICES FOR THE ELDERLY AT LOCAL LEVEL: SWIMMING AGAINST THE TIDE**

## **A REPORT ON TWO PILOT PROJECTS**

By

Michael Browne



NATIONAL COUNCIL FOR THE ELDERLY  
REPORT NO. 231\.

This Report has been prepared by Michael Browne

for

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## Foreword

Recent publications on services for the elderly in Ireland frequently stress the importance of improved co-ordination in the delivery of these services. However, this is the first study to focus exclusively on co-ordinating services for the elderly at the local level in this country.

The study, which evaluates the experience of two pilot projects, has its origins in the recommendations of National Council companion reports published in 1985. They were *Housing of the Elderly in Ireland* and *Institutional Care of the Elderly in Ireland*.

Good housing is central to the provision of good quality care in the community. Many elderly people are vulnerable to ill health and/or institutional referral as a result of poor housing conditions. Hence, co-ordination between health boards, local authorities and voluntary bodies is a necessary component of community care.

Other areas for better co-ordination identified by the Council's studies were:-

- liaison between acute hospitals and community care staff, particularly prior to discharging elderly patients home,
- sharing of expertise by health and social service professionals in the community with a view to reducing the vulnerability of the elderly at particular risk, and
- linking the statutory, voluntary and informal systems of care together and involving elderly people themselves.

Against a background of increasing numbers of elderly people and other demographic trends which indicate that there will be more elderly people at risk in the future, the Council proposed that the Department of Health should provide "funding to establish two pilot projects which would develop and evaluate the concept of co-ordination of services for the elderly in terms of both planning and provision at local level" (National Council for the Aged, 1985a, p. 80).

The projects were proposed at a time of growing concerns about the public debt and the level of public expenditure. It did not prove possible for the Department of Health to implement the Council's recommendation at the time. However, with the interest and willing support

of the Eastern Health Board and Dun Laoghaire Corporation on the one hand, and the South Eastern Health Board and Tipperary S. R. County Council on the other, the Council was able to promote and support the establishment of pilot projects in both Dun Laoghaire and Tipperary.

Once the authorities in the two areas committed themselves to their establishment, the Council enunciated terms of reference for the projects which, in the absence of models of formal co-ordination in care of the elderly in Ireland, were quite prescriptive in the circumstances. It will be appreciated that the Council was to a large extent working in the dark and could not advert to all the complexities of the co-ordination process when drafting its terms of reference.

Thanks to the efforts of all those working on the projects we now have the benefit of their experiences and the very professional articulation of these experiences in this evaluation report to guide those who will be concerned to improve the co-ordination of service provision for the elderly in the future.

As an added contribution, the Council proposes a number of its own conclusions which it hopes will be of assistance to those who may be convinced of the need for a teamwork approach to care and service provision for the elderly at the local level. The Council believes that a spirit of cooperation must be supplemented with good practice and appropriate mechanisms for co-ordination in care and service provision.

However, of even greater importance to the co-ordination enterprise is the commitment of the relevant agencies to take the necessary political and managerial steps to make it succeed. With this in mind, the Council offers a number of recommendations relating to considerations which must be addressed by the agencies concerned. Whilst not so prescriptive as might be expected, these recommendations represent the results of long consideration of the experiences of participants of the pilot projects and the detailed evaluation of these experiences compiled by the author.

The pilot projects owe their achievements over their four year life to the input of a large number of personnel. Between one hundred and one hundred and fifty people altogether were actively involved in the projects on steering and local committees. We would like to express our sincere thanks to them for maintaining their commitment throughout what was never an easy project to implement. We also thank all those who played a role in establishing and guiding the projects through uncharted waters. We include former Council members, particularly Mr. K. Hickey, Chief Executive Officer of the Eastern Health Board and Dr. M. Hyland for their contributions; the steering committee

chairpersons within the project, including Mr. Liam Gaffney, Mr. Seamus Shields, Mr. John Byrne, Dr. A. N. de Souza, Mr. James Harney; all participants in the Council's own advisory and consultative committees which were chaired respectively by Mr. Kieran Hickey and Dr. Finbarr Corkery.

We thank too those whose work was central in keeping the projects functioning. Particular thanks go to Ms. Aileen McNicholas and Mr. Brendan O'Keeffe whose secretarial work on several committees was pivotal.

A very special thanks goes to Ms. Catherine Lanigan who, for much of the first phase of the projects, was the Council's evaluator. In the second phase she became the project development worker in the Dun Laoghaire area. We are also very grateful to the two development workers in the Tipperary Project, Nurse Joan O'Dwyer and Ms. Margaret Flanagan.

The Council would like to express its special gratitude to the report's author, Mr. Michael Browne who, as former research officer of the Council, played a key part in the design and establishment of the projects. Subsequently, he became project evaluator and completed, with Ms. Catherine Lanigan, an *Interim Evaluation Report* in May 1989. We are very impressed with the high quality of his final report and are confident that it will be a milestone in advancing our understanding of the pre-requisites of good co-ordination.

Finally, we wish to thank the Council's Secretary, Mr. Bob Carroll, and Research Officer, Mr. Joe Larragy for their contributions to the establishment and evaluation of the projects. We thank also Ms. Céline Kinsella and Ms. Paula Kennedy for their competent preparation of the author's manuscript for publication and for their services to the Council and its committees throughout.



# Comments and Recommendations on Co-ordination by the National Council for the Elderly

## Introduction

The underlying rationale for better co-ordination is that the needs of the elderly cannot be accommodated in watertight compartments. Rigid boundaries between Government Departments, providing agencies, professionals and service users themselves, frequently are harmful to older people's interests. Moreover, inadequate co-ordination can also prove to be wasteful of resources, for example resulting in inappropriate institutional admissions, "bed-blocking" in acute hospitals, late detection of symptoms or needs, with long run cost implications that might be avoided.

In common with thinking internationally, policymakers in Ireland have become increasingly concerned about the lack of co-ordination of services for the elderly. This concern has been emerging in response to a mixture of factors, including:

- (a) the ageing of the population and related demographic trends, such as an increase in the number of very elderly people and of the elderly living alone, migration from rural areas, the attendant increase in risk of illness, dependency, mental infirmity and increasing consumption of health and social services,
- (b) changing economic and social circumstances and attitudes among older age groups, which both open up their potential for greater autonomy and require that they be more directly involved in determining their own care requirements,
- (c) a re-appraisal and re-definition of institutional care in all its forms — including long-stay geriatric units, general and psychiatric hospitals — as an integral component of a community care policy,
- (d) a focus on appropriate accommodation as the keystone of community care, with increasing attention on housing standards

and conditions, on adaptations required to accommodate disabled or less mobile persons, on the provision of emergency contact systems, warden services, communal meals and shared facilities and on alternative forms of tenure,

- (e) increasing provision of services in the community, such as day hospitals, day care centres and domiciliary care, together with the provision of more specialist assessment, rehabilitation and treatment methods on an outpatient or short stay basis,
- (f) public expenditure rationalisation and altered roles for public, voluntary and commercial service providers, and a concern with the cost-effective use of all services, but particularly of institutional services, and
- (g) growing concern about the survival of informal networks of family care, which are pivotal to the care of the frail elderly at home but too often subject to considerable stress for want of appropriate formal support.

## **Obstacles to Service Co-ordination**

There are major obstacles in the path of achieving a significant degree of co-ordination in response to the above-mentioned factors. For various complex reasons, we do not have what could be described as an "ethos of co-ordination" or a climate conducive to bringing about better co-ordination and the report presented here clearly bears out this contention. These obstacles are not exclusive to Ireland but they are very significant in this country. Among the particular difficulties which have to be addressed in improving co-ordination in Ireland are:

- (a) the separation of responsibility for assessing and meeting housing needs from responsibility for providing health and personal social services in the home and community,
- (b) the way health services have evolved historically, particularly the divisions of the health boards into separate programmes based on functional responsibility such as the hospital programme and the community care programme rather than a more integrated model,
- (c) the extent of the reliance on the voluntary housing and personal social services sector and the lack of adequate mechanisms for consultation about planning, provision and funding between voluntary and statutory agencies and within the voluntary sector itself,



- (d) the special difficulties for co-ordination entailed by the independent status of general practitioners which manifests itself in various ways, including, for example, difficulties in attending meetings, or insufficient liaison between public health nurses and general practitioners,
- (e) insufficient collaboration between health care professionals and sectors, particularly as this affects the elderly mentally infirm,
- (f) the increasing reliance on the private nursing home sector which requires improved liaison between it and the statutory sector, and
- (g) generally, a lack of focussed collaboration at interdepartmental level to deal with a range of welfare and service areas, such as transport needs, carers' allowances, developing voluntary organisations and fostering new services.

## Research and Models for Co-ordination

In recent years, efforts to test different models of co-ordination have been made internationally on the basis that it is essential not only to improving the quality of life of a growing number of frail elderly people, but that, in the long run, it might also contribute to a more cost-effective way of providing care.

One area which has been explored is the extent and nature of co-ordination practiced by agencies and professionals in a given geographic area. In the UK this has been explored particularly with reference to local government — housing and social service — departments and health departments.<sup>1</sup> While evidence has been found for case referral and the *ad hoc* exchange of information between different agencies, there is little sign of any attempt to achieve joint, inter-agency planning in the provision of housing, community care and related services for the elderly at local level. The research in the UK found that a forum or other mechanism for the systematic exchange of ideas was a rarity.

Another approach, the piloting of case management experiments and "packages of care", has been going on in the UK, the United States and elsewhere for some years and the results of these experiments are proving

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<sup>1</sup>Hearnden D., *Co-ordinating Housing and Social Services: from Good Intentions to Good Practice*, London: Centre for Policy on Ageing, 1984.

encouraging.<sup>2</sup> These experiments are broadly distinguished by a focus on individual elderly people at risk for whom a combination of services is put together by a case manager in consultation with all the relevant personnel and agencies after a full assessment of needs. The design of such studies is methodologically complex and requires significant and defined resource inputs. So far, no such studies have been undertaken in Ireland.

## Policy on Co-ordination in Ireland

The National Council for the Aged<sup>3</sup> outlined its perspective on the issue of service co-ordination in its companion reports, entitled *Housing of the Elderly in Ireland and Institutional Care of the Elderly in Ireland*, published in 1985<sup>4</sup> The issue was taken up by the Working Party on Services for the Elderly and included in its report, *The Years Ahead — A Policy for the Elderly*, which was published in 1988 by the Department of Health and later adopted as Government policy.<sup>5</sup>

## Pilot Co-ordination Projects

In the meantime, the Council had proposed the establishment of two pilot projects on the co-ordination of services for the elderly at local level to test in detail certain aspects of the model outlined in its reports. Responsibility for the establishment and running of the proposed projects was accepted by the Eastern Health Board and Dun Laoghaire Corporation in one case and by the South Eastern Health Board and Tipperary S. R. County Council in the other. The pilot co-ordination projects thus initiated, which form the subject of this evaluation report, centred on the establishment of formal arrangements for the exchange of expertise, joint planning and joint action at local authority and community care area level.

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<sup>2</sup>Challis D. and Davies B., *Case Management in Community Care: an evaluated experiment in the home care of the elderly*, Aldershot: Gower, 1986.

<sup>3</sup>The name of the Council was changed to the National Council for the Elderly in January, 1990.

<sup>4</sup>National Council for the Aged: *Housing of the Elderly in Ireland*, December, 1985  
National Council for the Aged: *Institutional Care of the Elderly in Ireland*, December, 1985.

<sup>5</sup>*The Years Ahead...A Policy for the Elderly*, Report of the Working Party on Services for the Elderly. Department of Health, 1988

The design of the projects, which is set out in greater detail in the report and the appended *Terms of Reference*, provided for the establishment of two steering committees, respectively in a rural and an urban catchment area with populations in the range of 75,000 to 100,000. The steering committees were to have a very broad planning brief covering all aspects of services for the elderly in their catchment area. The inter-agency, inter-professional and inter-sectoral composition of the steering committees was designed to reflect this broad agenda. Among the functions of these steering committees were

- the assessment of housing, health and welfare needs of the elderly,
- the proposal of programmes of action for parent bodies to implement,
- the identification of good practice elsewhere which could be emulated in the area,
- the co-ordination of agreed programmes of action,
- the evaluation of programmes implemented,
- the direction of a number of local committees with an action focus, and
- the integration of the private and voluntary sectors in the area.

Each steering committee was to establish local committees, ideally covering an area with a population of 15,000 to 20,000 people. These would have functions derived in a similarly broad manner to those of the steering committee, but with a more practical organisational role at the local level. Tasks would include

- improving co-ordination locally,
- identifying local needs and resources,
- maintaining an up-to-date "at risk" register,
- evaluation of existing service delivery,
- advocacy on behalf of elderly clients,
- liaison with local institutional care units,
- offering recommendations to the steering committee on measures to improve services, and
- offering consultation to local service providers.

These committees functioned over four years (1988-91) during which, as the evaluation report states:

the two pilot projects established and consolidated basic committee structures. Each project engaged in a programme of work which, though not as ambitious as that envisaged in the *Terms of Reference*, was practicable in terms of the resources available and the circumstances that prevailed. Day care centres were established, voluntary sheltered housing schemes were instigated, the issue of support services for family carers was addressed and a number of key policy issues in respect of service co-ordination and the elderly were highlighted, (p. 109)

There was a very high level of personal commitment on the part of steering and local committee members in both projects.

The steering committee participants, when interviewed, felt that many barriers were broken down. However, they also felt that they could not, given the time and resources available, implement the planning functions outlined for them in the *Terms of Reference* and resorted instead to an *ad hoc* approach. The inability of the steering committees to plan properly in turn negatively affected the functioning of the local committees.

The steering committees felt that a longer lead in period and more detailed preparation would have made a considerable difference to them. More involvement at senior statutory levels would have been appreciated. The proposed membership of the steering committee failed to fully materialise with notable deficits in the area of general practice, the general hospital and psychiatric services, the voluntary sector and the private nursing home sector. Other key areas of weakness concerned project staffing, delays in appointing full time development workers and inadequate time available to committee members for following through on decisions. Despite these problems the committees felt they proved able to identify various gaps in service provision and, as noted, took some initiatives. They also made submissions and recommendations to parent bodies, to the National Council for the Elderly, and to other statutory bodies.

In the case of the local committees the report points to evidence that they were constantly under strain during the course of the pilot project. While members felt that the concept of the co-ordination project was good, it was, they believed, poorly operationalised. The problems reported by the steering committees were also felt at local level with the

added frustration that there was a lack of guidance and direction; the *Terms of Reference* were beyond what they could achieve given the resources at their disposal; the goodwill of parent statutory bodies was not matched by resource inputs and the criteria used in evaluating progress, in the first phase, were rather ambitious.

Nonetheless it was reported that overall the projects were a very useful learning experience for local committee personnel, though this feeling was not universally shared. The key lessons identified by the local committees included the need for:

- the setting of clear and realistic goals at the outset to match resources available,
- a development worker from the initiation stage,
- an induction course for committee members,
- basic education in committee procedures,
- adequate secretarial staff and the blocking out of staff time for participants performing specific tasks, and
- additional resourcing for teamwork promotion.

Thanks to the persistence and endurance of the committee members involved in the projects we now know more about the key elements in the co-ordination enterprise and these have been thoroughly explored in the body of the evaluation report. The Council therefore has been greatly facilitated in drawing up a number of proposals and recommendations which are set out below.

The experience of the two pilot projects has revealed the complex nature of the co-ordination agenda. In effect, the projects have given policy-makers an insight into what actually goes on in practice "between" agencies with common interests and aspirations. The objectives, as set out in the *Terms of Reference*, proved ambitious for those who participated directly in the committees. We feel, nonetheless, that the *Terms of Reference* are broadly valid as a theoretical framework for co-ordination and likewise the perspective outlined in *The Years Ahead* report on co-ordination continues to be valid.

However, the real difficulty now is to concretise our thinking and develop a strategy on the issue:

- (a) We need to recognise that there are several *strands* to the co-ordination issue pertaining to specific task areas and services such as special housing, transport, day centres and voluntary activities.

- (b) There are also several *levels* at which coordination must be activated ranging from the national level to the local district, and different tasks will be appropriate to certain levels and not to others. The projects demonstrate that too onerous a responsibility may be placed on local personnel who may not be in a position to address tasks proper to their senior management. As the report shows, this will lead to a very selective and *ad hoc* approach to joint work with a focus on "tried and tested" as opposed to more innovative ideas.
- (c) We need to acknowledge that there is a very fine line between good co-ordination and mutual interference. The projects may shed light on this issue too, if only by identifying the fears that several agencies and personnel have of crossing it. The fact that inter-sectoral and interdisciplinary defensiveness was identified by the evaluator as a potent factor should be entirely understandable given the very wide and general nature of the brief and the difficulties involved in achieving a mutual understanding of roles.
- (d) It should be recognised that providing for some categories of elderly people requires special co-ordination. The elderly mentally infirm, for example, constitute one such group.

## Recommendations

The recommendations which follow below are not intended to be over-prescriptive. Rather, they are intended to stimulate a constructive discussion at all levels on how to take forward the policy of service co-ordination which has been outlined in *The Years Ahead* report and accepted in principle.

### *(a) Promoting an Ethos of Co-ordination at National Level: an Agenda for Action*

The recommendation contained in *The Years Ahead* report (Department of Health, 1988), that the Departments of Health, the Environment and Social Welfare agree administrative arrangements to ensure co-ordination of policy towards the elderly at national level, should be implemented immediately. Policy issues arising from the working of such an arrangement should be highlighted in a discussion document and brought to the attention of Government.

The three Departments should also consider the joint sponsorship of

further research into the area of local service co-ordination — and into such good practice as may exist — with a view to monitoring progress and identifying ways in which national policies might facilitate appropriate measures at local level.

A key task on the agenda of such an interdepartmental discussion should be to distinguish between measures which might more suitably be taken at different levels ranging through the following:

- (a) the identification of joint or interdepartmental tasks and tasks appropriate to specific Government Departments,
- (b) the identification of tasks which should be devolved to health boards and local authorities or to a level of operation closer to the point of service delivery such as the community care area or the district,
- (c) the identification of specific tasks which are amenable to joint action between health boards, between health boards and local authorities, between statutory and voluntary agencies or by means of any other appropriate combinations of agencies or professionals required to bring about real co-ordination.

In this context, discussions between Departments would be rendered more concrete if the experience of certain schemes which already involve co-ordinated action were reviewed. For example, the *task force on special housing aid for the elderly* involves health boards, local authorities and other agencies. A lot could be learned from a short evaluation of this scheme. Another issue that might benefit from joint review is the *carer's allowance* which the Department of Social Welfare provide and which the Minister for Social Welfare has decided to review. Another example is the growing voluntary housing sector catering for the elderly which is assisted by the Department of the Environment. Many such voluntary bodies seek to provide on-site services to tenants. Much could be learned from a review of the progress made and difficulties encountered in this context. A fourth possibility would be to jointly review the operation of *care teams* established following the publication of *The Years Ahead* report.

## **(b) Facilitating Co-ordinated Development**

### **(i) Enabling Legislation**

Joint action between agencies at local level was anticipated to a limited extent in the Health Act, 1970. For example, Section 25 of the Act provides generally for assigning health board functions or powers to local authorities. More use could be made of such provision in order to

give a firm statutory backing to new initiatives in co-ordination. The need for additional legislation should be addressed where existing provisions are inadequate.

*(ii) Joint Financing*

In addition to statutory measures aimed at enabling joint action and co-ordination to take place, there should be a method of providing joint financing for such initiatives. The key element in such financing is that it would be conditional on the initiative having a meaningful degree of collaboration between statutory agencies or between agencies in the statutory, voluntary, private or informal sectors in an area.

*(Hi) Terms of Reference*

Terms of reference for joint initiatives should be worked out in realistic and concrete terms with quite specific objectives, tasks and methods of work. These should be agreed at the most senior management level of the jointly contracting agencies who may then be expected to give their fullest backing to the personnel involved.

*(iv) Development Workers*

Health boards and local authorities engaging in co-ordinated development of services should deploy a development worker on a full-time basis to facilitate and develop collaborative arrangements for service planning and delivery. Such development workers should have appropriate direction and adequate administrative and secretarial back-up services.

In view of current public spending constraints, it might be necessary to initially assign certain of the tasks of a development worker to existing employees of the health boards.

*(v) Induction Courses*

Health boards and local authorities should arrange induction and training programmes for all personnel becoming involved in co-ordination initiatives and inter-disciplinary teams and should ensure that there is an adequate lead-in period for such personnel. This is particularly important when the initiative involves the systematic identification of the local service needs of the elderly population and the joint planning of services in a comprehensive way. The induction and training procedures should be appropriate to the tasks envisaged.

*(c) Education for Co-ordination and Inter-Disciplinary Teamwork*

Health boards and local authorities should collectively pool resources in order to develop a comprehensive education and training programme in



inter-agency co-operation and inter-disciplinary working. Such a programme might be organised in conjunction with the Institute of Public Administration.

#### ***(d) Integrating the Non-Statutory Sectors in a Co-ordinated Approach***

##### ***(i) The Voluntary Sector***

Health boards should assign personnel, one in each community care area, to work with and facilitate the development and organisation of voluntary bodies and networks providing services for the elderly and to facilitate their more effective and representative involvement in service planning and provision. While using district electoral divisions as units for the purposes of local area co-ordination, development workers should be sensitive to existing church/parish catchment area boundaries, particularly with reference to the fostering of good neighbour and community surveillance schemes in rural areas.

##### ***(ii) The General Practitioner Service***

The Department of Health should enter into negotiations with the Irish College of General Practitioners with a view to developing mechanisms for the representative and systematic involvement of general practitioners in planned local service co-ordination.

##### ***(Hi) The Private Sector***

Health boards should enter into discussions with the private nursing home sector with a view to identifying mechanisms for complementary and co-operative working.

#### ***(e) Co-ordination Between Health Boards and Local Authorities***

Meetings should be held between the health board chief executive officers and the relevant county manager to discuss co-ordination issues. The health board programme managers, the relevant director of community care, the local authority housing officer and any other relevant personnel should be involved in such meetings as deemed appropriate.

#### ***(f) Health Board Administration and the Elderly***

##### ***(i) Programme Structure***

Problems will continue to arise from the current programme division of services in the health boards. This is part of a more general issue which has been discussed in the report of the Commission on Health Funding and the reports of the Dublin Hospital Initiative Group. We support

much of the thinking behind these reports which appears to accord with the recommendations of the WHO on providing an integrated and comprehensive range of health services under area managements with responsibility for health promotion, community and hospital services.

While we are not advocating the creation of a special programme for the elderly, we feel that there is merit in the recommendation contained in *The Years Ahead* report that "the health and welfare needs of the elderly be considered as a distinct but integral part of a new planning system for the health services." Specific duties in relation to planning services for the elderly should be assigned to specified personnel at health board level, with or without other duties depending on the size of the board. The person in this position would also liaise with co-ordinators of services for the elderly at community care area level and with hospital administrators.

The co-ordinator of services for the elderly at community care area level should be the key liaison person at local level between community care services, acute hospital services and continuing nursing care services in long stay units. It is very important that those occupying this post receive the time, budgetary resources and authority necessary to establish new ways of working at local level.

#### *<ii) Co-ordinated Packages of Care*

Health boards should adopt a policy of seeking to co-ordinate packages of care for selected individual elderly persons in need of a high level of care. Such packages of care would be individually tailored and would involve the optimal use of available support services — statutory, voluntary and family-based. Careful piloting of such a policy would be required and this might be done in selected areas under the direction of co-ordinators of services for the elderly. A more precise model of case management for policy purposes could thus be developed.

#### *(Hi) Liaison Between Hospital Services and Community-Based Services*

The Department of Health should constitute a small working party to examine in detail the interface between hospital services and community-based services across existing programmes and to make recommendations for improving liaison between the two.

#### *(iv) Co-ordinating Services at District Level*

Health boards should ensure that adequate resources, personnel and administrative structures are made available to districts (25,000—30,000 population) where co-ordination mechanisms are to be established in accordance with *The Years Ahead* report bearing in mind the complexity

of the co-ordination task. Local co-ordination committees and district teams should also have some finances directly at their disposal and should be able to arrange basic training courses as required.

**(v) *Day Care Centres***

Problems have often arisen in relation to the successful establishment and targeting of day care centres. Day centres typically require the co-ordination of transport services, the appropriate mix of professional personnel and a combination of voluntary and statutory inputs. Health boards should address these issues and establish stronger mechanisms for the development of imaginative day care programmes involving a range of disciplines and for more effectively integrating the voluntary sector in the joint provision of such day centres.

**(g) *Family Carers Allowance***

The Minister for Social Welfare has, as noted above, decided to review the Carer's Allowance. In this context the Council would refer to its research on carers (National Council for the Elderly, 1988) where it recommended:

- (a) a broadening and reform of the Prescribed Relatives' Allowance provided by the Department of Social Welfare, and
- (b) the introduction of a constant care allowance from the Department of Health for carers providing care for heavily dependent persons at home.

The replacement of the Prescribed Relatives' Allowance by the Carer's Allowance in October 1990 did not adequately address the needs identified by the Council. The *combination* of a means test and the requirement that the carer provide constant care takes no account of the extraordinary burden of care carried by up to one third of carers. These, the carers of the *most heavily dependent*—often demented or incontinent—elderly, ought to receive support from the State in return for their caring contribution, without a strict means test. This matter ought to be jointly reviewed by the Departments of Health and Social Welfare.

**(h) *Housing Design for the Elderly***

The Design Guidelines of the Department of the Environment on "Elderly Person Dwellings" and the National Rehabilitation Board Guidelines on housing design for the disabled are important bases on which to further the development of appropriate new and adapted

housing services for the elderly. Local authorities, voluntary housing associations and private developers should promote consultation between architects, occupational therapists and potential users on the design aspects of housing for the elderly. Formal links should be strengthened between health boards and local authorities for this purpose.

***(i) Monitoring Progress on Co-ordination***

The National Council for the Elderly should continue to undertake research as appropriate on local service co-ordination for the elderly and continue to advise on co-ordination issues.

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All errors of fact or opinion in the report remain the responsibility of the author.

## CHAPTER 1

# Background and Origins of the Pilot Co-ordination Projects

### 1.1 Introduction

This report presents the findings of the evaluation of two *Pilot Projects on the Co-ordination of Services for the Elderly at Local Level*. One of the projects was located in Dun Laoghaire Borough, a predominantly urban area which forms part of the Eastern Health Board Community Care Area I. The other pilot project was located in Tipperary South Riding, a predominantly rural area which forms most of the South Eastern Health Board Tipperary South Riding Community Care Area (the additional part being in the County Waterford local authority functional area). The pilot projects were established in 1987 for a period of three years. This was subsequently extended by a year and the pilot projects ended in December 1991.

The overall context for the establishment of the pilot projects was a growing recognition that greater longevity and the consequent growth in the elderly population posed new challenges for the care delivery system. This is an issue which has been receiving considerable attention in recent years from policy-makers, planners and practitioners in many countries (Hokenstad, 1985). In particular, the co-ordination of service provision for the elderly is being emphasised and many policies and programmes are being developed which are aimed at overcoming traditional organisational obstacles and service fragmentation and at increasing collaboration in the delivery of social and health services to elderly persons.

In the Irish context, it is now generally recognised that the increasing numbers of elderly people in the community, and particularly the growing numbers of those aged 75 years and over with increased levels of dependency, represents a considerable social challenge and presents a major test to the health and social services. There is an increasing belief

that if this challenge is to be met there is a need for better co-ordination in the provision of services for the elderly at local level — housing, social and medical — than is currently the case (Department of Health, 1988).

There is also widespread acceptance that the various component parts of the care delivery system need to be fully integrated in order to provide a comprehensive system of care which maximises existing resources. The case for a co-ordinated approach to services for the elderly both at the level of planning and the level of provision, involving three inter-related sets of relationships, (i) families, voluntary groups and statutory services, (ii) hospital services and community-based services and (iii) health authorities and housing authorities has been stated by the National Council for the Aged (National Council for the Aged, 1985a).

This perspective was endorsed by *The Years Ahead*, a report of a Department of Health Working Party on Services for the Elderly (Department of Health, 1988) and was the basic rationale underlying the pilot co-ordination projects which are the subject of this evaluation report.

The core objective of the pilot projects was to bring the various service-providing agencies and key personnel at local level together so as to improve the quality of service provision for the elderly. It was envisaged that this would lead to an elimination of any overlap or duplication that existed and would maximise the contribution of existing services. It was also envisaged that the projects would provide a mechanism for integrating the voluntary sector, the private sector, the general practitioner service and the family caring network in the overall system of service planning and provision for the elderly at local level.

The projects were established in accordance with *Terms of Reference* drawn up by the National Council for the Aged<sup>1</sup>. These *Terms of Reference* will be referred to throughout the Report and are included in full as an appendix. The projects were initiated jointly by the health authorities and the local authorities in the two project areas, the Eastern Health Board and Dun Laoghaire Corporation in the case of the Dun Laoghaire project and the South Eastern Health Board and Tipperary S.R. County Council in the case of the Tipperary S.R. project. The aim of the projects was "to develop and evaluate the concept of co-ordination of services for the elderly in terms of both planning and provision at local level" (National Council for the Aged, 1985a, p.80). In order to achieve this each project was required to establish a steering committee

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<sup>1</sup>The term of office of the National Council for the Aged expired in May 1989. A new Council was appointed by the Minister for Health in February 1990 as the National Council for the Elderly. Both terms are used throughout this Report as appropriate.



and a number of local area committees, representative of the health board, the local authority and the voluntary sector in the respective project areas. These committee structures sought to co-ordinate services for the elderly being provided by health authorities, local authorities, the private sector, the general practitioner service and voluntary bodies within the project catchment areas.

Because of the pilot nature of the projects it was considered vital to monitor and evaluate the progress of the projects from the outset. This function was carried out by the National Council for the Aged.

## 1.2 Project Origins

The desirability of setting up new structures for the co-ordination of services for the elderly at local level had been accepted in principle since the publication of the 1968 *Care Of The Aged* Report (Department of Health, 1968). In 1985 the National Council for the Aged recommended that the Department of Health set up two pilot projects in order to develop in practice the concept of local service co-ordination.

The projects would seek to involve all levels of the caring system in the development of an appropriate co-ordinated community oriented range of services to meet the varying levels of need of the elderly population (National Council for the Aged, 1985a, p.80).

By early 1987 this recommendation had not been acted upon by the Department of Health. In the intervening years the Council had become even more convinced of the importance of a co-ordinated approach at local level to service provision for the elderly and decided, with approval from the Department of Health, to progress the idea further. Appropriate *Terms of Reference* for the pilot projects were drawn up and personnel from selected health boards and local authorities were approached to ascertain their support for and willingness to undertake such a project.

The *Terms of Reference* drawn up by the Council for the projects made five basic recommendations concerning the selection of the proposed project areas, as follows:

- (i) that there be an urban and a rural dimension to the project;
- (ii) that the designated areas have a population of 75,000—100,000;
- (iii) that, in as far as possible, the selected areas are ones where the health board community care area and the local authority functional area are co-terminous;

- (iv) that the project areas be broken down into local committee sub-areas with a catchment population of 15,000 — 20,000;
- (v) that the health boards and local authorities involved support in principle and in practice the concept of co-ordination of services at local level and be willing to make available the personnel for participation in and service of project committee structures.

Further considerations pertinent to the selection of the project areas were:

- (i) that the authorities concerned have evidenced an interest in, and have a track record of "good practice" in relation to the organisation of services for elderly people;
- (ii) that personnel in the areas chosen be interested in and open to innovation in service provision.

It was envisaged that the project areas would, in a general way, already have had a track record in co-operation and that good informal links would already have existed between the statutory agencies and between the voluntary sector and the statutory sector in the areas.

### **1.3 Identification and Selection of Project Areas**

Following the drawing up of *Terms of Reference* for the pilot projects, the National Council for the Aged engaged in a series of informal contacts with and approaches to various health authorities and local authorities in order to identify two project areas (one in a predominantly rural area and one in a predominantly urban area). It emerged at an early stage of these discussions that Dun Laoghaire would be an appropriate base for the urban project because of (i) existing liaison between the health authority and housing authority in the provision of services for the elderly; (ii) the high concentration of elderly people in the area and (iii) the willingness on the part of both the health authority and the local authority to set up and support the pilot project. One of the disadvantages of the Dun Laoghaire location identified was, however, the fact that the Dun Laoghaire Borough functional area was not co-terminous with the health board community care area, having less than 50 per cent of the population of the community care area.

The identification of an area for the rural-based project proved somewhat more difficult. Informal approaches were made by the National Council for the Aged to a number of health boards but without success. An approach to the South Eastern Health Board (through the director of community care for Tipperary South Riding) and to Tipperary South

Riding County Council established that there was an interest in the concept of the pilot co-ordination project and a willingness to put the required structures in place. A good working relationship already existed between the health authority and the housing authority in the area.

In April/May 1987 meetings were held in both project areas between representatives of the National Council for the Aged and key personnel in the project areas (in the case of Tipperary S.R. these were the director of community care, the assistant county manager, and the community care administrator and in Dun Laoghaire the director of community care, the borough manager, the Eastern Health Board co-ordinator of services for the elderly and the housing officer for Dun Laoghaire Borough). At these meetings the concept of the pilot projects was accepted and a commitment was given by the authorities involved to put the project structures into being. This commitment was not formally set out in writing in either instance.

It was agreed by the health boards and the local authorities in both cases to put the proposed structures for the projects in place during the Summer/Autumn of 1987 and to make available the necessary personnel to work on the various proposed committees. In each instance the health board undertook to initiate the project structures and to provide administrative and secretarial back-up services to the committees. The *Terms of Reference* for the projects, (see Appendix), drawn up by the National Council for the Aged, were accepted in principle as adequate and appropriate for both projects. The National Council for the Aged undertook to evaluate the pilot projects and committed resources for this purpose, initially for the first year of their operation. A researcher was appointed by the Council in October 1987 to work full-time for one year on the evaluation of the pilot projects in conjunction with the Council's research officer. A part-time researcher (the author) carried out the evaluation function during the remaining three years of the pilot projects. The Council constituted a Consultative Committee on Co-ordination in March 1990 to advise on issues relating to the pilot projects. (See 7.5 below for further discussion on this committee).

#### **1.4 Demographic Characteristics of the two Project Areas**

The demographic characteristics of the two pilot project areas are summarised in *Table. 1.1*. In 1986 Dun Laoghaire had a population of 54,715, 14 per cent of whom were aged 65 years and over and 6 per cent of whom were aged 75 years and over. The population of Tipperary South Riding was somewhat higher at 77,097 persons, 11.5 per cent of whom were aged 65 years and over and 4.3 per cent of whom were aged

TABLE 1.1 Tha pilot areas — basic demographic characteristics 1886

Area	Population	Percentage Population Aged 65 Years and Over	Percentage Population Aged 75 Years and Over	Persons Per Square Kilometre	Percentage Distribution of Population Aged 65 Years and Over Living Alone	Vital Age Rate Percentage	Age Dependency Per 100 Active Age Persons
Dun Laoghaire Borough	54,715	14.0	6.0	3,181	25.4	25.4	59.3
Tipperary South Riding	77,097	11.5	4.3	34	21.1	24.6	66.3
State	3,540,643	10.9	4.1	51	21.1	25.1	66.1

Source: Census of Population, 1986

75 years and over. The *vital age rate*, the proportion of the population aged between 25 and 44 years, which is a measure of a community's capacity to support its dependent population, points to a relatively healthy demographic structure in Dun Laoghaire Borough where the rate is marginally in excess of the State average. For Tipperary South Riding the vital age rate is somewhat below that of the State. The *age dependency rate* is calculated as the ratio of dependent persons aged 0 — 14 years and 65 years and over to the rest of the population. Dun Laoghaire Borough has a rate lower than the State rate of 66.1 and Tipperary South Riding is marginally above the State average. The elderly living alone are regarded as being more vulnerable and more at risk than those living in multi-person households. In Dun Laoghaire the proportion living alone, at 25.4 per cent, is higher than that of the State as a whole while the Tipperary S.R. figure of 21.1 per cent is the same as that of the State.

## **1.5 Interim Evaluation Report**

As part of the evaluation process an *Interim Evaluation Report* (Browne, 1989) on the pilot projects was prepared by the researcher at the end of phase one of the projects (December, 1988)<sup>1</sup>. This report outlined the main aspects of the initiation phase of the project structures in each area. It also discussed the issues and problems which arose during this phase. In addition, the Interim Report provided a detailed demographic profile of the two project areas and sub-areas. The level of provision of key services in both project areas was also outlined and compared with existing norms. The achievements of the projects to date (end of 1988) were set out and various constraints impinging on the projects were identified, many of which were outside the control of the projects themselves. The findings of a baseline survey of the social and economic circumstances of a sample of elderly persons in each project area were also presented. In addition, an agenda of future tasks for the projects was set out, identifying institutional, organisational and service issues crucial to the future development of the projects.

## **1.6 Final Evaluation Report**

The present report presents the findings of the evaluation of the pilot projects which was carried out over the four year period of their existence. The main objective of the evaluation was to identify the factors

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<sup>1</sup>Phase one is used throughout this report to refer to the period up to the end of 1988 and phase two to the period January 1989 to December 1991.

and processes which impinged on the development, programme of work and outcomes of the two projects. (For further elaboration of the research objectives see 3.2 below). The report deals with key issues relating to the establishment, development, programme of work and outcomes of the two projects and expands on some of the issues identified in the Interim Report. The assessment of the final outcomes of the projects constitutes a major part of the report. The achievements of the pilot projects are outlined, the constraints and difficulties are analysed, and the main issues arising are identified and the policy implications are considered.

## 1.7 Outline of the Report

The report contains eight chapters. *Chapter One* has set out the background and origins of the pilot projects. It has also described the process of identifying and selecting the pilot areas and presented their basic demographic characteristics. *Chapter Two* presents an overview of key issues relating to service co-ordination, as found in the research literature, which are considered relevant to the Irish context. The chapter examines the context of service co-ordination and why it is regarded as necessary. It discusses the general concept of service co-ordination and the practical implications of its operationalisation. The problems of co-ordination are identified with particular reference to voluntary-statutory relationships. A number of factors which pre-dispose towards successful co-ordination are identified. *Chapter Three* describes the research approach used in the evaluation of the pilot projects. It sets out the research objectives, the methodology used and identifies the main research problems encountered. *Chapter Four* sets out the committee structures and functions of the pilot projects, traces the main aspects of their establishment and development and summarises the programme of work undertaken by each project. *Chapter Five* presents the findings of interviews held with the committee members, both steering and local, of the two projects<sup>1</sup>. It sets out their experience and perceptions in respect of the initiation phase of the projects, the relationship with the parent statutory bodies and services, the structure and functioning of the project committees and the achievements of the projects. *Chapter Six* presents two case studies of schemes undertaken under the auspices of the pilot projects. These case studies point to some of the problems

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<sup>1</sup>A more comprehensive account of these findings in respect of each of the project committees (two steering committees and six local committees) is provided in *Co-ordinating Services for the Elderly at Local Level: The Experience and Perceptions of Project Committee Members* which is available from the National Council for the Elderly.

and difficulties associated with the practical implementation of local service co-ordination and discusses some of the possible issues underlying these difficulties. *Chapter Seven* sets out the findings in respect of the pilot projects based on the researcher's perspectives which were arrived at by means of the research techniques described in Chapter Three. These findings refer to key aspects of the pilot project process in respect of their establishment, programme of work, structures and outcomes. It identifies and analyses significant issues and relationships in respect of service co-ordination and discusses how these related to the experience and outcomes of the pilot projects. Finally, *Chapter Eight* summarises the main findings of the evaluation of the pilot projects and sets out a series of general policy issues arising out of the experience of the pilot projects and the analysis of that experience. *The Terms of Reference* for the pilot projects, drawn up by the National Council for the Aged, are included as an appendix to the report.

## CHAPTER 2

# Local Service Co-ordination: An Overview of Key Issues

### 2.1 Introduction

Service co-ordination is a complex and multi-faceted concept. This complexity is reflected in the vast amount of literature and research which the topic has generated internationally. This chapter summarises the research literature and findings. It identifies the key issues arising from the literature which are considered relevant to the co-ordination of services for the elderly in the Irish context. These issues are set out under a series of headings, as follows:

- (i) Why service co-ordination is necessary: the context;
- (ii) Elements of the concept of co-ordination;
- (iii) Operationalising the concept;
- (iv) Problems of co-ordination identified and the special problems of voluntary-statutory relationships;
- (v) Factors which pre-dispose towards successful co-ordination.

### 2.2 Why Service Co-ordination is Necessary: The Context

Universal health care and social services provision have come to be regarded as fundamental building blocks of the modern welfare state, all of which have tended to develop their own discrete organisational and programmatic systems within the structure of government in such states. From an administrative standpoint this may appear to be rational and efficient but for the consumer of services this structural arrangement may be dysfunctional, particularly where there is little provision for linkage and collaboration between the systems (Hokenstad *et al.*, 1979).

The increasing division of labour in developed countries into narrowly defined units of responsibility tends to create a situation where "the



Government deals with its citizens through a vast array of agents, each one of whom deals with a large number of people but on narrowly defined problems or issues" (Friedman, 1977, p. 14). Service delivery is surrounded by a large degree of specialisation, division of labour and proliferation of organisations (OECD, 1977). This results in a situation in the Irish context where:

a large number of mainly unrelated public bodies are discharging separately a wide range of often overlapping functions, usually in a non-related and — occasionally conflicting — way (Muintir na Tire, 1985, p. 50).

The social division of planning in society results in a fragmentation of responsibility (Booth, 1983):

- between the public sector and the private sector;
- between central Government Departments;
- between local government agencies;
- between central and local government;
- within departments and agencies.

While traditionally many service goals were perceived as having distinct and limited ends they "now appear as links in a chain of concerns, each of which is influenced by, and affects, a number of interests" (OECD, 1977, p. 218). Where such links are missing services may be "inadequate and even counter-productive by recipient standards" (OECD, 1977, p. 218). It is also the case that the "realisation that preventive policies require the co-ordination of health and welfare services is now international" (Bruce, 1980, p. 190). Emery and Trist (1969) refer to the current environment of service delivery as a 'turbulent field' in which large competing organisations, all acting independently, in many diverse directions, produce unanticipated and dissonant consequences in the overall environment which they share. Such an environment calls for a marshalling of resources from diverse sources so as to create "multi-organisation complexes" (Thompson, 1967, p. 157) or what Trist (1977) terms "inter-organisational domains" and bring about "a result that was beyond the ability of any single organisation" (Thompson, 1967, p. 157).

It is in the foregoing context that "many Governments have become concerned about developing systems that will seek to integrate and co-ordinate services where there are interdependencies" (OECD, 1977, p. 128). Policy-makers have attempted to integrate a diversity of services in the belief that better co-ordination among service providers will improve the delivery system (OECD, 1977).

The concept of collaborative service planning and provision between the statutory and non-statutory sectors

rests on the belief that if statutory and non-statutory provision can be better linked, overall provision will be better integrated and eventually more rational and comprehensive within the limits of available resources, as well as capitalising on the strengths and differing capacities of a plurality of organisations and people (Leat *et al.*, 1981, p. 7).

It is based on the view that services should be provided collaboratively by the citizen and the State (Hadley and McGrath, 1984) and should involve the three sectors, public, voluntary/informal and private.

The case for service co-ordination has been argued on the basis of effectiveness and efficiency.

Not only will citizen needs be met more adequately, but costs will be reduced through more effective administration and less duplication of services (OECD, 1977, p. 145).

Commenting on the Irish situation, Roche (1982) pointed out that "many social problems and social groups require multiple policy responses that cross over departmental boundaries" and that "it is not practicable to group all policy responsibilities for any social issue or social group in any single department" (p. 118). The National Economic and Social Council considered that there was an urgent need for much more effective evaluation and co-ordination of social policies across departments (NESC, 1982). The National Planning Board (1984) pointed to the link between housing policies and other social policies. For example, the Board suggested that greater emphasis on community care in the health area would require mechanisms in the housing area to facilitate this emphasis. In the United Kingdom it has been argued that an effective care delivery system is likely to "require much more collaboration across administrative and professional boundaries" (DHSS, 1978, p. 7).

Booth (1983) identifies five factors which form the backdrop to the emphasis on collaboration in service provision:

- (i) the *inter-relationship of needs* in the community — health and social needs overlap and shade into one another;
- (ii) the *complementarity of services* — health and social services depend on each other in a host of ways which may lead to problems if their policies and priorities are pulling in different directions;
- (iii) the need to get '*value for money*' — collaboration in resource

allocation is held to be vital if costly waste and duplication are to be avoided;

- (iv) considerations of *effectiveness* — if the plans of each authority and the priorities they embody are not carefully aligned then gaps and bottlenecks may arise to the detriment of the level and quality of services;
- (v) the development of the concept of *care in the community* — collaboration between all sectors is seen as a precondition of progress.

The emphasis on collaboration has come more sharply into focus in recent years when the pressure on social support services is acute as a result of severe budgetary restraint and public sector services cut-backs. At the same time the traditional but fragile informal care and family support networks are being eroded by trends of urbanisation, youth emigration, a decrease in family size (fewer children to share the burden of care of elderly relatives) and the growing participation of women in the labour market (removing them from the arena of informal unpaid care-providers). It is hardly surprising then that the concepts of co-ordination, integration and flexibility in service provision have received increased popularity and priority in many western countries as pressure on both statutory and voluntary social services grows in response to changing demographic structures. Brazier and Harris (1975) argue that a conscious effort must be made to develop new ways of decision-making which explicitly recognise the split in planning functions. New procedures must be developed to enable a continuously evolving planning process to operate in a complex organisational situation. The OECD Report on Service Linkage and Collaboration (OECD, 1977) concluded that "co-ordination cannot be achieved by invocation alone" (p. 130) and argued that "care and attention must be paid to developing structures within which co-ordination may be achieved" (p. 130).

### ***The Need for Service Co-ordination for the Elderly***

Greater longevity and the consequent growth in the elderly population in many western countries is making greater demands on all levels of the caring system — statutory, voluntary and informal — in such countries. This issue is one which is receiving considerable attention from policy-makers, planners and practitioners in many countries (Hokenstad, 1985). In particular, the co-ordination of service provision for the elderly is being emphasised and many policies and programmes are being developed which are aimed at overcoming traditional organisational

obstacles and at increasing collaboration in the delivery of social and health services to elderly persons (Hokenstad, 1985).

The context for collaboration and co-ordination in the delivery of services for the elderly was set out by the Vienna International Plan on Ageing (United Nations, 1983). It stated that the care of elderly persons should go beyond disease orientation and should take into account the interdependence of physical, mental, social, spiritual and environmental factors in enhancing their well-being. The Vienna Plan stated that Governments, local authorities and voluntary bodies should plan services with this perspective in mind.

The ability of elderly persons to continue independent living in the community may be said to be dependent on effective co-ordination among service agencies and full co-operation among help-givers (Hokenstad, 1985). For example, an elderly person may be able to continue an independent existence "not only through the efforts of the housing department (e.g. through improvements to an existing home or rehousing) but through the provision of domiciliary or other help by the social services department" (Hearnden, 1984, p. 3). The rationale for co-ordination in service provision for the elderly is that more than one service is usually involved in the provision of care at any one time and one agency inevitably has to rely on another agency to provide those elements of services that it is not authorised or equipped to supply. "Good co-ordination makes, therefore, both economic and social sense" (Wright era/., 1988, p. 2).

In the Irish context the case for co-ordination of services for the elderly has been argued by the National Council for the Aged (1985a) on the basis of two main considerations, as follows:

- (i) The needs of elderly people rarely fall into watertight compartments to be met by one service or one department only. Elderly people who need care require an integrated range of services from the provision of adequate and appropriate housing to the provision of acute hospital care and continuing nursing care for those who require specialist medical or nursing attention.
- (ii) Limited resources are likely to be best used where there is a joint approach resulting in appropriate collaboration and co-ordination of services and the consequent elimination of duplication and overlap in service provision.

The integration and co-ordination of services for the elderly has been the subject of much discussion and a number of policy recommendations

during the past two decades. *The Care of the Aged* report (Department of Health, 1968) stated that:

unless services are carefully planned there will be wasteful duplication of effort in respect of some of the aged, while others will receive little if any of the help they require (p. 107).

The report considered that co-ordination was essential at a number of levels, as follows:

- co-ordination at ministerial level (Minister for Health, Minister for Local Government (Environment), Minister for Social Welfare);
- co-ordination of public services at local level:
- co-ordination of public services and voluntary services at local level:
- co-ordination of voluntary and public services at national level.

#### *Service Co-ordination at Local Level*

The need for better co-ordination of services at the local level has been identified. For example, Jones (1984) refers to the fact that in the United Kingdom there is no one agency or forum at local level to discuss the interaction and development of services for elderly people in a particular geographical area.

Consequently, local housing departments are concerned as to how far they should expand as social and personal care providers. Social services departments are concerned as to how far they should provide a widespread general minimal service as well as coping with an increasingly pressurised response to high individual needs. Community health departments are also uncertain how far they should be committed to providing minimal social care services. How far these services should be an area of work delegated to the voluntary sector also remains problematic. Consequently, at the local level there is a wide variety of organisational patterns which are often the result of expediency (p. 20).

The National Council for the Aged (1983, 1985a, 1985b, 1987) has highlighted the need for more effective co-ordination of service provision for the elderly at local level in the Republic of Ireland. The Council argued that an effective community care system for the elderly could be brought about only if appropriate co-ordinating mechanisms were introduced. Such mechanisms included the setting up of a structure for joint planning for the elderly at local level, involving health authorities

and housing authorities, hospital programmes and community care programmes, the statutory sector, the voluntary sector and family carers.

The case for service co-ordination for the elderly at local level was stated forcibly by the Working Party on Services for the Elderly (Department of Health, 1988):

The present lack of co-ordination is evident in the tendency of each service and organisation to work independently of each other. Local authorities are responsible for housing elderly people living in inadequate accommodation, many of whom also have health problems, but no formal co-ordinating link exists between them and the health board services. General practitioners and public health nurses may visit the same patients but they have no formal reporting relationship to one another. The acute hospital may discharge an elderly person with a severe disability and in need of continuing attention without notifying those responsible for community care services or the general practitioner. People caring for elderly relatives at home receive little or no support from health board personnel. The separation of responsibility for community care, acute hospital, psychiatric and long term care into two or three administrative programmes of health boards contributes to the problems. Private nursing homes provide an increasing share of long stay accommodation for the elderly but they operate with the minimum amount of co-ordination with health board services. Voluntary bodies working with the elderly have repeatedly pointed out the inadequacy of their working arrangements with health boards and the absence of a formal method whereby they can influence policy or the direction of services. All these factors point clearly to the need for a co-ordinated health and welfare service for the elderly (p. 40).

The Working Party recommended that services for the elderly be organised as far as possible in districts serving a population of 25,000-30,000 people. It further recommended that the function of co-ordinating services for the elderly in each district should be the responsibility of a district liaison nurse who would be supported by a district care team, representative of the various statutory and voluntary agencies providing services for the elderly in the area. The Working Party recommended that each health board should be obliged "by law to co-ordinate and plan health and welfare services for the elderly" (p. 52). Such legislation would oblige health boards to appoint co-ordinators of services for the elderly (one in each community care area) and to establish at least one advisory committee on the elderly to facilitate planning and co-ordination of services.

Friedman (1977) refers to the need to engage the support of the central authority for action taken at the local level and states that "the complexity of tasks and specialised orientation of personnel in the human services seem to create serious obstacles to co-ordination of these services at the local level" (p. 147). The OECD (1977) argues that for an innovation to come about at the local level, it must either be contained within the framework set by the higher authorities, or else it must be possible to alter the framework. In either instance adequate resources must be provided "which, at least in the early learning stages, may be greater than required in conventional approaches to service delivery" (p. 140).

In the Irish context it has been argued that there is a need for more planning at central government level in respect of co-ordination of services for the elderly at local level if the potential of the agencies at local level in this regard is to be effectively developed and channelled into more formal arrangements. Such planning should be based on the premise that local knowledge, local discretion and local linkages are more likely to provide services which are more efficient and more humane than a more centralised approach. There is clearly a need for more effective linkage between central government departments, between central departments and local service agencies and between the various service agencies at the point of delivery. This requires a general commitment to the concept of 'integration' which has been defined as "the binding together in region, county and district of the operations of government as a whole" (Muintir na Tíre, 1985, p. 53).

For such a development to take place, a new emphasis and focus on local participation is required in the Republic of Ireland in the context of major reforms in local government. This requires an emphasis on service provision through multi-purpose, integrated local bodies, as distinct from several bodies discharging separately a wide range of often overlapping functions. An integrated response to the needs of the elderly requires a policy-shift towards planning for welfare provision for the elderly at local level where it would become a local responsibility, susceptible to local responses and local decisions and funded accordingly. Innovation at local level is unlikely to become widespread without such a shift in emphasis and resources. The widespread practical expression of the theoretical discussion on innovation and inter-agency collaboration, which is to be found at central department level, requires not only charismatic and committed local administrators but, also, and more importantly, a re-vitalisation of the concept of local responsibility and a related re-allocation of resources.

## 2.3 Elements of the Concept of Co-ordination

The concept of service co-ordination implies processes of exchange which are basically co-operative and refers to agencies and professions working together in order to make the best use of available resources and provide the optimum mix of services to client groups. Underlying the concept of co-ordination is the notion of organisational interdependence where each organisation perceives that its own goals can be achieved most effectively with the assistance of the resources of the other (Gilbert and Specht, 1977).

Commenting on the care delivery system in the United States, Arnold (1987) states that:

to achieve co-ordination of existing long-term care services we need to begin to implement truly, not just symbolically, co-ordinated organisational models of long-term care ..., models which are physically, financially and professionally integrated (pp. 41-42).

Stringer (1967) has developed the concept of the *multi-organisation* to describe the structure within which inter-authority decision-making takes place. He defines it as "the union of parts of several organisations, each part being a sub-set of the interests of its own organisation" (p. 105). A multi-organisation has a diffuse set of objectives, since the participating organisations or decision-makers have their own separate set of objectives but, at the same time, share a common task. A shared appreciation of this common task is essential if inter-authority networks are to function effectively. This requires that the various agencies understand and appreciate each other's language and, in so doing, appreciate the various policy and planning issues not only from their own perspective, but also, from the perspective of other members of the multi-organisation.

The literature offers a range of models for looking at inter-agency co-ordination which have been drawn together by Booth (1983) under three headings. (See figure 2.1).



**FIGURE 2.1: Models for understanding inter-agency co-ordination**

Exchange Model	Organisations collaborate on the basis of some mutual benefit from doing so. Co-ordination will not occur if one party is disadvantaged by the arrangement.
Political Economy Model	The main goal of each participating organisation is to maintain the <i>status quo</i> and to protect the budget and sphere of operation of each organisation.
Economic Model	Bureaucratic control and departmental growth are the key assumptions of this model. Co-ordination occurs so that bureaucrats can maximise the relative size of their own departments and, consequently, their own status and prestige.

- (i) The *exchange model* conceives inter-organisational relationships as a process of give-and-take. Organisations are basically goal-orientated and will collaborate voluntarily only when there is some mutual benefit to be derived from doing so: "no goods or services are ever transferred without reciprocity of some kind being involved" (Booth, 1983, p. 17). The exchange model recognises that, even where the sharing or transfer of resources may be desirable from the vantage point of the wider community, it will not take place voluntarily if one party is disadvantaged by the arrangement. For example, health authorities may see a joint approach largely as a way of getting local authorities to shoulder a greater share of the burden of caring for more dependent older people in the community.
- (ii) The *political economy model* represents the pattern of inter-organisational relations as a network of vested interests whose participants are all busy pursuing the same ultimate aim of securing and maintaining an adequate supply of resources for their own organisation. According to Leach (1980) the most fundamental organisational interest is survival and patterns of interaction and collaboration between organisations are formed on this basis. According to the political economy view, the preservation of the organisation's sphere of operation and existing programmes, the defence of the organisational view of things and the maintenance of the organisation's supply of resources are the governing principles in inter-organisational activity.

- (iii) The third model suggested by Booth (1983) is what he terms the *economic model*. According to this view, the benefits and value of collaboration will be judged and action taken accordingly in terms of whether it is likely to contribute to departmental growth and increased prestige rather than to the public interest or the general welfare.

These three models have in common the view that collaboration is essentially a self-interested process in which organisations will only become involved if it suits their own ends.

Walton (1966) refers to the "complex horizontal relationship" (p. 413) involved in any co-ordination system. He distinguishes between two opposite types of joint decision-making, a bargaining type and a problem-solving type. The bargaining process is defensive, while the problem-solving process is more open-ended and exploratory.

In bargaining, the orientation of the parties is 'how much will I gain or lose, and how much will the other man gain or lose?' The problem-solving process occurs when the parties explore problems for solutions which will involve maximum gain to both parties considered together (Walton, 1966, p. 413).

He suggests that a particular joint decision-making process can be conceived along a continuum bounded by these two types based on how information exchanges occur. "How much information do the departments share with each other at every stage in arriving at decisions; and how much consideration do they give to information about the other's problems?" (Walton, 1966, p. 414).

In the bargaining-type approach to co-ordination information exchange is based on gaining maximum information from the other party while making minimum disclosures about one's own organisation. By contrast, the problem-solving approach is based on a full sharing of information at every stage of the decision-making process.

We expect problem-solving to be accompanied by a high rate of interdepartmental interaction; many persons entering into these interactions; few limitations regarding the type of contact a person may have with the other department; infrequent appeals to higher officials; decision rules which are informal, loosely interpreted, and constantly changing; considerable experimentation in decision procedures and organisation. The bargaining process would be accompanied by a structure with opposite characteristics (Walton, 1966, p. 417).

Co-ordination mechanisms may have diverse purposes. For example,

they may operate to reduce areas of overlap and confusion between the responsibilities of different agencies, in order to optimise the functional autonomy of the agencies involved. On the other hand, co-ordination might mean the fostering of interdependence between agencies in order to launch new innovative programmes which require the resources of more than one agency.

Lindholm (1965) argues that unless it was in the interest of two organisations to co-operate no amount of co-ordinating machinery would be effective. He went on to argue that if it were in their interests, collaboration on a small *ad hoc* scale would happen in any case. He suggested that, in practice, an organisation took action to take account of what other organisations were doing. He sets out a number of strategies adopted by organisations in dealing with other agencies:

- (i) straightforward bargaining (for example, inter-authority flows of patients);
- (ii) a shift of appreciation achieved through the exchange of information about other authorities' future intentions;
- (iii) compensation — financial inducements by one authority to another (joint finance might fall under this heading);
- (iv) reciprocity — one organisation undertakes to do something in return for some future benefit from the others;
- (v) authoritative prescription — one department accepts the other's professional judgement;
- (vi) unconditional manipulation — one department simply tries to outmanoeuvre the other.

Wistow (1982) suggests a four-fold categorisation of collaborative activity:

- (i) the sharing of services;
- (ii) the co-ordination of service delivery;
- (iii) inter-authority service planning and policy development;
- (iv) joint action to promote and maintain the health and welfare of the community.

(i) *Collaboration as Sharing of Services:*

The sharing of services can occur in two ways:

- (a) the provision of professional skills by one side to the other;

(b) the operation of support services jointly or on an agency basis. This allows for a more economic use of resources.

(ii) *Collaboration as Co-ordination of Service Delivery:*

This dimension of collaboration is based on the premise that the provision of comprehensive care to individuals is likely to require the co-ordinated deployment of services by a wide range of health and social care providers. A family or an individual may, in a short space of time or even at one and the same time, require care provided by different professionals or agencies. Collaboration at this operational level is hindered because of difficulties in promoting harmonious working relationships between different professions and disciplines and because of difficulties in synchronising communication channels and other administrative procedures between separately administered organisational units.

(iii) *Collaboration as Joint Planning:*

There is a growing recognition that the effectiveness of care provision depends not only on improving inter-service and inter-professional liaison at the level of service delivery but, also, on developing a capability to plan an appropriate balance of provision across the whole spectrum of health and social care. Here it is worth noting that the Working Group on Joint Planning in the UK (Whyte, 1985) distinguishes between *joint planning* and *joint working*. The concept of joint planning is particularly pertinent in respect of the shift to community care being promulgated in recent years. Planned reduction of hospital and institutional care facilities needs to go hand in hand with planned development and expansion of housing and other community-based facilities and services. As is the case in joint provision of services, joint planning is also, and even to a greater extent, impeded by separate budgetary provision and separate prioritisation of needs for and by the different agencies.

(iv) *Collaboration as Joint Prevention:*

According to this perspective, overall health policies should be framed in terms of strategies for identifying and modifying the predominant behavioural and environmental influences (and the interactions between them) which create ill-health, in addition to planning and delivering curative services. Environmental health, physical planning, housing, transport, education and recreation need to be promoted hand in hand with conventional health services. This requires that agencies not directly

involved in health service provision explore the impact of their various programmes and activities on the health status of the communities for which they are responsible and take this into account in their own planning process. This approach should contribute to an increased understanding about the limitations of conventional models of intervention and to break down assumptions that improvements in health provision can only be attained through yet higher levels of investment in health services. For example, while local authorities are not involved in the direct provision of health services they do have a central influence on the health of their communities.

Glennerster *et al.* (1982) suggest four kinds of collaboration broadly similar to those put forward by Wistow: joint strategic planning; joint operational planning; co-operative service provision; joint working. Bruce (1980) identifies three possible modes of co-operation between agencies/professions:

- (i) *nominal* co-operation occurs when there is no structure in place and where the information flow between agencies is minimal;
- (ii) *convenient* co-operation occurs when some form of administrative structure underpins the links between agencies with a view to improving the flow of information;
- (iii) *committed* co-operation occurs when both an organisational stimulus (e.g. a team leader/co-ordinator) and the acceptance of superordinate goals exist.

Bruce (1980) concludes that each mode of co-operation forms a syndrome containing a variety of easily recognisable symptoms which allows inter-agency co-operation to be placed at an appropriate point on the continuum between zero and total co-operation. He suggests that:

there is a syndrome of committed co-operation, in which the individuals or agencies involved see their mutual interaction as part of their role, recognise the need for preparation and training for this interaction, maintain regular personal contact, ignore status differences, share mutual trust, have no problem of confidentiality, do not regard each other in terms of stereotypes, and operate an organic system of interaction, with the result that failures of communication are exceptional, clients receive consistent advice and optimum conditions exist for preventive care (Bruce, 1980, pp. 164—165).

This suggests an 'ideal type' of co-ordination which is rarely found in practice, as will be shown in 2.5 below.

## 2.4 Operationalising the Concept

Joint planning and joint working in practice are complex and difficult processes. "It is easier to theorise about teams on paper than to get them to work in practice" (Bruce, 1980, p. 194). Co-ordination involves the fashioning of new partnerships between the statutory, voluntary and informal care sectors and "provides a formidable test of the entrepreneurial capacity of people charged with managerial responsibility" (Chant, 1986, p. 51). While policy prescriptions have frequently pointed to the need for co-ordination and collaboration between agencies and emphasised the need for the development of voluntary-statutory partnerships, "tried and tested models are proving elusive" (Chant, 1986, p. 58). In most instances service integration is a relatively new concept which involves a fundamental adaptation by the agencies and personnel involved. "Co-ordination projects seek to change the network of inter-organisational relationships. Practitioners should bear in mind that, for all its potential advantages, this change may be perceived as threatening to organisational interests" (Gilbert and Specht, 1977, p. 78).

Wright *et al.* (1988) identify the following factors as important in developing successful joint working relationships between agencies:

- the establishment of formal links between services resulting in a one-to-one relationship between professionals on a regular basis allowing understanding and trust to develop and a mutual tolerance of attitudes;
- simplification of the existing administrative structures, allegiances and geographical boundaries of the services;
- the establishment of clear agreed policies between agencies over matters such as transfer of cases, appropriate referral, establishment of prime responsibility or key worker for a case;
- the establishment of an agreed minimum level of resources for the different services within a specific geographical area and of mutually agreed policies over their use;
- the acceptance of superordinate goals which would allow 'give and take' between agencies;.

### ***Teamwork and Collaboration***

Teamwork is an integral part of operationalising service co-ordination and is required at each level of the co-ordinating system. The concept of teamwork is frequently used to refer to people working collaboratively. In the broadest sense a team can be defined as a "group of

people who make different contributions towards achievement of a common goal" (Gilmore *et al.*, 1976. quoted in Wright *et al.*, 1988, p.4). The advantages of working in team settings are usually seen as the sharing of information, joint decision-making and obtaining feedback (Rowlings. 1981). The term team has "positive connotations of co-operation, continuity, sense of purpose" (Wright *et al.*, 1988, p. 5). It is seen as overcoming some of the disadvantages of specialisation by improving co-ordination and facilitating a more comprehensive view of issues.

The following have been identified as the functions of a multi-professional team:

- (i) to provide a means for people with different professional trainings to work together and understand what each has to offer in solving common problems;
- (ii) to overcome some of the disadvantages of specialisation, by improving co-ordination and by enabling a more comprehensive view of problems to be taken;
- (iii) to provide easier access for patients/clients, who often do not know what profession to approach for assistance;
- (iv) to improve the conditions of work for people who work under pressure and without the support of colleagues;
- (v) to help individuals to judge the best course of action to take.

The term 'collaboration' is used to refer to the process of two or more agencies or professions working together. Booth (1983) identifies three broad levels of collaboration:

- collaboration at the practical level which refers to co-operation between different professionals in the case setting aimed at meeting the needs of individual clients;
- collaboration at the operational level involving either the sharing of resources and skills or the integration of service delivery where two or more disciplines work together;
- collaboration at the strategic level in the making of policy, the setting of priorities, and the allocation of resources.

In the UK a Working Party on Collaboration (DHSS, 1973) set out an understanding of the concept embracing these three levels:

Underlying these propositions is an understanding that the real objective is not to achieve the joint consideration of plans which

have been prepared separately by the two sides and brought together at a late stage to see how well they match up. It is, rather, to secure genuinely collaborative methods of working throughout the process of planning, and close and continuing cooperation between the officers of the two sides (Par. 4.9).

This requires the presence of what Bruce (1980) terms superordinate goals, that is the subordination of immediate agency or professional goals to longer-term and broader objectives. The presence of superordinate goals "is likely to lead to changes in methods of working in the direction of less formal and less rigid organisational structures, less emphasis on professional or personal status and a flexibility of approach to shared problems" (Bruce 1980, p. 164).

Effective collaboration and organisational interdependence requires a recognition and understanding by one agency/discipline of the role of other agencies/disciplines involved in the partnership, what Bruce (1980) terms 'domain consensus'. 'Domain consensus' in this context can be defined as an area of activity over which both organisations agree the other has legitimate authority. This 'domain consensus' is difficult to achieve where there is overlap between disciplines.

Most professions have a core of knowledge and skills that are specifically their own, surrounded by an area in which there is an overlap with those of other professions; this overlap, although capable of facilitating a joint approach to problems and a sharing of values, may provoke difficulties when it comes to defining the division of responsibility within teams (Bruce, 1980, p. 177).

The achievement of domain consensus requires enriched information flows between agencies operating in multi-organisational settings (Brazier and Harris, 1975). Such information refers not only to actions and decisions of participants' own agency but, also, to other agencies and to the overall policy, planning and strategic context in which the multi-organisation operates. Comprehensive information facilitates the difficult and complex tasks of achieving inter-organisational domain consensus and, also, defining more precisely the task of the multi-organisation and eliminating possible conflicts and confusion.

Bruce (1980) cites three variables necessary for active co-operation and teamwork — physical proximity to promote face-to-face contact, social proximity to lessen status differences between the various professions, and positive motivation of team members. Wright *et al.* (1988) consider that the stability of team members, the allowance of time for close links and understanding to be developed, the acceptance of possible conflicts



and the provision of opportunities for staff to air and resolve mutual difficulties are important elements in teamwork. Some form of team leadership is also an important aspect of effective teamwork, particularly in situations where there are a large group of agencies/disciplines involved. Effective leadership can do much to facilitate mutual frankness and understanding which are essential if genuine consensus is to be reached.

Teamwork is a difficult concept to apply in practice and is quite problematic in many respects. While it is widely seen as desirable,

it is unfortunate that we have hardly begun to analyse what it is we are urging upon practitioners, why it is we are doing so or how we might recognise good co-ordination — or team work — when we see it (Webb and Hobdell, 1980, p. 79).

In the Irish context, O'Mahony (1985) refers to the considerable complexity and potential pitfalls of the inter-disciplinary team approach in relation to the community care services. She suggests that the development of productive and smooth working relationships in multi-disciplinary teams is a complex undertaking requiring a careful and considered response. The *Inbucon Report* (Inbucon, 1982), reviewing the community care programmes in the Irish health boards, pointed to the need for considerable in-service training and re-orientation of staff if the inter-disciplinary approach was to be effective.

In general, co-operation between professionals does not result automatically either from physical proximity or from being involved with the same client. Rather, according to Bruce (1980),

it appeared to develop step by step as the frequency of contacts increased, as the relevance of such contacts became clearer, as a better understanding of roles emerged, accompanied by the disappearance of stereotypes, as social proximity increased, as mutual trust began to grow and problems of confidentiality to shrink (p. 165).

The problems arising from the operationalising of the concept of co-ordination are now considered.

## **2.5 Problems of Co-ordination Identified and the Special Problems of Voluntary-Statutory Relationships**

Obstacles to effective linkage between health and social services have been the subject of a number of studies. (Altensetter, 1971; Hokenstad *et al.*, 1982). The OECD takes the view that the resolution of jurisdictional,

professional and institutional problems created by the overlap of interests and activities among organisations charged with the execution of particular services "are hindered by the presence of administrative and political traditions that are not easily modified" (OECD, 1977, p. 217). Hokenstad (1985) suggests that there are a number of basic factors which impinge on effective service delivery. Such factors relate to (a) the historical evolution of the various social service systems and (b) their current organisational structure and management style. He refers to boundary protection and administrative rigidity often evidenced within bureaucratic settings which frustrate attempts at linkage. Reference has also been made to professional ideology as a critical obstacle to effective linkage (Hokenstad *et al.*, 1979). For example, in the United Kingdom context. Bytheway and James (1978) point to a considerable and fundamental difference in belief and attitude between housing and social services officers which may give rise on both sides to exaggerated stereotypes and images which are dysfunctional.

The major problems in inter-agency co-ordination are differing priorities, different views about the nature of problems, different ideas about the division of responsibilities and lack of resources to pursue joint care (Rhodes and Green, 1987). As Brazier and Harris (1975) point out, "conflict always exists where problems and issues cross administrative boundaries" (p. 264).

Gilbert and Specht (1977) point to an additional potential problem of an integrated and highly rationalised comprehensive delivery system where there is little duplication and overlap of services, in that it

may provide less accessibility and accountability to clients than a delivery system that is fragmented with many overlapping services and many organisational 'doors' through which clients may enter the system (p. 56).

Carley *et al.* (1987) conclude that:

however substantial the potential benefits of multi-disciplinary working, the evidence is that concrete achievement of joint care, planning or finance are difficult to obtain, and the impediments should not be underestimated (p. 7).

For example, commenting on the experience of collaboration and joint working between the local authority and the NHS in the UK, Booth (1983) points to major differences between health and local authorities as follows:

- political                      health and social services are subject to different kinds of political control and public accountability;
- financial                     they are financed differently and have different budgetary processes;
- organisational              they operate with very different formal structures and administrative procedures;
- professional                they draw on different professional perspectives and traditions;
- planning                    they face different demands on their resources, and have different perceptions of what are the most urgent problems. Although the two authorities share a common concern for certain client groups, they rarely give the same priority to them.

Indeed, Booth suggests that both health and local authorities are "self-interested organisations which only co-operate when it suits them, or when they have to, and then very much on their own terms" (pp. 11-12).

While some aspects of these problems are particular to the UK context, they do, however, point to four problematic areas of inter-agency collaboration:

- (i) inter-professional;
- (ii) agency boundaries;
- (iii) joint planning;
- (iv) resources for joint working, each of which is now considered.

#### (i) *Inter-Professional Working*

The problems associated with inter-professional working and inter-disciplinary teams have frequently been documented. According to Bruce (1980), even a cursory review of literature describing professionals in teams reveals friction, incongruent role expectations, poor communication and status concerns which at times would seem to subvert the original purpose of the team's existence. Lonsdale *et al.* (1980) summed up the problems of inter-disciplinary working as follows:

Models of desirable or effective teamwork are none too easy to

discover. The barriers to effective teamwork are many, the experience of failure or partial success is not uncommon, and the identification of the need for teamwork greatly outstrips performance. (There is) ... a widespread recognition that effective care requires teamwork (coupled with) ... the frustrating experience that such collaboration is rarely perfect and often quite absent (p. 2).

In identifying the underlying reasons for these difficulties, attention must be drawn to the nature of professionalism and related education and training. According to Barber and Kratz (1980), a profession implies a particular expertise which is socially recognised by a degree of autonomy in that field. There exists, however, a ranking of professions. Etzioni (1969), for example, defines nurses and social workers as semi-professionals because their training is shorter than for medicine or law, their status less legitimised and they hold less of a specialised body of knowledge. Therefore, they have less autonomy from supervision or societal control. The issue is further complicated by the fact that within any occupational group there will be individuals at different levels or with different training and orientation. Training and early experience may have the effect of distancing one profession from another and creating some stereotyping. These problems are compounded by:

the marginal nature of interprofessional tasks, the difficulties in providing continuity and professional support, the conflict between different work priorities, the relationships between dominant and dependent professions, and other differences of status caused by seniority, academic qualifications, authoritarian attitudes, the location in which co-operative work is done and the type of relationship prescribed by the job description (Booth, 1983, p. 1).

Wright *et al.* (1988) refer to "failures in communication which led to ignorance of the roles, skills and outlook of other professional groups" (p. 59).

The different perspectives of different professions are reflected in the way the relationship between the individual and the client is described in terms of 'client', 'patient', 'user', 'resident' and in the case of older people by terms such as 'geriatrics', 'old folks' and 'senior citizens'. It is, therefore, somewhat naïve to bring together such a highly diverse group of people in terms of training, outlook and skills and expect that by calling them a team they will in fact function as one (Bruce, 1980). What is needed is an imaginative approach at a number of levels. A new approach to interprofessional co-operation requires fresh initiatives "simultaneously at the political level, the administrative level, the level

of service delivery and the level of education and training" (Bruce, 1980, p. 105).

### Integrating the General Practitioner Service

The general practitioner is the major referrer to all services and is thus a key gatekeeper in the system. As Hunter *et al.* (1988) point out, the general practitioner is frequently the first point of contact with the service system and operates at a "major intersection" (p. 154). However, Jeffrys and Sachs (1983) point out that the boundaries between general practice and other services are not fixed and clearly identifiable but are rather "individualistic, situational and constantly changing" (quoted in Hunter *et al.*, 1988, p. 54). Wright *et al.* (1988) point to the "relative isolation of general practice from other services, making more difficult the task of effective co-ordination" (p. 57). In the Irish context general practitioner services are provided by independent contractors. There are no formal arrangements for the inclusion of the general practitioner service within the structure of the health board community care multi-disciplinary teams. The different principles of organisation underlying general practice and health board services were regarded by the Department of Health Working Party on Services for the Elderly (Department of Health, 1988) as "a further factor inhibiting a co-ordinated primary care service for the elderly" (p. 86). Various recommendations have been made in respect of improving liaison between general practitioners and other community care services, particularly the public health nursing service (*Report of the Working Party on the General Medical Service* (Department of Health) and *The Years Ahead*, (Department of Health, 1988). However, the fundamental problem of the absence of a formal link remains which, as O'Mahony (1985) suggests "must undoubtedly be regarded as a serious weakness in the original McKinsey formulation of an appropriate organisational structure for the Community Care Services" (p. 134).

#### (ii) Agency Boundaries

It is generally acknowledged that there are substantial difficulties for agencies working jointly while simultaneously maintaining their own boundaries, functional responsibilities and budgets. "The network of relationships at the operational level is often extremely complex" (Wright *et al.*, 1988, p. 44). Indeed, collaboration between agencies is even more complex than between individual professionals. Agency personnel may lack the benefits that come from face-to-face team working but "still have to contend with differences in outlook engendered by

different training and background" (Wright *et al.*, 1988, p. 45). In addition to differences in outlook there is also the fact that different authorities may have "quite different organisational structures, administrative and political cultures, sources of finance, planning cycles and relationships with central government" (Wistow, 1982, p. 54).

There may also be different views about the nature of problems and how to solve them, different perceptions of responsibilities and disagreement about caring strategies and philosophies. These problems become evident in the case of the grey areas where it is not altogether clear which agency has responsibility for a particular group.

The cases which most clearly highlighted the lack of effective communications between agencies, and which presented most problems for the professionals dealing with them, were the elderly who were 'borderline' between hospital and residential care or between community and residential care (Wright *et al.*, 1988, p. 60).

This may give rise to defensiveness and manoeuvring on the part of agencies rather than genuine collaboration. Agencies set out to avoid carrying the workload belonging more properly to other agencies. "In times of resource shortage, there is a clear incentive to interpret need in terms of the other authority's mode of provision" (Wistow, 1982, p. 55). Thus, a 'good' service might be perceived as one which took over the care of a particular individual or group as distinct from one where there was effective joint working.

The Irish administrative system has been developed in such a way as to re-enforce discrete functional responsibility for separate agencies. Barrington (1980) points out that "government has no single or formal presence in any area smaller than that of the state itself (p. 47) and, therefore, no formal linkage at the local level between the various executive activities. This presents considerable difficulties for local service co-ordination in respect of the elderly.

### **(iii) Joint Planning**

Joint planning is central to the concept of service co-ordination and tends, in practice, to be complex and problematic. In the UK it has been pointed out that "the record of joint planning has been mixed" (Government White Paper, 1989, p. 50). Wistow (1982) refers to the shortage of planning skills and experience within the NHS and local authority system in the UK and suggests that joint planning cannot be assumed to flow from the establishment of structures for collaboration.

In practice, longer-term strategic issues tend to be crowded out with 'joint planning' "being confined to the exchange of views on separately prepared plans" (Wistow, 1982, p. 55) which is the antithesis of the aim of joint planning. There are two basic problems which arise in respect of joint planning. Firstly, agencies and organisations generally lack the required knowledge about each other's plans to adequately harmonize services. Secondly, organisations do not generally have the means to compel others to adjust their policies to accord with their own plans. Both of these problems need to be overcome if joint planning is to become a reality. Joint planning is difficult and complex precisely because the participants have different agendas generally. While "there may be a short agenda of common elements ... each will have other objectives" (Chant, 1986, p. 66).

Glennerster *et al.* (1982) conclude from their study of local authorities and health authorities in the UK that "they had limited capacity to draw up long term plans with an agreed balance of care" (p. 255) and that even when they did "these plans carried little weight against competing interests in a tight financial climate" (p. 255). Also, they point out that few officials associated planning with evaluation or with assessing the comparative effectiveness of services. For example, they ask the question "how could you choose a balance between sheltered housing and residential accommodation unless you had some idea what you were seeking to achieve in both, what constituted suitability or success from the old person's point of view?" (p. 201). They note that "most administrators who did touch upon this theme did so only to dismiss its practicability" (p. 201).

Wistow (1982) argues that the notion of integrative planning "demands a degree of consensus on objectives which simply does not exist within or between authorities" (p. 55). Rhodes and Green (quoted in Carley *et al.*, 1987) observe that one of the reasons for the lack of success of joint planning is "that naive assumptions have been made about the ways in which professions and organisations work together" (p. 8) and suggest that on larger inter-agency and inter-professional issues "officials acted more as 'negotiators or protagonists' than as colleagues" (p. 8). As Glennerster *et al.* (1982) put it, differences in organisational form and political accountability made collaboration difficult with authorities more often acting "like partisans or competitors than partners" (p. 255).

#### (iv) *Resources for Joint Working*

In discussing the issue of service co-ordination it is important to bear in mind that the basis for arguing for more effective linkage and collaboration in service provision is that adequate resources are already

at hand but that they are dispersed and fragmented by the existing administrative system (Rein, 1970). For example, the Seebohm Committee Report (1968) concluded that a unified Local Authority Social Service Department would rectify various problems associated with the provision of personal social services in Britain. Holman (1978), identifying continuing major deficiencies in the system, argues that the technical inefficiencies in and lack of co-ordination of the social services does not constitute a satisfactory explanation of social deprivation. He argues that if services are themselves impoverished of resources, the effects of rationalisation and co-ordination will be minimal. Better rationalisation which may or may not reduce the deficiencies of fragmentation, duplication, discontinuity and confusion will be of little avail if the services lack the essential resources. In other words, co-ordination is not a satisfactory substitute for shortage of resources (DHSS, 1978). Holman concludes that beyond the analysis of a lack of co-ordination rests a more fundamental political question — "what determines whether agencies will be given adequate resources to co-ordinate?" (p. 174). Wright *et al.* (1988) conclude from their study of inter-agency working in Gloucester that "collaboration worked best where services had sufficient resources and confidence in themselves and in each other to allow 'give and take' to occur" (p. 60).

In approaching the issue of co-ordination it must also be borne in mind that effective co-ordination is not necessarily a cheap option. It entails administrative costs which must be weighed up against the potential benefits it might yield. This point was recognised by the DHSS in the UK in 1978 when it noted that collaboration uses up time and money and that care must be taken to engage in it where it is seen to be a priority. As Dant *et al.* (1989) point out:

efforts to provide co-ordinated care cannot translate directly into savings; the provision must be seen as an extension and improvement of existing community services and funded as such and not as part of a cost cutting policy (p. 40).

Shifting the balance of care towards comprehensive community services based on a joint approach is costly in organisational terms. As Glennerster *et al.* (1982) suggest, joint activity "is not a 'natural' activity" (p. 260) in the sense that "separate organisational processes left to themselves will predominate" (p. 260). If a joint approach is to be successful "the financial and other incentives must be large enough and so structured as to make it worthwhile for both authorities to co-operate" (p. 260). The concept of joint finance was introduced in the UK in 1976 to finance developments by the health authority and local authority where



it was accepted by both authorities that this would yield a better return in terms of total care.

### ***Partnership Between the Statutory and Voluntary Sectors***

In recent years the voluntary sector has assumed a renewed significance in social policy debate and rhetoric. This higher profile for the voluntary sector comes at a time of public expenditure cuts and a general drawing in of the welfare state net. The mixed economy of welfare concept results in an emphasis on partnership between the statutory and voluntary sectors in the provision of social and health services. The concept of partnership between the two sectors implies their strategic co-existence and a high degree of inter-organisational interplay. While this partnership between voluntary and statutory bodies has had a long history — "it has not always been a smooth or an amicable relationship" (Butler and Wilson. 1990, p. 11).

The proponents of welfare pluralism see

the incorporation of voluntary groups and organisations into statutory decision-making as a necessary remedy for the shortcomings of the representative democratic system, and the funding of their activities as a valuable diversification in the face of large-scale public services dominated by bureaucrats and professionals (Brenton, 1985, p. 88).

It may also be the case that "the rhetoric of 'partnership' is a euphemism for a radical transformation of the established patterns of responsibility in the welfare state" (Brenton, 1985, p. 111). The Wolfenden Report (Wolfenden, 1978) on the development of the voluntary sector in the UK expressed the hope that, in future, the voluntary sector would work in a close and more equal partnership than hitherto with the statutory bodies. Indeed, the Report appealed to Government to work out a collaborative social plan with the variety of voluntary agencies in the field in order to make the optimum and maximum use of resources.

While the voluntary sector plays a significant role in the provision of housing, health, and welfare services for the elderly in the Republic of Ireland, its effective integration into the overall care delivery system has not been achieved. The National Social Services Board (1986) states that:

despite common practice in paying tribute to its work, the voluntary sector has been largely taken for granted, its contribution has not been extensively quantified or evaluated nor has sufficient attention

been paid to its difficulties and future development needs which are now increasingly urgent. . . . There is no coherent policy regarding funding of the voluntary sector, nor formal arrangements for communication, consultation, co-operation or co-ordination across the statutory sector (p. 18).

The National Council for the Aged (1983) summarised the problems of the voluntary sector and suggested that the greatest constraint experienced by voluntary groups concerned with the elderly (in common with other groups) was the fact that they were operating in a policy vacuum. In the absence of a policy framework an integrated approach to service delivery was impossible to achieve, according to the Council, and as a result the efforts of voluntary groups and statutory bodies very often did not properly mesh together to achieve their common purpose.

O'Connor (NESC, 1987) refers to the absence of an agreed framework for the involvement of the voluntary sector either in consultation or planning and emphasises the problems associated with discretionary funding. She poses the basic question as to how complementarity between health boards and voluntary agencies in service provision is to be achieved. O'Mahony (1985) concluded from her study on social need and the provision of social services in rural areas that:

the role of the voluntary organisations in the provision of the community care services is somewhat marginal to the mainstream of service provision... the general impression was of a fairly static sector engaged in a marginal role with little reflection or forward planning evident in its approach (pp. 173 — 174).

The Department of Health Working Party on Services for the Elderly (Department of Health, 1988) referred to the uneasy relationship between voluntary organisations and statutory bodies and recommended that the Government should undertake a formal review of the relationship of the statutory and voluntary sectors with a view to establishing national guidelines for the development of a more constructive relationship between the two sectors.<sup>1</sup>

### *The Concept of Partnership*

The notion of partnership implies a certain kind of relationship where both parties have a degree of autonomy and influence in their own

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<sup>1</sup>The Department of Social Welfare is currently engaged in the preparation of a charter for the voluntary sector and the National Council for the Elderly is currently undertaking a study of voluntary organisations working with the elderly in the Republic of Ireland.

spheres. It is debatable whether the term appropriately describes existing or potential relationships between statutory bodies and voluntary organisations.

For very many voluntary organisations who go, cap in hand, to statutory sources for funds, who live with the annual insecurity of bidding for grants vulnerable to cuts, and who have to trim their activities to their funder's priorities, the notion of a partnership may ring a little hollow (Brenton, 1985, p. 87).

Brenton (1985) suggests that "the concept of statutory-voluntary sector partnership has been developed ahead of the reality it prescribes" (p.128). The Barclay Report (Barclay, 1982), while arguing that the two sectors needed each other and "that the characteristic deficiencies of one sector could, to a considerable extent, be compensated by the characteristic strengths of the other" (p. 85), concluded that "the relationship to date between the two sectors could seldom be described as a genuine partnership" (p. 85).

### ***Joint Planning as an Integral Part of Partnership***

A key component of partnership is joint planning and joint assessment of needs. This implies a real participation by voluntary bodies in the decision-making process. "There is surely a crucial difference between voluntary agencies submitting their views, and being actively involved as partners in the statutory decision-making process" (Brenton, 1985, p. 126). In practice, planning is frequently concerned only with "how the statutory body is going to meet its legal responsibilities within its budget allocation" (Leat *et al.*, 1981, p. 18).

The interface between the statutory and voluntary sectors comprises a vast array of conflicting motives and goals on both sides. Voluntary organisations walk a tightrope between maintaining their identity and independence and yet qualifying for statutory funding. Butler and Wilson (1990) refer to the "potency of the funding relationship as eroding strategic autonomy" (p. 15), particularly as the proportion of government funding as a proportion of total income increases. The diversity and nature of the statutory sector and its lack of consistent policies across departments towards the voluntary sector also affect the relationship. There exists a range of attitudes to the voluntary sector among statutory personnel, from the friendly to the hostile (Leat *et al.*, 1981). Voluntary organisation involvement in services planning or provision is sometimes seen to involve elements of professional or political risk or uncertainty which results in a defensive and a cautious approach to

partnership on the part of statutory bodies. The problem is compounded by the fact that the statutory sector, though structurally united in a bureaucracy, is just as diverse as the voluntary sector:

Co-ordinating the diverse elements and legal responsibilities within its own political and administrative framework is the primary complex focus of statutory authorities. Any outside body wishing to influence planning or policy would seem to require a large measure of political sophistication (and staying power). (Leat *et al.*, 1981, p. 18).

There is no clearly recognisable statutory planning or policy-making process on which outside bodies can focus. While there are a wide range of mechanisms for drawing up and considering plans, priorities and budgets, they do not allow for systematic and regular involvement and input by voluntary groups. Statutory duties and responsibilities are the overriding framework within which relationships with outside bodies must fit. Co-ordination thus operates in terms of "its functional relation to statutory goals rather than as a development of pluralist democracy" (Leat *et al.*, 1981, p. 108). Leat *et al.* (1981) conclude from their study of voluntary bodies in the UK that:

the notion of a pluralist planning partnership between the statutory and the voluntary sectors is not one which guides present practice, nor is it yet accepted as the vision which will guide future practice (p. 151).

They found that consultation with voluntary bodies in respect of policy was not the norm among statutory authorities even in cases where there is a good working relationship. Among the reasons cited by the authors for this are "lack of clarity in both sectors concerning the proper role of the voluntary sector within the context of a (statutorily controlled) welfare state, lack of commitment on both sides to a pluralist vision, local statutory defensiveness and lack of consistent central government policy" (p. 151).

### ***Voluntary Sector Representation***

The problem of voluntary sector representation is one which has been frequently addressed and, in particular, the need for a catalyst to promote development in this respect has been identified. Attention has been drawn to the "need for somebody to assist in developing voluntary organisations, in rectifying some of the unevenness within the voluntary

sector, and in bringing together voluntary bodies to consider their contributions to a mixed economy" (Leat *et al.*, 1981, p. 153).

The Wolfenden Report (Wolfenden, 1978) placed a strong emphasis on the need for intermediary bodies to develop, co-ordinate and represent local voluntary bodies. It was argued that there was a need for a single multi-purpose body which could draw together the various disparate interests of local voluntary bodies and represent their views in the policy-making and planning area. The role of the intermediary body would be to assist, support and strengthen individual voluntary organisations and to develop them in such a way as to enable them to participate effectively in joint planning with the statutory sector. Leat *et al.* (1981) argued that the capacity for voluntary bodies to take a more active part in collaborative planning would be limited unless additional resources could be devoted to fostering planning and development within the voluntary sector as Wolfenden envisaged. They concluded, however, that little response was forthcoming from Government in this regard.

Leat *et al.* (1981) point to the "difficulty of trying to represent the voluntary sector whose diversity belies the unity implied in such an abstract conception" (p. 119). Indeed, it could be argued that reference to the 'voluntary sector' is meaningless in that there is not one sector but rather a more or less unrelated collection of groups and organisations engaged in a wide range of activities and characterised only by the fact that they do not belong to either the statutory or the commercial sectors. "To talk about the 'voluntary sector' is, in itself, although a necessary shorthand, to ascribe a homogeneity and unity to this vast range of activities that is totally artificial and misleading" (Brenton, 1985, p. 58).

In addition, it is the case that the voluntary sector itself very rarely demands to be taken as a whole for any significant practical purpose (Leat *et al.*, 1981). For the most part relationships between voluntary organisations and statutory bodies are on an individual basis. Such relationships tend to be functional ones and to be based on questions of resources for specific service provision. In general, they have little to do with overall planning, policy and representation.

The general conclusion drawn by Leat (1983), Brenton (1985) and Butler and Wilson (1990) is that while the rhetoric on voluntary-statutory partnership is strong, the actual practice falls very far short. While theoretical support for the voluntary sector comes easily from the statutory sector and from politicians the reality is that there is little true partnership in practice. As Brenton (1985) points out "there is little sign as yet of voluntary agencies emerging as full participants in planning and policy-making and so gaining equality of status with their local authority

'partners'" (p. 124). In practice, voluntary organisations exercise very little influence upon the funding priorities or upon the totality of services in which they play a part. While there is a sharing of tasks with transfers of funds in one direction and of voluntary sector energies in the other, this exchange cannot be said to have the attributes of partnership as normally understood.

The understanding of 'partnership' as a collaborative relationship between local authorities and local voluntary organisations through which each carries a joint responsibility for planning, policy-making and implementation as part of a whole, and where voluntary agencies enjoy parity of status and influence, is one that exists more in theory than in reality. The reality is that in most areas, with a few exceptions, the two sectors operate as if they were entirely separate (Brenton, 1985, p. 128).

The development of joint planning and effective partnership between the voluntary and statutory sectors requires a planning capability in both the statutory and voluntary sectors and an acceptance by both sectors of an approach to decision-making based on real partnership.

This requires that statutory bodies and voluntary bodies become less focussed on tangible service provision as the prime function of voluntary organisations. Voluntary bodies need to pay equal attention to planning in an overall context as well as 'doing'. As Leat *et al.* (1981) suggest, 'they would need to become more self-critical and evaluative in relation to their own and others' functions, more fact and research orientated' (p. 175). Statutory authorities, in their responsibility for comprehensive planning within the context of partnership between the two sectors, need to go some stages beyond the rhetoric.

## **2.6 Factors which Pre-dispose towards Successful Co-ordination**

The putting in place of effective machinery for inter-agency collaboration presents a major challenge to administrators, planners and policy analysts. The experience to date is less than encouraging. For example, Wright *et al.* (1988) conclude from their study of a project on collaboration between services for the elderly mentally infirm in two health districts in the South of England that most contact between agencies was at such a low level that "one would seriously question whether it could be called collaboration" (p. 48). They conclude that "satisfaction was based on the relatively low expectation of the provision of a specific resource rather than on any concept of a joint approach to client or

patient care" (p. 48) and that "overall, personnel lacked not only the willingness to approach other agencies, but the structure and resources to enable close working relationships to develop" (p. 48).

However, Wistow (1982), commenting on the experience of inter-agency working in the UK to date, concludes that "collaboration has been placed firmly on the agenda of both health and local authorities ... (and that) the experience of joint working has increased understanding of service system inter-relationships" (p. 55). The study of Joint Care Planning Teams carried out by Glennerster *et al.* (1982) found that they were useful in that they

brought people into contact, they legitimated other contacts, they made it easier to pick up the phone and discuss issues with members of the team in the other authority and provided a forum where a new proposal or problems could be aired without it being a crisis or confrontation (p. 199).

They also served the purpose of helping professionals and planners to think about the relationship between the various parts of the service and related gaps in provision and in this sense were a mutual learning exercise. They were, however considered by respondents to have been extremely burdensome in terms of "fitting things into a crowded timetable of fixed activities in your own authority that always had first call on your time" (Glennerster *et al.*, 1982, p.200).

Effective service co-ordination requires appropriate structures, resources and "above all, the will from all the services concerned" (Wright *et al.*, 1988, p. 62). Hunter and Judge (1988) refer to the need "for fundamental change in the thinking and practice of many people currently planning, managing and providing services at both national and local levels (p. 12). They suggest that what is required is a cultural revolution rather than what Brazier and Harris (1975) call "the pious hopes for co-ordination expressed by central government" (p. 255). Such a change in perspective requires:

- (i) the commitment of government to the development of full partnership with non-statutory bodies;
- (ii) the development of a planning capability among all parties to a joint plan so that all activities would be planned and carried out as part of a rational whole;
- (iii) a value-critical analysis of all aspects of co-ordination and a systematic consideration of the attitudes, aspirations and fears of all agencies likely to be involved;

- (iv) the production of a management timetable from day one, setting out what services are to be delivered, to whom, and what has to be done in the intermediate stages to achieve these goals.

Chant (1986) points out that joint working with other agencies "means for most managers the need to learn new behaviours and new-skills" (p.51). This raises the issue of education and training for joint working. Carley *et al.* (1987) argue the case for "modified professional training to reduce divergent outlooks, increased joint in-service training, and increased locally based teamwork" (p.8).

What is required is (i) an ability to agree a basic philosophy of care; (ii) a common approach to defining and measuring need; (iii) an ability on the part of officers from the constituent bodies to carry jointly agreed plans and priorities through their own authorities' planning and budgetary procedures; and (iv) an ability to sustain agreed plans over a period of time despite differences in outlook and responsibilities.

Service integration is essentially an evolutionary process which takes time, time for specific joint projects to become consolidated and time for participating agencies to develop an adequate and comfortable working relationship. Co-ordination and joint working may begin in relatively safe areas auxiliary to the main functions of the organisation. As structures are put in place and informal networks grow, joint working relationships are likely to become more systematic and more integrated.

More frequent and more extensive interaction patterns, more freedom regarding intergroup contacts, more flexible and informal decision rules, more flexible organisational procedures, and less frequent recourse to use of outside influences — all of these tend to result in more favourable attitudes in the working relationship. (Walton, 1966, pp. 420 — 421).

Co-ordination in practice requires administrative structures which lend themselves to addressing these issues and to reconciling, or at least, diverting actual and potential conflicts. Chant (1986) sets out the following as vital components for an effective co-ordination project.

- (i) the designation of a full — or nearly full-time — co-ordinator or 'key worker' at an early stage is enormously helpful;
- (ii) the delineation of clear lines of accountability both horizontally and vertically through what are often large unusual coalitions of executive staff, and the regular clarification of communication along those lines.



The following have been identified by Wright *et al.* (1988) as the key features behind successful teamwork and collaboration:

- (i) positive motivation towards collaboration;
- (ii) adequate resources to reduce the compensation element of one service 'helping' another (and leading to confusion over appropriate referral of cases), and to allow 'give and take' to develop between services;
- (iii) the establishment of formal links — liaison, regular meetings, case discussion;
- (iv) physical proximity to promote face-to-face contact and to increase mutual understanding of roles and resources;
- (v) agreed policies over transfer of cases with clear demarcations between services and specific arrangements for dealing with 'borderline' cases;
- (vi) simplification of administrative structures and boundaries, for example, housing professionals from different agencies in the same building and/or giving individual professionals responsibility for particular geographical areas.

Two of the factors which contribute to successful co-ordination warrant some further elaboration — the *key worker* and the provision of *joint finance*.

### *Key Worker*

The need for a key worker to draw together the disparate elements of the caring network and to supervise the implementation of a jointly agreed package of care for an individual or a group of clients has been frequently referred to in the literature.

Goldberg and Connelly (1982), commenting on the role of social workers with elderly people, suggest that:

the role of case co-ordinator and resource person is coming more to the fore, as various combinations of statutory, voluntary and informal supports are being developed or strengthened and as it is being recognised that these support networks can make their optimal impact only if they are co-ordinated and reviewed regularly (p. 90).

Bulmer (1987) argues that given the likely continuing fragmentation of different services, with all the problems to which this gives rise, the idea of a 'key worker' to co-ordinate care is one which has wide applicability.

The term 'reticulist' has been coined by Power (1971) to describe the role of creating and using co-ordination networks through:

- (i) the development of communication between members of a multi-organisation by sounding out opinion, bringing issues which require joint decision-making to the attention of the appropriate people, and generally acting as a contact person/trouble shooter;
- (ii) initiating and cultivating a network of human relationships in such a way as to maintain access to information about changing problem situations;
- (iii) sounding out opinion in his sponsoring organisation, implementation agencies and interest groups and putting forward possible solutions which will enable mutually acceptable adjustments to take place between them.

Brazier and Harris (1975) suggest that "inter-authority planning is likely to be much more successful where authorities have specifically allocated staff to perform reticulist roles; and where arrangements are made for frequent contact between members" (p. 264).

In 1985 Gloucester Health Care Authority in the United Kingdom, in conjunction with The Open University and Policy Studies Institute, established a research and development project in respect of care for elderly people at home. A main assumption of the Gloucester project was that their social situation and needs could not be simply categorised as 'social' or 'medical'.

The service innovation in Gloucester was based on the provision of key workers, called care co-ordinators, attached to three primary health care teams in the area. There were three aspects to this role:

- (i) gathering and exchanging information on services and resources available locally that may help elderly people to remain in their own homes for as long as possible;
- (ii) gathering information for research purposes both on the effect of services on individuals and on the general availability and appropriateness of services;
- (iii) assessing the individual needs of elderly people who were patients of the practice and assisting in meeting these needs.

An interesting outcome of the care coordinator's role identified by Pharaoh (1989) was that it brought to light the fact that "lack of

information about possibilities, or lack of awareness could limit service provision as much as shortages in resources" (p. 2).

An innovative feature of the Gloucester project was the use of a biographical approach in understanding people's current needs. This involved a consideration of people's past experience with a view to offering appropriate and acceptable services. On the basis of agreed needs the care co-ordinator set up a 'package of care' that linked statutory, voluntary and informal services to enable the elderly person to remain at home. The use of the biographical approach, however, produced its own tensions. The care co-ordinators found that in some instances more immediate and pressing needs of their clients had to take precedence over planning for the longer-term. However, it was found that addressing immediate needs often became the key to acceptance of the care coordinator's involvement (Pharoah, 1989).

In 1977 the Kent Community Care Scheme (Challis and Davies, 1980) in the UK also appointed case managers (qualified social workers) with responsibility for providing a community care alternative to people who were seeking or considered to be in need of residential care. This involved designing, managing and monitoring a package of care utilising existing resources — statutory and informal — to support the elderly person at home. The main emphasis was on the provision of individually-tailored services to support normal service provision.

In Ireland the National Council for the Aged (National Council for the Aged, 1985a) recommended that each local authority and each health board should designate an officer to be responsible for liaison in designing structures and services to maintain and support elderly people in the community. These officers were seen as having responsibility for such matters as joint planning, information sharing, joint financial allocation where appropriate (e.g., sheltered housing) and joint in-service training for selected staff of both agencies. The Department of Health Working Party on Services for the Elderly (Department of Health, 1988) recommended that health boards should appoint a co-ordinator of services for the elderly in each community care area. It also recommended that the function of co-ordinating services for the elderly at district level (population of 25,000-30,000) should be the responsibility of a district Liaison nurse. Some health boards have appointed personnel to service co-ordination roles. For example, the Eastern Health Board has appointed an overall co-ordinator of services for the elderly and a medical co-ordinator of services for the elderly in each community care area with responsibility for planning services for the elderly. The Eastern Health Board has also established a number of district teams to organise care at home for short periods of time for selected elderly persons and

has appointed senior public health nurses to co-ordinate these teams. The North Western Health Board has appointed a co-ordinator in each community care area with responsibility for managing services for the elderly and for co-ordinating hospital and community services in respect of the elderly. Seventeen district co-ordinators have also been appointed with responsibility for co-ordinating services for the elderly in the district, including in-patient services. The Southern Health Board established a district care team on a pilot basis in 1990 covering a section of Cork City in order to co-ordinate all health services at the operational level and to promote the concept of inter-disciplinary teamwork (Southern Health Board, 1991).

### ***Joint Finance***

The issue of resources raises the question of finance for joint working and innovative development and, specifically, the question of joint finance. This was a significant development in the UK which, according to Booth (1983) "changed the face of collaboration and joint planning" (p. 26).

Above all, joint finance taught that some sort of tangible inducement, in the form of a reward or sanction, which can be measured in terms of their own organisational interests, was an essential ingredient of any partnership between the health and social services (Booth, 1983, p. 27).

This point was recognised by the DHSS in the Consultative Document on Care in the Community (DHSS, 1981), when it stated that to be successful, any scheme "should contain some incentive for both health authorities and local government" (Par. 7.1).

Joint finance has been described by Glennerster *et al.* (1982) as "one of the most successful innovations of the new joint machinery" (p. 169). The importance of joint finance has been recognised by the Government in the UK. It was seen as having

provided a real incentive for health and local authorities to work together, in part at least, because the money cannot be spent unless both parties agree. . . . (It) has pump-primed many valuable and innovative joint social and health care developments" (Government White Paper, 1989, p. 51).

Joint finance facilitated new modes of interaction and practice and provided the necessary currency for bargains to be struck "and compensated for the cost of such transactions" (Glennerster *et al.*, 1982, p. 169). One of the reasons for the success of joint finance was that "it was

almost the only development or growth money there was... and therefore concentrated attention on producing proposals that fell into that category" (Glennerster *et al.*, 1982, p. 162). However, on the negative side, the putting in place of proposals to avail of joint finance tended "to push longer term planning discussions aside" (Glennerster *et al.*, 1982, p. 162).

## **2.7 Summary**

This chapter has traced and summarised the key issues pertaining to service co-ordination as found in research literature. It has sought to point to the sheer complexity of the concept of co-ordination, to draw attention to its many facets and to highlight the major challenge facing policy planners and administrators in their efforts to come to grips with the phenomenon of co-ordination. It has also noted the many problems associated with service co-ordination in practice and identified some of the factors which pre-dispose towards successful co-ordination. Some of these points will be taken up again in Chapter Seven with particular reference to the experience of the pilot co-ordination projects and their applicability to the development of a policy on service co-ordination in the Irish context.

## CHAPTER 3

# Evaluation of the Pilot Projects: The Research Approach

### 3.1 Introduction

The *Terms of Reference* (National Council for the Aged, 1987) for the pilot projects stipulated that an independent evaluation of both projects be carried out. This function was undertaken by the National Council for the Aged. Initially, a full-time researcher was appointed on a contract basis for a period of one year to work with the Council's research officer on the project evaluation. From October 1988 onwards the evaluation was undertaken by a researcher working on a part-time contract basis. The purpose of the evaluation was to monitor and record the development and main outcomes of the pilot projects. The evaluation of pilot projects, which are effectively social experiments, is important because it so often happens that the valuable insights from innovative social experiments are lost due to the absence of mechanisms for monitoring and evaluation. Whatever the outcomes of social experiments, whether positive, negative or neutral, the insights gained from the venture have much to contribute and so should be recorded and analysed. In the case of the co-ordination of services for the elderly at local level there were important structural, inter-agency and inter-professional issues which came into focus during the course of the present projects. The identification and assessment of these issues is important for policy-making and service integration. This chapter describes the methodological approach used in the evaluation of the pilot projects, sets out the research objectives, identifies the research problems encountered and outlines the main research tasks and strategies.

### 3.2 Research Objectives

The main objective of the evaluation of the pilot projects is to identify the factors and processes which impinged on the development, programme of work and outcomes of the two projects. The subsidiary objectives are as follows:

- (i) to analyse the development, organisation and functioning of the projects;
- (ii) to identify and document the experience and outcomes of the two pilot projects;
- (iii) to identify significant factors and relationships which had a bearing on the functioning and outcomes of the projects;
- (iv) to identify factors and issues which are likely to be generalisable to the domain of local service co-ordination for elderly persons;
- (v) to set out the main policy implications arising out of the experience of the pilot projects.

### 3.3 The Methodological Approach

The evaluation of projects or programmes is undertaken in order to provide feedback which will assist decision-making on management objectives, programmes and resource allocation. It provides detailed and systematic analysis of programme objectives, processes and outcomes. Wholey *et al.* (1971) consider that evaluation "assesses the effectiveness of an ongoing program in achieving its objectives ... (and) aims at program improvement through a modification of current operations" (p. 23). While it may be the case that "social evaluation cannot and will not optimise resource decisions" (Carley *et al.*, 1987, p. 11) it is very likely that it can contribute to improvements in programme content and implementation.

Some authors distinguish between evaluative research which should be aimed at contributing to new knowledge and programme evaluation which addresses questions about specific programmes. Perkins (1983) suggests, however, that "the scientific methods that have been developed for classical research are equally appropriate for programme evaluation". Rossi (1971) argues that there are no formal differences between 'research as such' and 'evaluation research'.

Research designs, statistical techniques, or data collection methods are the same whether applied to the study of the most basic principles of human behaviour or to the most prosaic of social action programs (p. 97).

What distinguishes evaluation research from other types of research is "not method or subject matter but intent — the purpose for which it is done" (Weiss, 1972, p. 6). The main function of evaluation research is to inform the policy-making process. In this context information on why a particular approach or action plan is not working may be just as valuable

and instructive in policy planning and formulation as information relating to successful implementation.

In the case of the pilot projects on the co-ordination of services for the elderly at local level the evaluation focussed on the specific structures and mechanisms put in place on a pilot basis and consisted of the systematic application of social research procedures in assessing their "conceptualisation, implementation and utility" (Rossi and Freeman, 1985, p. 19).

The research methodology used in the evaluation was based on the principle of triangulation and on the concept of 'pluralistic evaluation' (Smith and Cantley, 1985). Triangulation is a process of "building checks and balances into a design through multiple data collecting strategies" (Patton, 1987, p.60). This process is characterised by the use of multiple approaches to ascertaining project outcomes. It allows for data to be drawn from a range of sources using complementary methodologies. Bloor (1978) points out that "the appropriate methodology for any given study can only be chosen with reference to situational factors, factors specific to the study in question" (p. 345). In the case of the pilot projects it was necessary to adopt a research design appropriate to the task. This required a methodological approach which would allow the key aspects to emerge, to crystallise and to be refined over time. It required an approach broadly similar to that used in ethnographic research in which "both questions and answers must be discovered in the social situation being studied" (Spradley, 1980, p. 32). This involved using a number of methods to monitor project development and to identify and validate the researcher's perceptions on various aspects of the functioning and development of the two pilot projects. The process of ascertaining the perceptions of project participants was particularly important in this context. Here it is important to recognise that the classic scientific research paradigm is not easily applicable to complex social realities. Therefore, in a complex situation such as the pilot project context, it is very difficult to be totally absolute about any findings irrespective of what methodologies are used. The researcher cannot, for example, know for certain that his/her perceptions of social processes are valid where indisputable causal relationships have not been established. Rather, the researcher operates on the basis of marshalling a variety of pieces of evidence in order to establish a probability which may have some influence on policy thinking. As Hunter *et al.* (1988) point out:

All one can hope to achieve in such circumstances is a description of decision-making which, although incomplete, is acceptably accurate in its essentials and where the missing pieces do not distort reality to the point at which it becomes invalid (p. 23).



The researcher can, however, strengthen the validity of his/her observations by using a number of data collection methods. In the case of this study, three principal methods of data collection were used in the evaluation of the pilot projects — (i) participant observation, (ii) documentary analysis and (iii) in-depth interviews with project participants. These were augmented by a fourth method, (iv) a process of negotiating realities.

#### *(i) Participant Observation*

The participant observation was carried out in two distinct phases. During phase one of the projects the researchers participated in all project committee meetings in so far as this was practicable. They acted in an advisory and information providing capacity to the committees while at the same time documenting and recording key aspects of the committee process in each project. While every effort was made to attend all committee meetings during phase one of the projects, the number of meetings held and the geographical locations of the two projects sometimes made this impossible. During phase two of the projects (January, 1989 — December, 1991) the nature and extent of the participant observation changed. There was only one part-time researcher and, consequently, participation had to be restricted primarily to the meetings of the two project steering committees. The researcher attended nineteen meetings in respect of the Dun Laoghaire project and sixteen meetings in respect of the Tipperary S. R. project between 1989 and the end of 1991. Detailed notes of all meetings attended were kept which were subsequently written up, processed under thematic headings and analysed by the researcher. In addition to attendance at committee meetings during phase two, the researcher also held meetings with the development worker in each project on at least a quarterly basis.

#### *(ii) Documentary Analysis*

Two types of documentary analysis were undertaken by the researchers.

- (a) All documents relating directly or indirectly to the projects (minutes, progress reports, policy documents, position papers) were examined and key issues and trends were distilled.
- (b) During phase one census data pertaining to the two project areas together with housing and health services data for the two areas were analysed and profiles of the areas were compiled. This data was presented in the *Interim Evaluation Report* (Browne, 1989).

### *(Hi) Interviews*

Current project committee personnel (totalling eighty five<sup>1</sup>) were interviewed during the final year of the projects in order to establish a broadly-based picture of the development of the projects and the issues arising from the experience. The researcher was assisted in this task by a colleague and a semi-structured interviewing schedule was used. Local committee members in both projects were interviewed during May, 1991 and steering committee members were interviewed during September, 1991.

### *(iv) Negotiating Realities*

These three methods of data collection were supplemented by an additional method, which was a process of negotiating realities and validating the researcher's perceptions of events and outcomes. This was arrived at by way of a four-stage process carried out during the final year of the projects and involving the researcher and key personnel in each project. Firstly, the researcher interviewed the steering committee chairperson of each project using a semi-structured interview format. Secondly, the researcher drew up a comprehensive series of headings and topics relating to various aspects of the projects and requested a written report under these headings from the development worker in the case of the Dun Laoghaire project and both from the steering committee secretary and development worker in the case of the Tipperary S. R. project. (In the latter case the development worker was only in post for the final year of the project). Thirdly, the researcher drew up a draft position statement on each of the projects on the basis of the interview carried out and report received in each case. Fourthly, this draft position statement was circulated to the chairperson and development worker in each project who provided feedback to the researcher. These position papers set out key aspects and issues in respect of the establishment, development and outcomes of the pilot projects and provided an additional research tool.

### *Processing of Data*

Because of the range of research methods used in the evaluation process the research data was in the form of documents, field notes, observations and interview notes, all of which constituted a large volume of written material. The processing, ordering and categorisation of this material was a complex process which required the continuous identification and

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<sup>1</sup>It was not possible to arrange interviews with four current committee members. Four key former committee members were included in the list of respondents.

refinement of themes so as to incorporate the wide range of experiences, happenings and perspectives that came through in the research.

The process began with making broad descriptive observations which gave an overview of what was perceived to be happening. These were followed by a gradual progression towards more focussed observations which in turn enabled the distillation of key factors and the identification of significant themes. Because of the variety of research methods used it was possible to cross-check emerging trends and refine them accordingly. For example, it was possible to check findings that had emerged from the documentary analysis and participant observation in the interviews with project personnel.

### *Evaluation Framework*

The conceptual framework used in the evaluation was adapted from Powley and Evans" (1979) (See Fig. 3.1). This framework incorporates three inter-related and not altogether distinct phases:

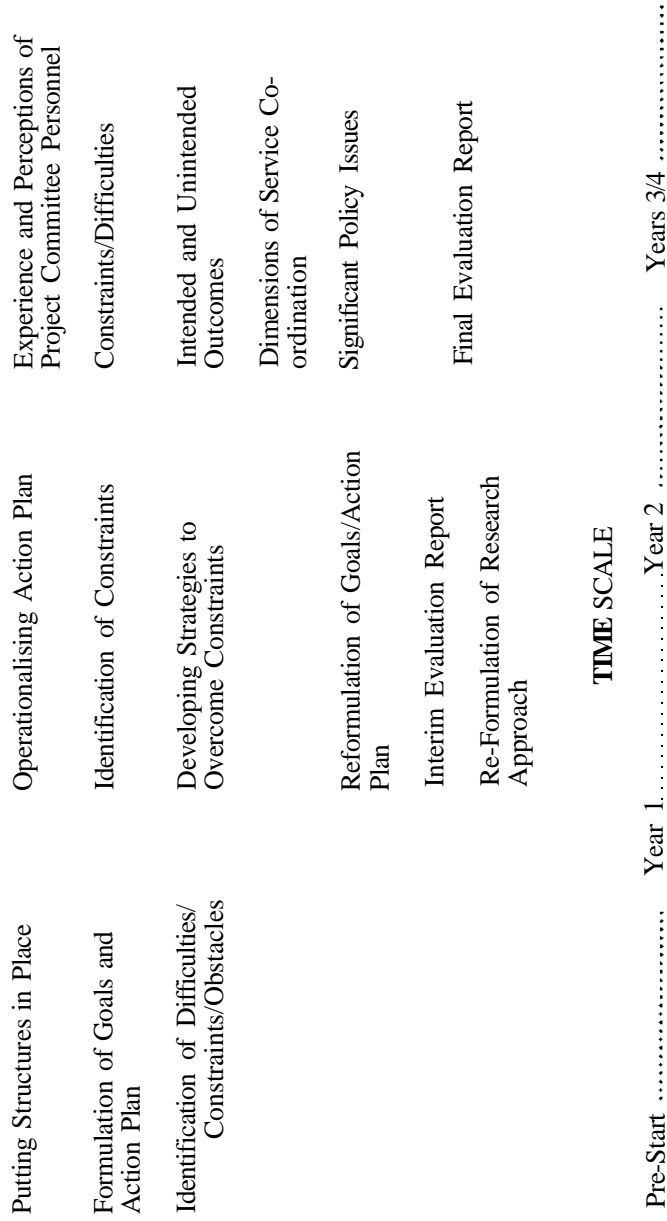
- (i) the initiation of the project which includes the formulation of project goals and action plan and the identification of relevant structures;
- (ii) the operationalisation of the project action plan which may involve some redefinition of project goals as constraints or obstacles come to light;
- (iii) the assessment of final outcomes in terms of the project goals and also identifying latent or unintended consequences.

The *Interim Evaluation Report* on the pilot projects (Browne. 1989) outlined the main aspects of the initiation phase and discussed issues and problems relating to this process. The present report deals with key issues relating to the development, operation and programme of work of the projects. The assessment of the final outcomes of the pilot projects constitutes a major part of the report. The achievements of the projects are outlined, the constraints and difficulties are analysed, the main issues arising are identified and the policy implications are considered.

## **3.4 Research Problems Encountered**

There were a number of research problems which were encountered during the evaluation of the pilot projects. Firstly, the project *Terms of Reference* envisaged a level of needs assessment and related specific goal-setting by the projects which in hindsight proved not to be feasible. The research approach was initially conceived in terms of assessing the

**FIGURE 3.1: Framework for evaluation of project**



match between goals and outcomes. In order to facilitate this approach the researchers made considerable efforts during phase one to get the projects to set specific goals and targets. This process has been described and the issues arising from it considered in the *Interim Evaluation Report* (Browne, 1989). As the projects evolved, the research approach was adapted in order to cater for the more *ad hoc* approach to the setting of goals adopted by the projects. The key elements of this approach have been set out in 3.3 above.

The second research problem encountered related to the issue of resources. Neither the projects or the researchers had the resources available to carry out the type of needs assessment envisaged in the *Terms of Reference* and this affected the process of goal-setting. In addition, neither project appointed a project development worker at the outset and, as a result, the researchers adopted a strong action/animation role in respect of the development of the projects during phase one. While this was considered to be an essential role at the time, it did, however, result in some dilution of the primary evaluation role of the researchers. Another aspect of resources which affected the evaluation of the pilot projects was the fact that there was only one researcher working part-time (average 12 hours per week) on the evaluation for all of phase two and for the final three months of phase one. (i.e. October 1988— December 1991). There were thus considerable limitations on the amount and nature of the actual research work that could be carried out. This was particularly problematic because of the complex nature of the research methodology used in the evaluation (See 3.3 above). A third research problem encountered related to the role of the National Council for the Aged. The Council was responsible for the evaluation of the pilot projects. An advisory committee appointed by the Council to monitor its progress during phase one met on only two occasions. There was also a period of ten months (May 1989 — March 1990) when, with the expiry of the Council's term of office, this committee was also disbanded. This meant that the systematic consideration of issues and developments which might have been facilitated by such a committee was a significant missing link at a crucial stage in the evaluation process. While a broadly-based consultative committee was established by the incoming National Council for the Elderly in March 1990, by that stage the evaluation framework had been finalised by the researcher on the basis that the pilot projects were due to finish by December of that year. (The role and functioning of this consultative committee is considered in Chapter Seven of this report).

The final research problem identified here concerns the *Interim Evaluation Report* (Browne, 1989) on the pilot projects compiled by the

researchers at the end of phase one (December 1988). This report presented detailed demographic data on each project area and sub-area, provided a broad profile of services in each area, identified the main issues arising from the projects to date and set out an agenda of future tasks. The Interim Report was prepared as part of the evaluation process and was intended by the researchers to be of assistance to the projects. The report, however, had relatively little impact on the projects and failed to fulfill the role intended. This matter is considered more fully in Chapter Seven.

### **3.5 Main Research Tasks**

The following were the main research tasks undertaken:

- (i) an assessment of the functioning of the project structures:
  - did the committees function effectively?
  - did the voluntary/statutory sectors integrate at committee level?
  - did the health and housing sectors integrate at committee level?
  - was there an input from the target group (elderly persons and their carers)?
  - were difficulties acknowledged and dealt with where possible?
  - role of development worker;
- (ii) the identification of factors which enhanced or hindered the co-ordination process;
- (iii) identification of the outcomes of the projects
  - programme of work of each project
  - specific services established
  - impact on service co-ordination
  - match between goals and outcomes
  - unintended outcomes
  - difficulties encountered;
- (iv) the identification of project outcomes that are generalisable to

other areas, and which are likely to have application at wider regional and national policy-formulation levels;

- (v) the identification of the professional, institutional and structural considerations affecting co-ordination of services at local level.

### **3.6 Summary**

The purpose of the evaluation is to investigate the nature and extent of co-ordination between the various partners providing services for the elderly in the context of the two pilot co-ordination projects. Of particular importance is an investigation of the ways in which effective links were achieved and the circumstances and factors which impeded this process. The results of these investigations are documented and set out in the present report and their general implications are considered. This chapter has described the research methodology used in the evaluation of the projects and has pointed to some of the research problems encountered. The following chapter will describe the establishment, committee structure and programme of work of the two pilot projects.

## CHAPTER 4

# Establishment, Committee Membership and Programme of Work of the Two Pilot Projects

### 4.1. Introduction

This chapter describes the pilot project structures and the proposed committee membership and functions. It also sets out the main working objectives as adopted by the projects. It traces the establishment of the project committees in the two pilot project areas and outlines the actual core membership of these committees. It also sets out in a general way the programme of work undertaken by both projects and identifies the principal issues addressed. The process of appointing project development workers is described and the role of inter-project meetings is also discussed.

### 4.2 Project Structures

#### *Steering Committee*

The project *Terms of Reference* (National Council for the Aged, 1987) stipulated that the project steering committees were to be the primary project structures with responsibility for the establishment, development and monitoring of the project activities and structures. The main function of the steering committees was set down in the *Terms of Reference* as a planning one in respect of services for the elderly in the project areas. This required project steering committees to develop an overview of existing needs and services in the areas and to bring together existing service-providers in order to provide an integrated and comprehensive range of services to meet identified needs. A series of subsidiary functions for the steering committees were set out in the *Terms of Reference*:

- (i) to assess the special accommodation, health and welfare needs of the aged in the area having regard to local social and demographic factors;



- (ii) to propose programmes of action to the parent statutory authorities for meeting these needs;
- (iii) to make recommendations to the parent statutory authorities on the priorities which should be adopted;
- (iv) to co-ordinate the implementation of agreed programmes and regularly evaluate the effectiveness, efficiency and degree of satisfaction with the accommodation and support services for the aged provided by statutory authorities and by voluntary bodies;
- (v) to maintain contact with regional, national and international developments in providing for the special needs of the aged, and, in particular, to identify "good practice" in other areas that might be followed;
- (vi) to provide a mechanism for the integration of services for elderly persons provided by the voluntary sector and the private sector;
- (vii) to engage in two-way liaison with the local committees, (the membership and functions of which are set out below).

The composition of the project steering committees recommended in the *Terms of Reference* was as follows:

- a senior health board administrator (with clearly designated responsibility for matters relating to the elderly);
- a senior local authority administrator (with clearly designated responsibility for matters relating to the elderly);
- the director of community care for the designated area;
- the superintendent public health nurse for the designated area;
- a consultant physician in geriatric medicine;
- a representative of the voluntary sector;
- other relevant personnel to be co-opted by the steering committee as deemed necessary.

### ***Local Committees***

The *Terms of Reference* for the projects also required that each steering committee establish local committees to co-ordinate services for catchment areas of 15,000 — 20,000 population. The recommended membership of these local committees was:

- a public health nurse;

- a home-help organiser:
- a social worker:
- a physiotherapist;
- a general practitioner:
- an occupational therapist:
- representatives of local active voluntary organisations;
- an officer designated by the housing authority:
- an officer designated by the health board:
- family carers:
- elderly people.

The functions of the local committees as set out in the project *Terms of Reference* were to:

- (i) co-ordinate the delivery of services to the elderly at this level so as to ensure the most effective use of local resources;
- (ii) identify the needs of the elderly in the area and the local resources with a view to informing the planning process in the designated area:
- (iii) maintain an up-to-date inventory of the elderly persons likely to be "at risk" in the area and carry out a regular assessment of their needs:
- (iv) evaluate regularly the contribution of existing systems of service provision both voluntary and statutory:
- (v) provide an advocacy role for individual elderly persons with relevant service agencies, (e.g. in relation to an application for a local authority dwelling or an application for a home help service):
- (vi) maintain close contact with institutional facilities both private, voluntary and statutory in the area:
- (vii) make recommendations to the steering committee as to how services should be developed in the particular local area.

### **4.3 Project Objectives**

The *Terms of Reference* proposed a committee structure for the pilot projects and set out a series of committee functions as outlined above

but did not identify project objectives. However, the following set of working objectives, drawn up by the National Council for the Aged evaluation team, were endorsed by both projects at the outset:

- (i) to improve the quality of life and level of care for elderly persons in the designated areas:
- (ii) to develop mechanisms for inter-agency collaboration (initially the steering and local committees) which would improve the delivery of care services to the elderly:
- (iii) to identify and document the special health, accommodation and general welfare needs of the elderly as perceived by:
  - elderly persons themselves
  - their family carers
  - professional carers
  - health, housing and voluntary body policy-makers and administrators;
- (iv) to ensure that sufficient and appropriate information was gathered to enable future planning of "good practice" service provision for the elderly:
- (v) to establish an accurate and detailed profile of the target population and subtarget groups:
  - the elderly
  - those elderly most at risk
  - kin-carers;
- (vi) to establish an accurate and detailed profile of the existing health, housing, welfare and social services for the elderly and the structures (both voluntary and statutory) underpinning them.

These objectives formed the backdrop against which the project structures were put in place in both pilot areas and provided the basis for the initial approach to identifying a programme of work by each project and for carrying out the functions as set out in the *Terms of Reference*.

## **4.4 Dun Laoghaire Project**

### *4.4.1 Establishment of Project Committees*

The Eastern Health Board co-ordinator of services for the elderly

was assigned administrative responsibility for the Dun Laoghaire pilot project and for putting the structures in place. The inaugural meeting of the project steering committee was held in May 1987 and was attended by the director of community care, the superintendent public health nurse, the co-ordinator of services for the elderly, the housing officer for Dun Laoghaire Corporation and an officer from the health board general hospitals programme. The committee unanimously nominated the Dun Laoghaire Corporation representative to be the chairperson of the steering committee. At this meeting the project *Terms of Reference* were accepted. An officer of the general hospitals programme of the Eastern Health Board was designated to act as secretary to the committee. It was agreed that the pilot phase of the project should be for three years (this was subsequently extended to four years). It was decided that the four persons nominated to the steering committee from statutory bodies should retain membership of the committee for the full period of three years and that additional members should be co-opted for an initial period of one year after which consideration would be given to replacing them by other representatives of the agencies, sectors or disciplines concerned. The difficulty of identifying representatives from the voluntary sector and the private sector was noted at the inaugural meeting and a decision was taken to invite the Society of St. Vincent de Paul and the Irish Private Hospitals and Nursing Homes Association to nominate representatives to the steering committee for its first year of operation. Representatives of these two organisations and a consultant physician in geriatric medicine were co-opted to the steering committee in July 1987. Consideration was given by the steering committee to co-opting a psycho-geriatrician but the view was taken that the services of such a person could be more effectively used on a consultancy basis as required. The committee did not pursue this option during the course of the project.

At the inaugural meeting of the steering committee it was stated that the health board would make available to the project the equivalent of one person (whose rank was not specified) for one day per week to carry out work in respect of servicing committees and any other administrative work associated with the project. It was pointed out that the health board was not in a position to deploy an officer to work full-time on the project as stipulated in the project *Terms of Reference*.

### Local Committees

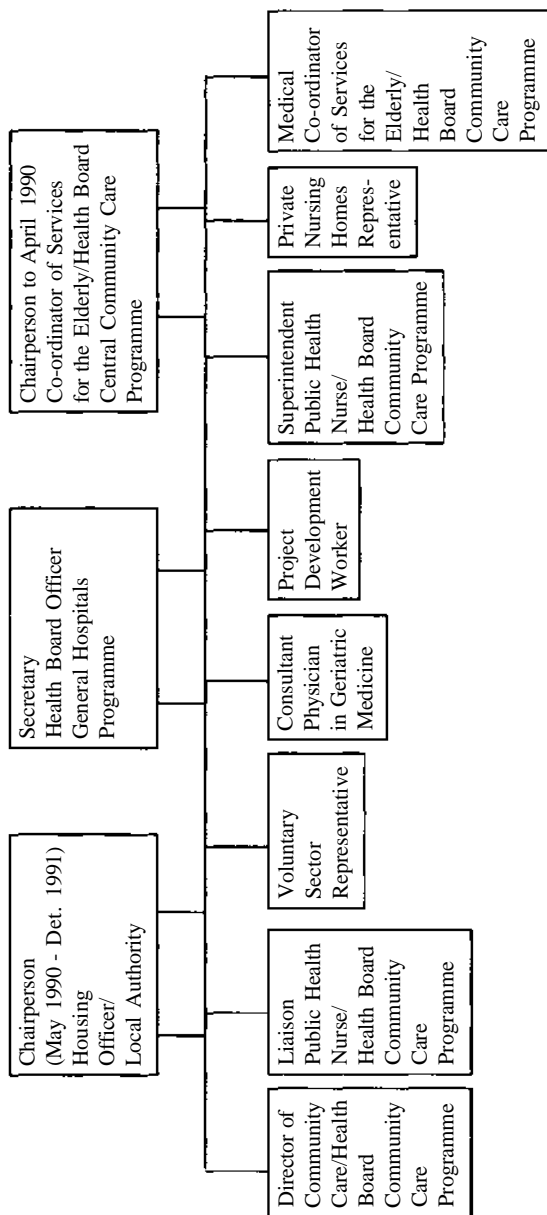
The first task undertaken by the Dun Laoghaire project steering committee was the establishment of the local committees in accordance with the *Terms of Reference*. While it was considered desirable to have three

local committees for the project area, the lack of availability of statutory personnel to act on the committees made this impracticable. It was decided, therefore, to establish two local committees for the project area, one, the Blackrock local committee, to cover the Blackrock/Boosterstown/Sallynoggin catchment area (population 25,900) and the other, the Dun Laoghaire local committee, to cover the Dun Laoghaire/Dalkey/Glasthule catchment area (population 28,800). The steering committee organised an introductory meeting to discuss the project structures and the role and functions of the local committees (as stated in the *Terms of Reference*) with the personnel involved. Personnel from the statutory agencies were nominated by their respective agencies to act on the local committees. The secretary to the steering committee was nominated to both committees to act as liaison person between the steering committee and the local committees. The chairpersons for the two local committees were nominated by the steering committee, a representative of the voluntary sector in the case of the Dun Laoghaire local committee and a trainee registrar in community medicine in the case of the Blackrock local committee. The co-option of non-statutory personnel on the local committees was by invitation from the steering committee. A physiotherapist from Leopardstown Park Hospital (which caters for some of the elderly from the project area) was asked to be a member of both local committees. (During the course of the project she was appointed as community physiotherapist by the Eastern Health Board). A medical social worker from St. Michael's Hospital (voluntary) was invited to be a member of the Blackrock committee and a medical social worker from St. Colmcille's Hospital, Loughlinstown, (Eastern Health Board) was invited to be a member of the Dun Laoghaire local committee — both hospitals catered for elderly people from the project area. Two general practitioners working in the area and known to health board personnel were invited to participate, one on each of the local committees. The Society of St. Vincent de Paul was asked to nominate a representative for each of the local committees and did accordingly. The two local committees for the Dun Laoghaire project area were established by November 1987. A full time project development worker was employed on a contract basis by the Eastern Health Board and commenced work in November 1988. Two one-day training courses in committee functioning and procedures were organised for local committee members during the final year of the project.

#### 4.4.2 *Committee Membership*

The membership of the Dun Laoghaire project steering committee is set out in *Figure 4.1*. The core membership of the committee remained the same throughout. The membership was extended during phase two by

### Actual membership structure of Dún Laoghaire project steering committee 1989 • 1991



Notes (1) The liaison public health nurse and the medical co-ordinator of services for the elderly were on the committee in their capacities as chairpersons of the two local committees.

(2) The project development worker attended all meetings of the steering committee.

the co-option of the chairpersons of the two local committees in April 1989. There were three different steering committee chairpersons during the course of the project. The initial chairperson, the local authority representative, resigned in February 1988 and was replaced as chairperson by the Eastern Health Board co-ordinator of services for the elderly. The latter resigned as chairperson in May 1990 and was replaced by the local authority representative who remained as chairperson until the end of the project. There were changes in personnel in the case of the voluntary sector and private sector representatives and in the case of the director of community care. There were also changes of personnel in respect of the chairpersons of the two local committees who were co-opted on to the steering committee.

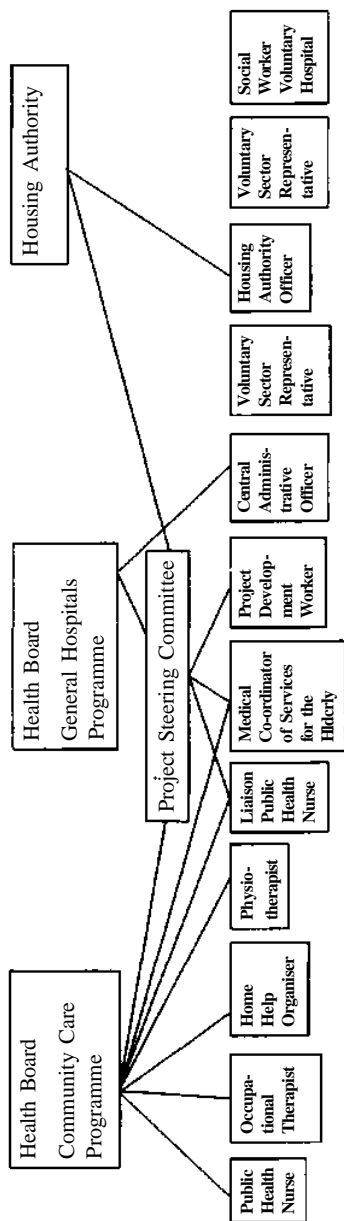
The core membership structure of the Dun Laoghaire project local committees is set out in *Figure 4.2*. During phase one four people, the occupational therapist, the physiotherapist, the registrar in community medicine and the steering committee secretary were members of both local committees. There were a number of changes of personnel on the two local committees during the course of the project. The chairperson of one of the committees (registrar in community medicine) resigned in April 1990 on transfer to another health board community care area and the chairperson of the other local committee (a voluntary sector representative) resigned in June 1990. These were replaced as chairpersons by health board officers in both instances, the medical co-ordinator of services for the elderly in the area in one instance and by a liaison public health nurse in the other case, both of whom had joined the committees at the end of phase one of the project. Three of the people with dual membership of the local committees during phase one opted for membership of one committee during phase two. There were two changes in personnel in respect of the local authority representatives on the committees. Additional voluntary sector personnel were co-opted on to both committees and at the end of the project there were four voluntary sector representatives on one of the committees and two on the other. In the case of both committees, general practitioner involvement ceased with the resignation of the general practitioner from one of the committees in June 1988 and the death of the general practitioner on the other committee in June 1990. The social worker on one of the committees also resigned in July 1988 and was not replaced. Family carers were co-opted on to both local committees but did not continue as members.

#### 4.4.3 *Programme of Work*

During the period up to the end of 1988 (phase one of the project)

FIGURE 4.2

Actual core membership structure of Dun Laoghaire project local committees 1989 -1991



- Notes
- (1) The liaison public health nurse and the medical co-ordinator of services for the elderly acted as chairpersons of their respective committees during phase two.
  - (2) The occupational therapist was a member of one of the committees and the physiotherapist was a member of the other committee during phase two.
  - (3) There were four voluntary sector personnel on one of the local committees.
  - (4) There was no social worker on one of the local committees during phase two.
  - (5) There was no general practitioner on one of the local committees during all of phase two and none on the other committee from June 1990 onwards.
  - (6) The project development worker attended all meetings of the local committees.



the Dun Laoghaire project committees set about assessing the special accommodation, health and welfare needs of the elderly in the project area in accordance with the working objectives set out in 4.3 above and some work was undertaken in this regard. The project *Terms of Reference* implied a fairly rigorous quantitative approach to needs assessment which would facilitate the setting of specific goals and service targets for the project and the carrying out of project committee functions. In practice, the Dun Laoghaire project had difficulty in carrying out this task. While much work was done in terms of examining and considering existing records and information from the various agencies and disciplines involved in the project and while some small-scale surveys were carried out, an overall comprehensive assessment of needs was not completed. This process did, however, help to identify and highlight a number of key service issues which needed to be addressed.

As the committee structure was gradually consolidated, the Dun Laoghaire project focussed on five main areas of work during phase two:

- (i) the establishment of a voluntary/statutory forum to enable voluntary and statutory personnel working with the elderly to co-ordinate their activities and interventions;
- (ii) the establishment of an additional day care centre for the elderly in the project catchment area;
- (iii) the development of additional support systems for family carers of elderly persons;
- (iv) the identification of key service and co-ordination issues in the light of the experience of the pilot project;
- (v) compilation of a project report.

#### *(i) Voluntary/Statutory Forum*

The establishment of a forum to co-ordinate the voluntary and statutory sectors of service provision for the elderly was undertaken by one of the local committees. The forum was envisaged as a mechanism where the various support services for individual elderly persons could work together in a manner of which complementarity was the essence. The operationalisation of the forum concept took the form of discussions with a range of voluntary bodies in the catchment area over a number of months so as (i) to explain the nature and purpose of the proposed forum and (ii) to elicit the co-operation of the relevant voluntary groups. As part of this process a general meeting was held in February 1990 between representatives of the statutory sector, representatives of a large range of voluntary bodies working in the area and representatives

of the pilot project. The voluntary/statutory forum concept was not advanced, however, beyond this stage during the course of the pilot project.

#### *(ii) Establishment of Day Care Centre*

This task was undertaken by the Blackrock local committee. The location identified for the day care centre was a local authority housing complex which was managed by a local voluntary group. The development of the day centre project, therefore, necessitated the involvement of the local authority, the voluntary body, the health board and an additional pool of volunteers. In the foregoing context the concept of the day care centre was progressed systematically, with issues of cost, funding mechanisms, refurbishment and installation programme, transport, staffing, management, activity programme and potential clientele being identified and dealt with as appropriate. The project committee acted as the primary catalyst in identifying the various resources required for the day care centre and in finding such resources. The committee carried out a study of the existing theory and practice of day care services for elderly persons so as to devise the optimum programme and structure from the outset and acted in a consultative basis to the centre and to its management committee throughout. It also assisted in the recruitment and training of volunteers to assist in the running of the day centre.

#### *(Hi) Support for Family Carers*

The principal activity in respect of family carers was that of developing a comprehensive series of information leaflets on the various aspects of caring for the elderly. The process adopted in the preparation of these leaflets consisted of bringing together in working groups a range of professions including occupational therapists, psychologists, physicians and day care centre staff. This process was facilitated by the project development worker and the designing and printing of the information leaflets was funded by the Eastern Health Board. Some preparatory work was also undertaken by the project in respect of a voluntary relief-sitting service for family carers and a protocol for the establishment of such a system was drawn up.

#### *(iv) Service and Co-ordination Issues*

In addition to the above three areas of work the project also addressed a number of other aspects of care provision and care co-ordination:

- Issues in respect of inter and intra-statutory liaison and co-ordination in the project area were identified and a submission was made to the National Council for the Elderly in this regard.
- The establishment in 1990 of a care team in the project catchment area, as proposed in *The Years Ahead* (Department of Health, 1988) and endorsed in the Eastern Health Board policy document. *Services for the Elderly* (1989), was considered. Of particular concern here was the relationship between the care team and the pilot co-ordination project and how the experience of the pilot project to date could inform the care team concept.
- The housing needs of elderly persons in Dun Laoghaire Borough were documented with particular reference to (a) an emerging serious shortage of local authority housing, (b) the additional responsibilities of the local authority as a result of the Housing Act (1988) which came into effect in 1989, (c) the nature and effectiveness of existing repair and maintenance schemes, (d) the working of the Disabled Persons Housing Grant Scheme, (e) the need for a co-ordinated approach to design in respect of both new dwellings for elderly persons and adaptations to existing dwellings and (f) issues relating to housing schemes provided by voluntary housing associations.
- The *Nursing Homes Bill* (1989) and the related *Code of Practice* were considered by the project committees. This was regarded as important because of the high number of nursing homes within the catchment area, and submissions were made to the Department of Health on the Bill and on the Code of Practice.
- The Interim Report of the Dublin Hospital Initiative Group (Kennedy, 1990), which was prepared for the Minister for Health, was discussed with particular reference to the needs of the elderly in the Dun Laoghaire area and the organisational arrangements most likely to address these needs. A submission was made by the project on this report.
- The need for a comprehensive review of transport arrangements for elderly persons was identified. A small-scale voluntary car pool to provide limited transport for selected elderly persons was put in place on a trial basis. Recommendations were made to the appropriate agencies in respect of the design and access aspects of public transport.
- Emergency information leaflets (which were to be filled in by the elderly persons or their carers and provide basic information likely

to be of use in an emergency) for display in the homes of elderly persons were circulated to a number of homes in the area. It is not clear to what extent these leaflets were actually used.

- A possible need for a community based social work service for the elderly was identified — some background research and liaison work was carried out in this respect by project personnel.
- The project identified a need for additional support services for the elderly mentally infirm — day care, night care, relief care and long-stay care but did not succeed in developing any of these services.
- A system for the computerisation and mapping of demographic data relevant to the project area was put in place.

#### *(v) Compilation of Project Report*

During the course of the pilot project a wide range of service and co-ordination issues were identified by the project committees covering many aspects of the caring system for the elderly. A process was set in motion by the project steering committee to bring these issues together and to present them in a project report under the following headings:

- housing provision and housing needs;
- the development of the care team concept;
- extended nursing care and the private nursing home sector;
- statutory/voluntary liaison;
- day care facilities;
- liaison between general hospitals and community care services.

Much of the programme of work of the steering committee during the final year of the project related to the preparation of this report. The report was envisaged as drawing together the work and experience of the pilot project and was also seen by committee members as setting an agenda for the future development of services for the elderly in the project area.

## **4.5 Tipperary S. R. Project**

### *4.5.1 Establishment of Project Committees*

The South Eastern Health Board director of community care for Tipperary South Riding took on the responsibility of setting up the structures

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<sup>1</sup>This report had not been finalised at time of writing (June 1992).

for the pilot project. The inaugural meeting of the Tipperary S.R. project steering committee was held in June 1987 and was attended by the director of community care, the county secretary (representing the local authority), the senior area medical officer, the superintendent public health nurse, the medical officer for St. Patrick's Geriatric Hospital, Cashel, the warden of the welfare home/sheltered housing complex in Clonmel (which is run by a voluntary committee), representing the voluntary sector and the community care administrator for Tipperary S.R. The county secretary had been nominated to the steering committee by Tipperary S.R. County Council. The senior area medical officer, the superintendent public health nurse and the community care administrator were nominated by the director of community care. The medical officer of the geriatric hospital was invited to participate in the steering committee by the director of community care in place of a consultant physician in geriatric medicine as stipulated in the *Terms of Reference* since the latter post did not exist in the area. The director of community care was unanimously appointed as chairperson of the steering committee and the community care administrator was designated to act as secretary to the committee.

The *Terms of Reference* for the project were accepted by the steering committee and it was agreed, with some reservations, that the pilot project should be established for a period of three years. This was later extended by one year so that the pilot project ran to the end of 1991. It was noted at the outset that there would be no additional funding or resources available to the project from the health board or from any other source and that work in respect of the project would be over and above existing work responsibilities. Specifically, as in the case of the Dun Laoghaire project, it was pointed out that the health board was not in a position to second an officer to the project on a full-time basis as stipulated in the *Terms of Reference*. Some of the health board staff also took the view that the additional workload which would result from the project might be over burdensome and might in fact be counter-productive.

At its inaugural meeting the steering committee took the decision to co-opt a consultant psychiatrist and a representative of the Irish Private Hospitals and Nursing Homes Association on to the steering committee. Neither of these co-options took place due to (i) a non-response from the Irish Private Hospitals and Nursing Homes Association and (ii) a feeling on the part of the consultant psychiatrist that he would assist the steering committee best by agreeing to act in a consultative capacity to the committee in respect of issues relating to psycho-geriatric care.

Such consultation between the committee and the psychiatrist did not materialise during the course of the project.

### Local Committees

The steering committee established four local committees with catchment areas around each of the four main towns in the project area — Cashel (population 15,300), Carrick-on-Suir (population 11,900), Clonmel (population 29,500) and Tipperary (population 20,400). Boundaries for the four committees were drawn up by the steering committee. The health board nominated a public health nurse, a geriatric liaison nurse and a community welfare officer to each of the local committees and the local authority nominated one representative to each of the local committees.

General practitioners (identified by the health board) and representatives of the voluntary sector (identified by the health board) in each area were invited to participate in the local committees. Initially, efforts were made to identify general practitioners through the local branches of the Irish College of General Practitioners. This approach proved unsuccessful and contact was then made directly with a number of selected individual general practitioners who agreed to join the committees.

The senior area medical officer was delegated to be a member of all four local committees and to be the liaison person between the local committees and the steering committees. This was subsequently changed and the community care administrator became the liaison person for two of the local committees with the senior area medical officer continuing to have responsibility for liaising with the other two committees.

The inaugural meeting of each of the local committees was attended by members of the steering committee who introduced the project and explained its focus. It was pointed out at these inaugural meetings that no additional resources were available for the pilot project. There was a general consensus at these meetings that the project would be of value and that the local committees would serve a useful purpose. By February 1988 each of the four committees had elected a chairperson and had begun to function.

The chairpersons elected were as follows:

Carrick on Suir: public health nurse  
Cashel: social worker, Cashel Social Services Council  
Clonmel: geriatric liaison nurse  
Tipperary: community welfare officer.

In the case of three of the committees voluntary people were specifically recruited to take on the role of secretary. This role was taken on by the local authority representative in the fourth committee until he resigned in November 1989. This committee operated without a secretary for the remainder of the project. The secretary also resigned from another of the committees and the local authority representative took on this role for the final year of the project.

A part-time project development worker was recruited on a voluntary basis from February 1989 to July 1990 and a full-time development worker was employed by the South Eastern Health Board for the final year of the project.

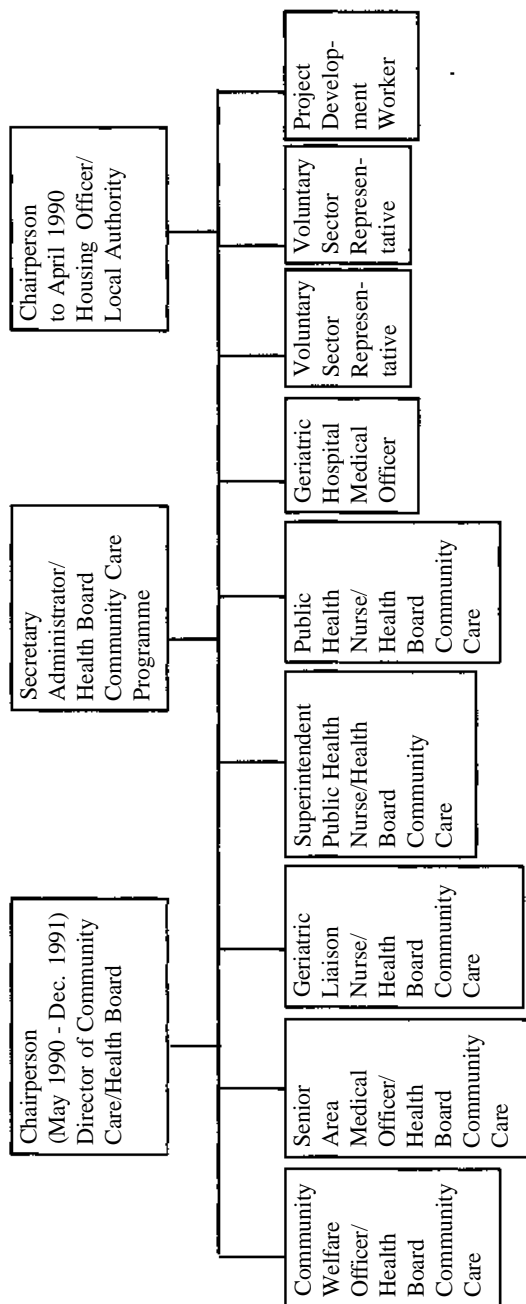
#### 4.5.2 *Committee Membership*

The membership of the Tipperary S.R. project steering committee is set out in *Figure 4.3*. The core structure of the committee remained the same for the duration of the project. There was a change in the local authority representative on the committee in November 1987 with the housing officer replacing the county secretary. There was also a change in personnel in the voluntary sector representative on the committee. In May 1990 the chairpersons of the four local committees were co-opted on to the steering committee. An administrator from the health board special hospitals programme was co-opted on to the committee at the beginning of 1990 but did not continue as a member. There was a change of committee chairperson for the period May 1988 to April 1990 when the local authority officer replaced the director of community care, the latter having been assigned the post of acting health board programme manager on a temporary basis.

The actual core membership structure of the local committees in the Tipperary S.R. project is set out in *Figure 4.4*. The core structure of the four project local committees remained the same throughout. However, there were a number of personnel changes on some of the committees. During the early stages of the project some voluntary sector personnel resigned from one of the committees. In the case of three of the committees the local authority representatives resigned on transfer to other posts outside the area and were replaced on the committees (after an interval of some months) by other local authority personnel. Efforts to recruit additional local authority personnel to represent the rural parts of the committee areas were not successful. While County Council representatives were nominated to three of the local committees, they ceased to attend meetings after a short period. (Existing local authority representatives were from the three Urban District Councils and Clonmel Corporation, the functional areas of which were confined to the

FIGURE 4.3

Actual structure of Tipperary South Riding project steering committee 1989 -1991

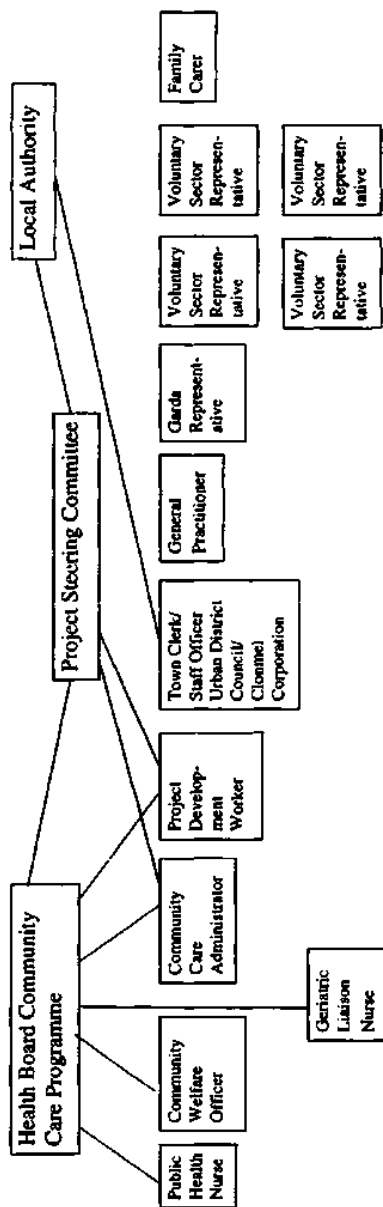


- Notes (1) The community welfare officer, geriatric liaison nurse, public health nurse and one of the voluntary sector representatives were on the committee in their capacities as local committee chairpersons.
- (2) The project development worker attended all steering committee meetings.



FIGURE 4.4

Actual core structure of Tipperary South Riding project local committees 1989 -1991



- Notes
- (1) The local committee chairpersons were members of the steering committee from May 1990 onwards.
  - (2) The local authority representative was the relevant town clerk in the case of two of the committees and a staff officer in the case of the other two.
  - (3) One of the committees had a social welfare officer (Department of Social Welfare) as a member.
  - (4) The community care administrator acted as liaison person with the steering committee in respect of only two of the committees.
  - (5) General practitioner membership and garda membership operated in respect of only two of the committees.
  - (6) One of the committees had seven voluntary sector representatives.

respective towns.) One of the local committees had a change in chairperson at the beginning of 1989 when the existing chairperson resigned from the committee. The chairperson of another of the committees resigned during the final year of the project and was not replaced. Two of the committees had general practitioners as regular members with a change in actual personnel in the case of one of these committees. All of the local committees extended their number of voluntary sector members as the project evolved and three of the committees co-opted family carers. During the final year of the project particular attention was given by the committees to co-opting voluntary personnel from outlying parts of their catchment areas.

#### 4.5.3 *Programme of Work*

During the period of phase one (up to the end of 1988) the project engaged in a general assessment of needs as stipulated in the project *Terms of Reference* with a view to prioritising and setting out specific goals and targets for phase two. This consisted of a review of existing services — housing, hospital and community-based, which was carried out by examining existing service records and waiting lists and by drawing on the views and experience of committee members. Each of the local committees engaged in this process in respect of its own catchment area and based their deliberations on the philosophy and recommendations set out in *The Years Ahead* report (Department of Health, 1988). While a number of areas of need and gaps in service provision were identified through this process, the identification of specific goals and targets for phase two of the project based on a systematic assessment and prioritisation of needs proved beyond the capacity of the resources and skills available to the project. In practice, during phase two the project committees operated more in an *ad hoc* manner responding to issues as they arose and embarking on schemes that were feasible within existing policy and funding arrangements. In this context, each of the project local committees established a voluntary housing association to develop a sheltered housing project under existing Department of Environment grant schemes. These housing schemes were set in progress and were at various stages of development by the end of the pilot project.

Day care services were identified by the project as another area for potential development. Two day centres for the elderly were established under the auspices of the project committees and plans for a number of others were put in place. A particular effort was made during the final year of the project to develop day care services at locations outside the main towns in the project area. The development and expansion of community alert and neighbourhood watch schemes was also identified

by the project as important and some development work was done by one of the local committees in this regard. The issue of support services for family carers was addressed and a number of voluntary support and counselling groups were established for this purpose. Greater involvement of the voluntary sector in service provision and development was also a key aspect of the project thinking and some development work was also carried out in this regard, particularly during the final year of the project. An information booklet, *Directory of Local Services*, was compiled and published by each of three of the project local committees.

The Tipperary S.R. project also piloted and drew up an assessment form for identifying elderly people at risk. This process resulted in the putting in place of a uniform system for developing and maintaining a health board register of elderly persons at risk in the project area. It was also envisaged that the local authority would use this register in assessing the housing needs of the elderly in the area.

In addition to the areas of work outlined above, there were a number of other key issues addressed by the project with recommendations being made to the appropriate bodies:

- A need for better rationalisation between the health board community care services and the health board psychiatric services in respect of elderly persons was identified and brought to the attention of the health board.
- The need to make provision at design stage for the installation of alarm/communications systems in all local authority houses for the elderly was identified and a recommendation was made to the local authority in this regard which was adopted as part of local authority policy.
- Problems experienced in respect of the Department of Social Welfare Allowance for family carers of elderly persons were highlighted with specific reference to (a) the need for broader eligibility criteria and (b) the need for the involvement of health board personnel in assessing entitlement to the allowance. This issue was brought to the attention of the Department of Social Welfare.
- The attention of the South-Eastern Health Board was drawn by the project to the need for changes in the organisation and funding of the home help service in the area.
- A range of transport needs of elderly persons in the project area was identified and representation was made to the Health Board and to Bus Éireann in this regard.

- A need for better planning and co-ordination between statutory agencies in respect of the development and operation of voluntary housing schemes for the elderly was identified as was a need for better rationalisation and liaison in regard of the various repairs and maintenance schemes in operation in respect of dwellings occupied by elderly persons. These issues were brought to the attention of the National Council for the Elderly.
- The need to install a lift in one of the district hospitals in the area and a related proposal that some long-stay beds for the elderly should be provided in the same hospital was highlighted by one of the local committees and a recommendation was made to the South-Eastern Health Board in this regard. However, no action was taken by the board during the life-time of the project.
- The co-ordination of voluntary efforts in local areas in respect of elderly persons so as to avoid unnecessary overlap and duplication (for example, the rationalisation of voluntary agency help for elderly persons at Christmas time) was addressed by some of the project local committees.
- Some of the service needs of individual elderly persons and problems associated with these were brought to the attention of the relevant agencies and personnel.
- A need to set up a locally-based unit to cater for the elderly mentally infirm, particularly those suffering from Alzheimer's disease, was identified and discussions with the South-Eastern Health Board and the Alzheimer Association were instigated in this respect.
- Social/environmental issues affecting the quality of life of older people were identified and brought to the attention of the respective agencies. These included:
  - public seating;
  - public transport services;
  - closure of rural post offices;
  - legal advice to and representation for older persons;
  - electricity and telephone charges.
- An information and video library on issues relating to older people and to the process of ageing was established.

## 4.6 Project Development Workers

The pilot project *Terms of Reference* (National Council for the Aged, 1987) stipulated that "an officer of the health board be seconded on a

full-time basis to promote the project in the various sub-areas, during the first year at least" (p. 7). This requirement was considered by the statutory personnel involved in the initial establishment of the two projects. In both instances the secondment of an officer for this task, while desirable in principle, was considered to have been out of the question in the existing climate of budgetary restraint and staff cutbacks in the statutory sector. However, there was a general consensus in both areas at the time that the pilot projects would be worthwhile and that they should be established even without the services of a full-time officer. Indeed, there was also a clear recognition that no additional resources could be made available from any source for the pilot projects. The choice was seen as clearly being between establishing the projects without additional resources and, specifically, without the services of a full-time worker and not establishing the projects at all.

During phase one of the projects, the non-availability of a statutory officer working full-time on each project came to be recognised as a significant problem in both projects. This issue was brought to the attention of the National Council for the Aged by the project evaluation team who in turn raised the issue with the Department of Health in April 1988. The Council asked the Department to consider making additional funds available to the two health boards concerned for this purpose. The Department did not accede to this request but did communicate the Council's concern to the two health boards involved. The project steering committees had also entered into negotiations with senior executive personnel in their respective health boards with a view to having funds allocated for the deployment of full-time project development workers.

In the case of the Dun Laoghaire project, the Eastern Health Board made funds available for the employment of a project development worker on a temporary contract basis and the appointee took up the post in November 1988 for an initial period of one year. The contract for this appointment was reviewed on an annual basis and renewed to cover the period up to the end of the project. The resolution of the problem proved more difficult in the Tipperary S. R. project with the South-Eastern Health Board being unable to allocate funds for a project development worker. Efforts to recruit such a person under the Social Employment Scheme during 1988 were unsuccessful. At the beginning of 1989 the South-Eastern Health Board made funds available for defraying the expenses of a project development worker operating on a part-time voluntary basis and an appointment on those terms was made in February of that year. This appointment continued until June 1990

and in January 1991 the South-Eastern Health Board appointed a full-time project development worker for the remainder of the project. The contribution of the project development workers is discussed and analysed in 7.4 below.

#### **4.7 Inter-Project Meetings**

During the course of the pilot projects four inter-project meetings were held involving committee members, steering and local, from both projects. The purpose of these meetings was to afford project personnel an opportunity to meet their counterparts, to provide a forum where common issues could be articulated and explored and to facilitate the exchange of information between the projects.

Some specific issues relating to the project committees were addressed at the joint meetings:

- the need for training/education in committee procedures;
- the need for statutory personnel to be given work time to engage in project committee work;
- the need for more direction for project local committees;
- the need to review project committee membership, with particular reference to increasing the representation of the voluntary sector.

Some general issues affecting service co-ordination were also identified:

- the problem of insurance cover for volunteers/voluntary groups providing services on a voluntary basis;
- the need for a review and a broadening of the criteria for eligibility for the Department of Social Welfare Carers' Allowance;
- the need for the provision of a more comprehensive system of transport provision for elderly persons, particularly transport to day care centres and to outpatient clinics;
- the need to address specific environmental issues, e.g. access and seating facilities which would enhance the quality of life of frail elderly persons.

The inter-project meetings would appear to have been of some assistance to project personnel. In particular, a two-day joint workshop held in October 1991 provided an opportunity for participants to reflect on the project experience, to identify factors which both enhanced and hindered the working of the projects and to agree joint recommendations in respect of the future development of a co-ordinated approach.

## 4.8 Summary

This chapter has set out the proposed committee structure and agreed working objectives of the pilot projects. It has described the initial establishment, actual committee structure and programme of work of the two projects. Reference has been made to problems encountered in respect of the implementation of the *Terms of Reference* in regard to (i) the secondment of staff by the statutory bodies to project committees and (ii) the carrying out of needs assessment and goal setting tasks as envisaged in the *Terms of Reference*. The key issue of the deployment of a full-time officer was eventually resolved by both projects, by the Dun Laoghaire project in November 1988 and by the Tipperary S.R. project in January 1991. These issues will be elaborated and discussed further in Chapters Five and Seven below. While the committee structure put in place in both projects was generally in accord with that set out in the *Terms of Reference*, there were many changes in the membership of most of the committees during the course of the project. Members' views on the structure, membership and functioning of the project committees will be presented in Chapter Five.

During the four-year period of their existence the two pilot projects established and consolidated basic committee structures. Each project engaged in a programme of work which, though not as ambitious as that envisaged in the *Terms of Reference*, was practicable in terms of the resources available and the circumstances that prevailed. Day care centres were established, voluntary sheltered housing schemes were instigated, the issue of support services for family carers was addressed and a number of key policy issues in respect of service co-ordination and the elderly were highlighted.

## CHAPTER 5

# The Experience and Perceptions of Pilot Project Committee Members

### 5.1 Introduction

This chapter sets out the experience and perspectives of the project committees in respect of the establishment, development, programme of work and outcomes of the pilot projects. It presents the findings of interviews held with committee members and development workers in both project areas<sup>1</sup>. The interviews with local committee members were held during May 1991 and those with steering committee members were held during September and October of 1991. Five local committee members who were also on the steering committee in their capacity as chairpersons of their respective local committees were interviewed during May 1991. The pilot phase of the projects ended in December 1991. The interviews were carried out using a semi-structured interview schedule and each interview was of one to one and a half hours duration. The researcher was assisted in this task by a second interviewer. The classification by sector of all committee members interviewed is presented in Table 5.1. Twenty-three steering committee and 62 local committee members were interviewed.

The findings of the interviews with committee members are set out in respect of (i) the project steering committees and (ii) the project local committees. Respondents' views are presented under the following headings: initial establishment of project; relationship of project to parent statutory bodies and services; membership and structure of the project committees (including the actual membership, operation of the committees, development of a programme of action, liaison between the steering committees and local committees and resources); and achievements of the projects. There were a variety of views expressed

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<sup>1</sup>A more comprehensive account of these findings in respect of each of the project committees (two steering committees and six local committees) is provided in *Co-ordinating Services for the Elderly at Local Level: The Experience and Perceptions of Project Committee Members* which is available from the National Council for the Elderly.



**Tabla 5.1: Classification of Committaa Imambars Intarviawad**

Sector	Membership					
	Steering Committees	%	Local Committees	%	All Members	%
Health Board	13	56.4	19	28.8	32	36.0
Local Authority	2	8.7	6	9.1	8	9.0
Voluntary Sector	3	13.0	34	51.5	37	41.6
Private Nursing Home Sector	1	4.4	—	—	1	1.1
Geriatric Physician	1	4.4	—	—	1	1.1
Medical Officer/Geriatric Hospital	1	4.4	—	—	1	1.1
General Practitioner	—	—	3	4.5	3	3.4
Project Development Workers (Health Board)	2	8.7	—	—	2	2.2
Total Interviewed	23	100.0	62	93.9	85	95.5
<b>Total Membership</b>	<b>23</b>		<b>66</b>		<b>89</b>	

by committee members in respect of many of these topics and these are ranked in order of priority as given by the respondents. Differences in perception and emphasis which emerged are identified. Finally, the chapter summarises the key issues as identified by the respondents.

## **5.2 The Steering Committee Perspective**

### *5.2.1 Initial Establishment of Project Steering Committees*

Of the twenty-three steering committee personnel interviewed, twelve (eight health board officers, one local authority officer, one consultant physician in geriatric medicine, a geriatric hospital medical officer and the project development worker, who was then a member of the National Council for the Aged evaluation team) were involved during the initial establishment of the project.

Steering committee members were asked by the interviewers to comment on the initial establishment of the pilot project in their area. The majority of members expressed the view that the methods used for establishing the project were unsatisfactory. Three aspects of this were identified as being particularly problematic: (i) the failure to acknowledge the resource and time implications at the outset; (ii) the absence of a comprehensive induction programme which would have examined in detail the project *Terms of Reference*, considered the resource and time implications and pointed to some of the potential difficulties likely to be associated with such an undertaking; (iii) a feeling on the part of some local health board personnel that the project was imposed on them from the top without adequate consultation and (iv) various personality factors which led to less than satisfactory committee functioning during the early stages of the project.

A number of members expressed the view that the project's practical implementation was not thought through sufficiently in terms of aims, resources and administrative arrangements and that this resulted in a lot of unnecessary confusion at the outset about the task in hand and in a high level of frustration. A contrasting view articulated by a minority of steering committee members was that the approach adopted to the establishment of the project was functional in terms of getting the project off the ground. According to this perspective, a long lead-in/induction process would have inevitably raised major problems about resources which would have resulted in a reluctance or unwillingness on the part of some key personnel to become involved. This would almost certainly have meant that the pilot project would not have got off the ground.

Members were asked to comment on the adequacy and appropriateness

of the project *Terms of Reference*. There were a range of views on the *Terms of Reference*, from the majority who considered they were much too vague to those who felt they were adequate but over-ambitious. All members felt that more preparatory work should have been done in respect of expanding and applying the *Terms of Reference* and in clarifying administrative structures before the project committees were put in place. It was also felt that the Departments of Health and the Environment should have been involved in drawing up the *Terms of Reference*, the provision of resources and in instigating the pilot projects in the selected areas.

There was a strong feeling that one person should have been assigned overall responsibility for the project in each pilot area on a full-time basis at the outset and that this person should have had executive responsibility for the day-to-day running and overall development of the project. It was felt by some members that many of the early problems encountered would have been avoided if such a project leader had been appointed.

### *5.2.2 Relationship of Project to Parent Statutory Bodies and Services*

Steering committee members acknowledged that the initial establishment of the pilot project co-incided with and to some extent reflected an emerging emphasis in various policy documents on the need for service co-ordination at local level. In the case of the Eastern Health Board, it was felt that the 1989 Policy Document, *Services for the Elderly* (Eastern Health Board, 1989) grew out of the underlying philosophy and early experience of the pilot project. There was a general consensus among committee members that there was a very high level of goodwill toward the project on the part of statutory members involved. It was felt that this goodwill carried the project through difficult times and ensured its survival when no progress was evident. The statutory officers involved considered that they gave as much time as they could to the project, bearing in mind their various other responsibilities and that this was indicative of their commitment to the project. The time input of statutory staff over the four-year period was considered to have been quite substantial. The majority of members felt that the statutory bodies co-operated with the pilot project in all cases where such co-operation was feasible.

There was agreement that statutory support for the project improved as it evolved. Evidence for this cited was the provision of funds for project development workers, the greater availability of work-time for committee meetings and the funding of a joint project workshop. However, some committee members considered that in practice the project was

quite peripheral to the mainstream work of the statutory bodies and that it did not really impinge on the service delivery process. This latter observation was illustrated by members by reference to a number of factors.

- (i) The respective health boards and local authorities at planning level continued to develop their own policies separately with little reference to each other or to the pilot project.
- (ii) There was an absence of resources to deal with service gaps identified by the project.
- (iii) Statutory budgets and staffing levels were drawn up at central level and were not generally re-negotiable. This meant that the project had to act within statutory policies and budgets already determined. This limited the scope of the project.
- (iv) Statutory officers, particularly those on the steering committees, were perceived by other committee members as having a conflict between their roles as statutory agency personnel and their roles as members of the project committees. Members commented that this conflict of interest had a somewhat negative impact on the way steering committees approached their task and on the way issues were defined. Here, it was noted that the steering committee chairpersons were at all times officers of either the health board or local authority.

Overall there was a range of views among committee members about the nature of the relationship between the project and the statutory bodies. Some members considered that there was a high level of commitment towards and interest in the project and that the experience of the projects would be very valuable in informing future service development in respect of the elderly. Others felt that there was a commitment towards a co-ordinated approach but not towards the pilot project. A minority of members considered that the statutory bodies took the view that possibly some useful lessons might be learned from the pilot project and, if not, very little would have been lost in any case.

### *5.2.3 Membership and Structure of Project Steering Committees*

#### *Membership*

The membership of the Dun Laoghaire project steering committee consisted of six health board officers, (four from the community care programme with two of these being members in their capacity as local committee chairpersons), one local authority officer, one representative of the private nursing home sector, one voluntary sector representative

(nominated by the Society of St. Vincent de Paul) and one consultant physician in geriatric medicine. The membership of the Tipperary S.R. project steering committee was as follows: the director of community care, the superintendent public health nurse, the senior area medical officer, the community care administrator, the local authority housing officer, a representative of the voluntary sector and the medical officer of the geriatric hospital serving the catchment area. In addition, two public health nurses, a community welfare officer and a voluntary sector representative were members in their capacity as local committee chairpersons. The project development workers, whose appointments were funded by their respective health boards, attended all steering committee meetings.

Commenting on statutory representation on the steering committees, members felt that in general this level of membership was satisfactory in that it reflected the various component and interrelated parts of the caring and service provision network.

There was a general feeling that the hospital side of the health services was not adequately represented on the steering committees. Representing the hospital sector was identified as being a particularly complex question because of the various dimensions to the service. Members also felt that the psychiatric services should have been involved, at least in a consultative capacity. In this context it was noted that both steering committees had made a decision early in their existence to bring in a psychiatrist on a consultative basis but that this never happened in practice.

On the question of local authority representation on the committees, most members considered that the level of representation was satisfactory given that the housing officer was a key person in respect of services for the elderly. Some members, however, were of the view that the project might have had a higher profile with the local authorities if more senior officers were on the committees.

There was a consensus among committee members that the voluntary sector representation was less than satisfactory at steering committee level. The fact that there was no overall umbrella group for voluntary agencies meant that the steering committees would have needed to engage in a developmental process in order to identify appropriate representatives of the voluntary sector. There was also a consensus among committee members that the involvement of the private nursing home sector on the committees was less than satisfactory. In the case of the Tipperary S.R. project there was no representation of this sector on

the steering committee and the involvement in the case of the Dun Laoghaire project was regarded as peripheral.

In summary, membership of the project steering committees was regarded as not entirely satisfactory. The general hospital sector and the psychiatric services were considered not to have been adequately represented. The involvement of the voluntary sector and private sector on the steering committee was also regarded as less than satisfactory.

### Operation of the Committees

A range of views were expressed by committee members in respect of the operation of the committees. The majority of steering committee members expressed the view that their committee did not function as effectively as it might have, particularly during the early stages of the project when there was what one member described as an "unbusiness-like approach" to the committee. Factors identified by members as impinging on the work of the committees during the early stages were:

- (i) insufficient concentrated time being given by members to the work of the committee;
- (ii) the absence of an identified person with responsibility and time to progress the work of the committee;
- (iii) over-emphasis during the initial stages on a goal-setting approach as envisaged in the project *Terms of Reference* which demanded data collection and data analysis skills which were not available to the committees;
- (iv) the absence of resources to address service gaps identified;
- (v) personality differences between members;
- (vi) failure to adopt clear committee procedures and rules and to process issues brought to the attention of the committee members.

The general view of members was that many of the initial problems encountered by the committees were resolved over time as people got to know each other, as the task of the committee became more clearly defined and after project development workers were appointed.

Most members felt that the absence of development workers during the first year of the project greatly affected the operation of the committees. It was felt that some important issues were lost because there was no one with the time available to process them. Most respondents felt that the situation improved when development workers were appointed.

A number of members pointed to the fact that the steering committees did not have executive power and lacked a formal input into health board and local authority policies, and, therefore, were quite limited in their operation even if it were possible for them to generate and progress innovative ideas and plans.

A comment made by a small number of members in respect of the operation of the committees was that, as already stated, there was a conflict of interest between some statutory representatives' roles as steering committee members and their role as statutory officers. It was felt that some had difficulty representing a steering committee perspective in cases where it differed from their own statutory agency policy on a particular issue.

Two contrasting views emerged in members' overall assessment of the operation of the committees. Firstly, there was the view that in general, the steering committees worked well within the obvious constraints which existed, that it was a good experience and that the committee was a "useful forum to toss around ideas and thoughts and raise important issues." The second view was that four years was far too long for so little achievement and that the committees never really operated effectively or came to terms with their task.

### Developing a Programme of Action

The project *Terms of Reference* did not set out a programme of action for the project but rather implied that such a programme would be put in place. Consequently, the task of setting goals and targets for the project fell to the project committees. The general view of committee members was that this proved a considerably difficult task. Efforts to put in place a programme of action during the early stages of the project were regarded by all members as having been less than satisfactory. A number of reasons were cited for this:

- (i) The approach to needs assessment implied in the *Terms of Reference* and set out by the project evaluation team was totally unrealistic in terms of the resources available.
- (ii) The concept of goal-setting was too vague, too far removed, and outside the experience of many of those involved in the committees. In such a situation more immediate problems and issues took precedence in committee discussions.
- (iii) Committee members had a lot of difficulty in coming to terms with what was meant by a co-ordination orientation as distinct from a single discipline/agency orientation.

- (iv) There was no individual who took overall responsibility for drafting a programme of action.
- (v) There was a lack of consensus among members as to what were the priority issues.

There were divergent views among committee members as to whether the steering committees succeeded in putting in place a satisfactory programme of action. The majority of members of each steering committee considered that they were only now (during the final six months of the project) at a stage where a goal-orientated approach could be adopted. A number of members considered that very useful work on a range of issues was undertaken by the steering committee after the initial six to nine months and that this in effect constituted a programme of action.

Members felt that the working method adopted by the committees which consisted of a more *ad hoc* approach to issues and problems was useful in its own way. As one member put it, "the steering committee was a forum where I could raise issues affecting my work." A number of important issues were investigated and considered and, where possible and within the ambit of the steering committee's power, action was taken. For example, in the Tipperary S.R. project a number of members considered that the putting in place of a mechanism for drawing up and maintaining an *elderly at risk* register in the area was a very useful undertaking. It was also pointed out that the steering committees facilitated as much as possible the projects and schemes undertaken by the project local committees. In the case of the Dun Laoghaire project, it was generally acknowledged that the Final Report on the project, being prepared by the steering committee, was a most useful exercise which would draw together the work of the project and would be a very valuable planning document on which an ongoing co-ordinated approach to service provision could be based.

#### Relationship between Steering Committee and Local Committees

Steering committee members were asked to comment on a strong view emanating from the interviews with local committee members that the steering committee was most ineffective in respect of directing, facilitating and supporting the work of the local committees (See 5.3.3 below). The majority of steering committee members agreed that the relationship with the local committees was less than satisfactory throughout. They felt, however, that some of the difficulties encountered at the beginning of the project were resolved as the project evolved. Other members expressed the view that the difficulties were exaggerated by



the local committees and that there was a tendency for the local committees to project their own problems on to the steering committee. It was also felt that the steering committees' own uncertainty and lack of clarity about the project during the early stages communicated itself to the local committees.

Some of the committee members felt that some of the difficulty arose because the local committees had a misconception about the role and authority of the steering committees and were under the impression that they had much more power than they actually had in practice. These members pointed to the actual powerlessness of the steering committees.

On the overall question of guidance and direction to the local committees, members felt that it was only in retrospect that the steering committees came to recognise that the local committees required more direction and that this should have been provided for the local committee chairpersons early on in the project. The majority of steering committee members considered that the local committees were established too soon in the project's existence and before any overall plan for the project was worked out. They expressed the view that more specific directives should have been given to the local committees at the outset. A small number of members took the view that it was right to give the local committees a free hand at the beginning and allow them to define their own parameters and priorities within the context of a broad set of guidelines as set out in the *Terms of Reference* (National Council for the Aged, 1987).

## Resources

Steering committee members were asked to address the issue of project resources and the extent to which this issue impinged on the development and working of the project. On the question of general secretarial and administrative back-up and support for the project, some members considered it quite satisfactory. Other members considered that secretarial back-up was totally inadequate. An example of this inadequacy noted by a number of members was the absence of effective secretarial support for the project development worker and for the local committees.

There were also divergent views as to what effect the lack of a specific budget had on the project. The majority of members expressed the view that the availability of a specific budget for the project would have helped the committees to define parameters and engage in some level of innovative thinking. As one member stated, "funding is an integral part of planning". Other members, however, felt that funding was not a major problem and that no coherent proposal/scheme was lost because

of a lack of funding. On the issue of funding for training for the project participants, some members considered that such training was not a priority while others felt that funds for such training should have been provided as a priority at the outset.

There was general agreement that the climate of financial stringency and cutbacks which pertained when the project was being established did not help. Committee members were already overstretched in their own work and there was no back-up or relief for time allocated to project work. This meant that the committee members could not devote an adequate amount of time to project work and frequently the only time given by members to the project was attendance at meetings.

Most members felt that the presence of development workers contributed significantly to the work of the project. In the case of the Dun Laoghaire project, some members felt that the development worker's role did not develop as it might have and that much of the time that might be spent on development work was used up on secretarial tasks. The issue of project development workers is considered further in 7.4 below.

Commenting on the role of the National Council for the Elderly, the majority of steering committee members considered that the role of Council's evaluation team had been a positive one and, in particular, had helped to maintain a momentum in the project during the early stages of its existence. (See 3.4 above). Some members did state, however, that initially they were unsure as to what precisely the role of the Council was. Some of this uncertainty was seen as relating to the fact that the evaluation team adopted an action research approach which involved some developmental work during phase one. Most respondents felt that the *Interim Evaluation Report* (Browne, 1989), prepared by the evaluation team at the end of phase one, did not have any marked impact on the project. The report was seen as one which raised substantive issues but requiring detailed consideration which the project committees did not have time to give it. The Consultative Committee on Co-ordination established by the Council in March 1990 was regarded as having been a useful development at the time but as not having achieved very much in concrete terms. Some members expressed the hope that some of the issues brought to its attention and referred to the Department of Health would in time be addressed. The *Interim Evaluation Report* and the Consultative Committee on Co-ordination are considered further in 7.5 below.

A number of members pointed to the amount of time given by members to the project over a four-year period as a major contribution of resources

even allowing for the fact that the only significant time involvement for most members was attendance at committee meetings.

On the general issue of resources, a number of members considered that some of the frustration experienced by the committees arose because the process of identifying service needs and service gaps implied in the *Terms of Reference* created unrealistic expectations which could not conceivably have been met out of existing resources.

#### 5.2.4 *Achievements of Project*

Steering committee members were asked to identify the achievements of the project. The achievements mentioned are set out here under four headings — improvements in co-ordination, implementation of steering committee functions, teamwork and information exchange and, finally, general achievements.

##### Improvements in Co-ordination

There was a general consensus that the project built on and developed the already good *ad hoc* working relationship that existed on the ground between the health board and local authority in both project areas. There were mixed views among members as to whether there were any improvements in the relationship between the health board programmes in respect of providing services for the elderly in the two areas. Some members felt that a good working relationship had developed, others were of the view that small-scale improvements had been achieved which could be built upon and a minority of members felt that there were no improvements in the relationship between the programmes. In the case of the Dun Laoghaire project, most members felt that the relationship between the office of the co-ordinator of services for the elderly and community care personnel had improved considerably. However, some members were of the view that improvements in co-ordination that occurred on the ground were not reflected at the higher management levels of the health boards involved.

With regard to liaison between voluntary services and statutory services, there was general agreement that some improvements and important beginnings were made in this respect. However, some members expressed the view that improvements were only at the level of information exchange and that there were no improvements at the policy input level. On the question of improvements in co-ordination and liaison between voluntary services themselves, it was felt that very little happened in this area and that much more work was required. It was generally recognised that the general practitioner service, a key aspect

of community care, was not at all adequately involved in the project. A similar view was expressed by most members in respect of involvement of the private nursing home sector in a co-ordinated approach. All members also expressed disappointment at the failure to involve family carers more effectively in the project.

### Implementation of Steering Committee Functions

The majority of members considered that the steering committees did not either systematically address or carry out these functions. While it was felt that during the early stages of the project efforts were made to assess the needs of the elderly in a systematic manner, this process was not developed or followed through. For example, it was pointed out that various service needs were identified but could not be met. Some members felt that these functions were carried out to a limited extent and in an informal manner. They pointed out, for example, that submissions and recommendations were made to relevant bodies on a number of issues. It was also stated that some committee members in their ordinary statutory capacities would have carried out to an extent some of the functions assigned to the committees. The majority of members felt that the main *planning* function of the steering committees did not materialise in either project and that, while some efforts were made to identify priorities, no general consensus or plan of action emerged. Indeed, some members questioned whether a committee set up without any formal statutory base could in any meaningful sense have carried out the planning function. A small number of members stated that they were not familiar with the functions of the steering committee as set out in the *Terms of Reference*.

### Teamwork and Information Exchange

There was general consensus that the personnel on the committees developed good interpersonal and working relationships. On the question of personality differences on one of the steering committees, one member expressed the view that "it was a major achievement that we learned to tolerate each other". It was also generally considered that communication and information exchange between the various personnel involved in the committees improved considerably and that members developed a more comprehensive view of services and needs. However, it was felt by some members that these changes on the ground did not have an impact on policy deliberations at higher level in the statutory sectors. The majority of members were of the view that the

improved information exchange and improved interpersonal relationships that evolved would in the longer term result in better service co-ordination. A small number of members were more sceptical and felt that people would still tend to be protective of their own territory and, as one member put it, "remain in their own professional ivory towers".

### General Achievements

The main achievement of the project that emerged from the interviews with the steering committee personnel was that it drew together and created bonds between people on the ground with common interests. Here, it was pointed out that this was the first structured effort at multi-disciplinary and inter-agency working in the areas and that in this regard it was a most worthwhile undertaking. Another significant achievement identified by members was the further advancement and strengthening of the concept of co-ordination as a vital part of service provision. As one member put it, "independent sovereign states were beginning to break down". Most members agreed that towards the end of the project members were more conscious of adopting a more global co-ordination perspective, as distinct from a single-agency or single-discipline perspective on services. In terms of achievement, it was also felt that the project experience subtly influenced thinking in respect of policies for the elderly and brought into focus the needs of the elderly.

## 5.3 Local Committee Perspectives

Local committees were a key part of the pilot project structure and their membership, functions and establishment have already been described. (See 4.2 above). Essentially local committees were established in order to cater for catchment areas of 15,000 — 20,000 population within the project areas. Their main functions were to identify needs, to co-ordinate services at this level and to liaise with the project steering committees as appropriate.

### 5.3.1 *Initial Establishment of Local Committees*

In general, respondents considered that the initial establishment of the local committees was most unsatisfactory. Firstly, it was felt that there was no one in either project area who understood the pilot project concept. Secondly, staff from statutory bodies were expected to become involved in the project committees in addition to their existing work. This was considered by one statutory member as being "a major imposition which was neither realistic nor feasible". The time implications of this involvement were not explained and were not anticipated by those

becoming involved. Thirdly, the project *Terms of Reference* were felt to have been "too much up in the air" and needed to be broken down, interpreted and applied more specifically. Fourthly, members pointed out that many of the personnel assigned to the committees had relatively little experience and no training in committee procedures.

There was a general feeling that a lot of valuable time was wasted at the beginning because the practical implications of putting such a project in place were not thought through. All of the local committees experienced major difficulties in identifying programmes and tasks. The committee members felt that they were effectively left, as one member put it, "to find our own way". This resulted in the committees floundering for much of phase one (up to the end of 1988) despite making substantial efforts to come to grips with what the project was about. There was no one person in either project area with clearly designated responsibility for directing and ordering the work of the local committees from meeting to meeting. Committee members felt that there should have been an induction process, for example, a one-day seminar, through which participants in the project would have had an opportunity to examine in detail the *Terms of Reference* and to clarify issues. There was general agreement among members that one statutory person should have been given responsibility for clarifying the *Terms of Reference* before the committees were established. Some members also felt that more specific targets should have been set out in the project *Terms of Reference* and possible options identified.

### 5.3.2 *Relationship to Parent Statutory Bodies and Services*

There was a general consensus on the part of the local committees that the parent statutory bodies supported the pilot project concept in principle. However, some were unsure of the role of the local authorities and saw their involvement as somewhat peripheral. Respondents pointed out that the fact that the project was established at a time of severe budgetary constraint in the statutory sector had a significant bearing on the development of the project. It was not possible to allocate time for project committee work and the view was expressed by some statutory personnel that the project was seen as getting in the way of normal work and was an unacceptable drain on already overstretched resources.

There was a general feeling that at senior management level both the local authorities and health boards gradually came to accept the merits and advantages of a co-ordinated approach to service provision and that this resulted in greater recognition being given to the pilot project by the statutory agencies involved. However, some wondered if the statutory interest which emerged at local level was reflected "higher up in the

system". While there was a strong belief among respondents that there was a high level of information exchange and working together at an informal level and while people on the ground developed improved working relationships, the general conclusion of committee members was that the pilot project remained outside the mainstream of statutory service provision.

Many committee members expressed the view that the statutory bodies involved did not take clear responsibility for ensuring that the project developed and that problems identified were resolved. This was felt to be particularly the case during the early stages of the project when the problem was felt to have been compounded by a lack of clarity as to what precisely the role of the National Council for the Aged was in respect of the project. Many voluntary members considered that the voluntary representatives should not be expected to take the lead in such pilot project committees established by the statutory sector.

### *5.3.3 The Structure and Functioning of the Local Committees*

#### **Membership**

The actual membership of the local committees in each project area is set out in Figures 4.2 and 4.4 above. There was a general feeling on the part of those interviewed that the committees were top heavy with health board personnel. However, it was felt that this was somehow inevitable because of the central role of the health board in service provision. Local authority involvement and participation was generally regarded as appropriate to local authority responsibilities in respect of the elderly and, at any rate, as all that was practicable in the circumstances. While some statutory representatives saw committee membership as an unnecessary chore, the main area of complaint was that statutory representatives had not time to devote to committee work. This resulted in most unsatisfactory committee procedures, particularly during phase one.

The overall view of committee members was that voluntary sector involvement in the committee was less than satisfactory. Difficulties were experienced in recruiting voluntary sector representatives. While a number of individuals were perceived as having made very useful contributions to the work of the committees, the broader voluntary sector representation envisaged in the project *Terms of Reference* did not materialise. Also, with the exception of two committees, family carers were not considered to have been adequately involved in the committee process.

Respondents considered that the involvement of the general practitioner

service in the project was quite unsatisfactory and regarded this a significant shortcoming. While a small number of individual general practitioners made useful contributions to the work of the committees, this involvement was on an individual basis only and did not create any systematic links with the overall general practitioner service in the project areas.

### The Operation of the Local Committees

The view of the majority of committee members was that during the first two years of the project the committees, with one exception, operated without direction or focus. The meeting structure during the early stages was felt to have been too informal with meetings being "squeezed in during lunch-times" and with little or no preparation or follow through between meetings. The problem was stated by one committee member as follows: "There was a real sense in which people were not really expected to carry out tasks between meetings because they did not have the time." This meant that there was no guarantee that tasks agreed and assigned at meetings would be carried out. In addition, there was the problem of people "still being in another reality when attending meetings."

The following were listed by committee members as additional factors which affected the operation of the committees:

- (i) lack of direction and feedback from the steering committees — as one member put it, "the steering committee was as much at sea as ourselves";
- (ii) lack of resources to deal with gaps in service provision identified;
- (iii) the fact that some committee members saw themselves as observers rather than participants;
- (iv) the lack of committee skills.

Committee members were of the view that the operation of the committees improved considerably as time went on and during the final year of the project was quite satisfactory despite all the shortcomings referred to. There was a consensus among the Dun Laoghaire project local committee members that two-day training courses undertaken by committee members were particularly helpful in this respect.

### Developing a Local Committee Programme of Action

At the outset, each local committee was asked by its project steering committee to put in place a programme of action for its catchment area. This was experienced as a difficult and time-consuming process which



contributed to high levels of frustration among committee members. The general feeling was that much time was wasted during the first two years of the pilot project with very little of a tangible nature being achieved. The process of assessing needs, as stipulated in the *Terms of Reference*, was regarded as too complex. Members stated that they experienced much frustration and confusion because they felt unable to identify a practical programme of work. Initially, some of the committees held considerable expectations about what the local committee could achieve and it took a long time to accept a more modest set of goals and aims. Eventually the schemes adopted by the committees, while seen as worthwhile, were generally far short of the more ambitious expectations of the beginning of the project. Some members raised the question as to whether some of the schemes put in place by the committees were undertaken in response to clearly identified needs or in order to ensure that a committee had something tangible to show for its efforts.

The overall view was that, while the schemes undertaken were worthwhile in themselves, they did not constitute an adequate programme of action for the local committees in either project area over a four-year period.

#### Liaison between Local Committees and Steering Committee

The issue of liaison between the steering committee and local committees was one with which local committee members were particularly concerned. In general, local committee members felt the local committees were left too much to their own devices, particularly during the first year of the project. The feeling of most members was that the steering committees should have done much more to give the project focus and direction and to provide a context for the work of the local committees. As one member put it, "there was no overall sense of direction from the top.\*

Some of these problems were remedied in part with the deployment of development workers and when local committee members were co-opted as members of the steering committees. However, there was a general feeling that because the steering committees had difficulty in developing their own goals they were unable to provide a sense of direction or support to the local committees. The problem of the relationship between the steering committees and the local committees remained unresolved and a significant proportion of local committee members expressed the view that this inhibited the development of the project. Some members had no contact with the steering committee at all and remained uncertain as to what the role of that committee was intended

to be. Considerable frustration was expressed that the steering committees had failed to fulfil the supportive and motivating role expected by the local committees and that the problems in the relationship had only been partially resolved.

### Local Committee Resources

The question of resources for the local committees was considered by respondents to be one of crucial importance in respect of the development of the project. Firstly, the lack of a specific budget for the local committees was felt to have had a significant limiting effect on the committees. The majority view was that the presence of specific additional funds would have focussed discussions, stimulated interest, ideas and research and boosted morale among committee members. As one committee member stated, "you can't plan without a budget." Secondly, the ability of statutory personnel to work effectively on the committees was severely curtailed because of time constraints. Statutory representatives stated that in general they "did not have time to reflect on committee matters or do committee work between meetings" and that, for example, committee chairpersons and secretaries rarely had time to meet between meetings in order to discuss agendas or progress. As one statutory representative stated, "my own job had to come first" and another, "we had to do the project work at home" and "meetings were squeezed in during lunch-time." While time for project work became a little more feasible as the project evolved, statutory personnel stated that they continued to be very pressurised in their work and, consequently, could not give the project the level of consideration it required. Thirdly, secretarial back-up for the committees was considered by members to have been very unsatisfactory. There was no locally-based secretarial back-up and the concept of busy professional people having to do secretarial work was regarded as a very bad use of time. Most of the local committees did not have funds for even the most basic of secretarial services. As one member stated, "we weren't even allocated money for stamps." Fourthly, it was felt that the fact that service improvement was generally not financially feasible had a dampening effect on the committees and militated against the development of ideas. As one member put it, "the project was established at the lowest point in the cutbacks."

While the absence of satisfactory resources was generally considered to have had an overall negative impact on the committees, one statutory member expressed the view that scarcity of resources was a characteristic of the real world of service delivery and that it was important that the project committees had the experience of operating in this real world.

Committee members were asked to express their views on the role of the project development workers. Members felt that the absence of development workers at the beginning of the project was a major drawback. In the case of the Dun Laoghaire project the presence of the development worker was regarded as a very positive contribution to the work of the committees. A similar feeling was expressed in respect of the presence of the development worker in the Tipperary S.R. project even though members felt it was too early to say because the full-time development worker had only been in post for four months at time of interview, (May 1991). On the role and contribution of the National Council for the Elderly, it was felt that the Council's evaluation team put in a lot of effort during phase one to get the committees working and maintain the project in existence. Some members felt that the Council should have been much more directive and should have, for example, set out possible options for the committees. The *Interim Evaluation Report* (Browne, 1989) compiled at the end of phase one (December 1988) was regarded, by those who were aware of it (half of the members) as having helped somewhat by pointing to the positive achievements to date and placing the problems in a broader context. Commenting on the role of the Council's Consultative Committee on Co-ordination, established in March 1990, members were generally not optimistic that it would achieve much.

### 5.3.4 Achievements of the Local Committees

Each of the local committees engaged in a number of specific tasks which have been described in Chapter 4 above. While the committees did not systematically address the functions of the local committees as set out in the *Terms of Reference*, (see 4.2 above), there was a feeling among committee members that from a retrospective point of view these functions were carried out on an *ad hoc* basis and to some extent and that in an informal way the committees did help to co-ordinate services. It was pointed out, for example, that many relevant service issues were raised and discussed by the committees. It was felt generally, however, that a more systematic approach to these functions would have improved the work of the committees.

The main achievement identified by committee members was improved communication on the ground and better channels of communication between those working with the elderly. Getting to know people involved in other services and agencies and being able to put "faces on names" was regarded as a very positive development. In general, it was felt that as a result of the project people providing services who wouldn't otherwise meet were now meeting on a regular basis. This resulted in

people getting to know and understand each other's roles and pressures better, which was felt to have made a useful contribution to teamwork between various service personnel. It was also felt to have resulted in improved information exchange. Representatives from the various agencies and disciplines involved were exchanging information and thereby getting a broader overall picture of issues and problems. Voluntary sector representatives in particular felt they learned a lot by being involved in the committees.

There was an overall consensus that as a result of the project a greater understanding of service co-ordination and the real problems associated with it emerged. However, there existed major problems in respect of service co-ordination which still required to be addressed. Members felt that co-ordinating services was an extremely complex task and that a vital prerequisite was the establishing of a spirit of trust and teamwork between all those involved. In itself this prior task took considerable time and effort to achieve. There was also a strong feeling among members that real co-ordination of services would have required a mechanism whereby the views of the committees could have been integrated into the actual planning process in the health board and local authority and other relevant agencies whose jurisdiction impinged on the lives of the elderly. No such mechanism existed. While some progress was identified in respect of the relationship between the voluntary and statutory sectors, some members pointed to ongoing divergent perspectives between the sectors. It was also felt that there was little progress in respect of voluntary agencies co-ordinating their efforts.

Overall, committee members felt that relatively little was achieved of a tangible nature. As one member put it, "people met , talked about needs, made recommendations, but very little got done that would not have been done without the committee." However, most respondents considered that there were many useful less tangible achievements as a result of the committees' work over a four-year period. The most important of these was the "face on the name" concept referred to above, which it was felt was a most beneficial achievement in a practical day-to-day manner. The fact that the project continued for four years despite many obstacles was regarded by respondents as a major achievement in itself. However, some questioned whether this development would go beyond the personnel involved or impinge on the overall service structures.

## **5.4 Summary and Conclusion**

There was a strong similarity in the perceptions and experiences of respondents in both project areas. In both project areas the experience

of the local committee personnel was somewhat different than that of their respective steering committees. Specifically, local committees appeared to have experienced more strain and higher levels of frustration than the steering committees. On the other hand, however, all of the local committee members could point to some tangible achievements on the ground.

The general picture which emerges from the interviews with committee members in each project area is one of a high level of personal commitment to the pilot projects. Considerable efforts were made to establish, develop and maintain the projects despite very severe restrictions on time and resources. However, despite these efforts a picture emerges of a committee process under strain for the duration of the pilot project. There was a strong feeling among respondents that there were many positive outcomes from the pilot projects. The view of the majority of members was that important groundwork had been carried out and that a number of barriers between both agencies and disciplines had been broken down. While all members regarded the pilot projects as a very useful learning experience, some considered that what was achieved did not justify the amount of time and energy that had been expended.

There was a general consensus that the project committees did not carry out the functions as set out in the *Terms of Reference* in any systematic way. In general, it was considered that the type of approach to needs assessment envisaged in the *Terms of Reference* was quite beyond the scope of the resources and skills made available to the local committees. It was agreed that the steering committees did not engage in the primary *planning* function assigned to them. Rather, the projects adopted a more *ad hoc* approach to programme development and consideration of issues. Most members considered that this was very worthwhile while others felt that it was indicative of a lack of seriousness of intent on the part of the statutory bodies concerned. There was a general consensus that the project *Terms of Reference* should have been elaborated and spelled out in more specific terms before the projects were established and that more preparatory work should have been done. In the case of the Tipperary S. R. project it was felt that more work should have been done at the outset to involve the senior management of the South Eastern Health Board in the establishment of the project. In the case of the Dun Laoghaire project there was a strong feeling that more preparatory work should have been done at the local level before the project was initiated in the area. On the question of support for the project local committees from the steering committees, which was regarded as most unsatisfactory by local committee members, the

majority of steering committee members acknowledged that more should have been done to direct and support the local committees.

The relationship of the statutory bodies to the pilot project was regarded as one of goodwill and support in principle. This, however, was felt not to have been matched by either the provision of resources or support at the higher administrative levels of the agencies involved. While the involvement of the respective health boards in the projects was clearly evident, many respondents were unclear about the local authority involvement. While the local authorities were in theory jointly responsible for establishing the pilot projects, their involvement, with two exceptions, was generally regarded as being marginal to the work of the local committees and concerned only with housing issues.

There was a general agreement that the membership of the project committees was in practice less than satisfactory. The projects did not succeed in effectively involving the general hospital sector or the psychiatric services. Adequate representative involvement of the voluntary sector, the general practitioner service, the private nursing home sector, family carers or elderly persons themselves was not achieved by either project.

On the question of resources there was a strong consensus that the presence of project development workers was essential to the establishment and consolidation of such a project. All respondents considered that the absence of a development worker in each project area during phase one of the projects was a major omission. The time factor was regarded as the other major problem in terms of resources. Statutory officers, other professionals and voluntary sector representatives felt that in practice they did not have sufficient time to devote to project committee work and that as a result the development and focus of the project was somewhat unsatisfactory.

While there was a general agreement that the project experience had been useful, a number of members considered that the committees had achieved relatively little *vis a vis* their potential. While the concept of the co-ordination project was regarded as a good one, there was a strong feeling among respondents that it was poorly operationalised. As one member stated, "you just don't get local co-ordination by bringing busy professionals and nice people together".

Respondents considered that many relevant policy issues and gaps in service provision had been identified throughout the course of the project. Many of these had been brought to the attention of the relevant parent statutory bodies and some issues which could not be resolved at local level were referred to the National Council for the Elderly

Consultative Committee on Co-ordination. In the case of the Dun Laoghaire project, many of these issues were being included in the Project Report which was in preparation at the time of writing and which was seen as setting the agenda for future policy development in the Dun Laoghaire area. The Tipperary S.R. steering committee planned to continue meeting on a quarterly basis in order to review these issues.

As stated above, the overall view of respondents was that the projects had been worthwhile despite the various problems that were encountered. It was considered that important beginnings had been made in terms of developing a co-ordinated approach to service provision for the elderly at local level. However, there was also a feeling that much more was required in order to advance the concept of co-ordination upwards through the statutory organisational and administrative system. The positive *ad hoc* working relationships that had been developed at local level in both projects were seen as been dependent on the individuals involved. Many members expressed the view that the termination of the pilot projects might also result in an end to these working relationships unless some ongoing structures were put in place. This was felt to be particularly the case in respect of the involvement of the voluntary sector. On balance, most members saw the project as having been a very useful learning experience. However, there was a view held by a minority of members that it was largely a waste of time and that any achievements that had been attained did not justify the amount of time, energy and effort that had been put in over the four-year period of the project.

There was a general consensus among respondents that local service co-ordination and specifically the type of committee process envisaged in the pilot projects would be greatly enhanced by:

- (i) the clear identification of realistic tasks and goals at the outset in accordance with available resources;
- (ii) the presence of a development worker from the beginning;
- (iii) some induction process for committee members;
- (iv) the provision of basic budgets for committees;
- (v) the provision of basic training in committee procedures;
- (vi) the provision of secretarial and administrative support services and staff time appropriate to meeting the tasks and goals specified.
- (vii) the provision of resources by parent statutory bodies to encourage and promote co-ordinated development and teamwork.

Overall, committee personnel were aware of the limitations of the pilot project in terms of the resources available and the complex tasks in hand. However, there was a general sense of achievement that the pilot project was members' first experience of inter-agency and inter-disciplinary working and that it survived over a four-year period during which many useful insights were gained. This, in essence, was what was regarded by the respondents as the pilot project's most important contribution.



## CHAPTER 6

# Problems in Implementing a Co-ordinated Approach: Two Case Studies from the Pilot Projects

### 6.1 Introduction

The previous chapter has described the experience and perceptions of project personnel in respect of the establishment, development and outcomes of the two pilot projects. Project participants experienced a number of difficulties in relation to various aspects of the project structures and programme of action. In order to further illustrate some of the difficulties associated with a co-ordinated approach this chapter presents two brief case studies. The aim of the case studies is to highlight potential problems inherent in the process of collaboration between different sectors in the provision of services and in so doing to point to the potential difficulties in any co-ordinated approach which require to be anticipated. A planned and sensitive approach is required on the part of all the parties involved if misunderstandings are to be avoided and if joint programmes are to be successfully developed.

It is frequently the case that problems which do arise in respect of inter-sectoral co-ordination are resolved satisfactorily early on, in other cases the resolution of problems is a slower process and in some instances the circumstances may be such that the problems cannot be resolved. Different perceptions of events and circumstances and separate agendas being pursued by different parties require to be recognised and addressed at all stages of the co-ordinated approach. The present case studies focus primarily on the co-ordination aspects of the schemes described. They are based on an analysis by the researcher of relevant documents, on interviews with key project personnel and on the researcher's own perception of events. The first case study refers to a voluntary-statutory forum which formed part of the programme of action of one of the projects and the other to a voluntary sheltered housing scheme for the elderly which was also undertaken under the auspices of the pilot projects.

Before presenting the case studies, it is necessary to set out some aspects of the policy-making process in order to understand its complexity and the factors which influence and shape the pace and nature of its development. This complexity is accentuated in the context of a co-ordinated approach to policy development and service provision involving both the statutory sector and the voluntary sector, which underpinned the present pilot projects. Policy-making and programme implementation are essentially selective processes through which conflicts are resolved in a way which allows the development and implementation of some programmes rather than others (Hall *et al.*, 1975). It is important to focus attention on the various factors in operation which may contribute to the speedy implementation of some policy proposals and the stifling, thwarting or slowing down of others at an early stage of development.

Account must be taken of the various components of the policy-making process which involves recognising that such a process usually has both decision-making and non-decision making elements (Bachrach and Baratz, 1970). Decision-making evidently refers to the normal operation and functioning which enables the appropriate tasks to be undertaken at the various stages of a policy process. Non-decision making, on the other hand, refers to the various means by which demands for change

can be suffocated before they are even voiced; or kept covert; or killed before they gain access to the relevant decision-making arena; or failing all these things, maimed or destroyed in the decision-implementing stage of the policy process (Bachrach and Baratz, 1970, p. 44).

Non-decision making can take many forms, ranging from an extreme form where force is used to prevent demands for change from entering the political process to a, perhaps, more common form where demands are deflected by a process of reference to committees for prolonged discussion and deliberation and/or delays in dealing with the bureaucratic, administrative and technical aspects of the issue in question. In order to understand the policy-making process it is necessary to approach it from both the decision-making and non-decision making perspectives.

In any given policy-making situation there are a number of aspects which need to be recognised (Hall *et al.*, 1975). Firstly, there is the political process which determines what issues are likely to have priority at a particular point in time. Such issues are likely to be the ones that are deemed to have popular appeal or, at least, are considered by those who exercise political control as likely to find acceptance with the majority of the electorate. Secondly, there is the administrative process which

applies limits and constraints from a perspective of resources and administration. For example, agency budgets are usually pre-determined and preclude innovative developments in the short-term. Related to this is the fact that certain policy developments require not only extra resources but "also new patterns of collaboration and new levels of commitment on the part of those individuals and organisations upon whom successful implementation depends" (Hall *et al.*, 1975, p. 481). The capacity for the required adjustment and change may not always be present within the existing administrative and organisational framework. Agency tradition and bureaucratic practices may also be barriers to policy changes and innovation and statutory functional responsibilities and protection of budgets may militate against the development of a truly co-ordinated approach to service provision. Thirdly, there is the question of ideology or values. Social policies are usually developed within and reflect an existing set of values which are normative in a particular society. Issues which challenge in a fundamental way these values and norms are unlikely to gain acceptability or legitimacy or to form part of the policy agenda. For example, there may be a prevailing understanding of the concept of partnership which defines the extent to which voluntary bodies may become involved with the statutory sector in the planning of services. The fourth factor which has a significant bearing on the policy-making process is that of power and the way power is distributed in society. Powerful individuals and pressure-groups exert major influence on the policy-making process in stark contrast to that exerted by weakly-organised groups and less articulate members of the community. Thus, small voluntary groups are unlikely to be able to exert as much influence on the policy process as are powerful commercial interests. Here, also, the ability of some professional groups to exert influence to a greater extent than other professional or non-professional groups may be a relevant factor.

The fifth factor affecting policy development referred to here is what can be termed the crisis intervention factor. Crisis intervention tends to take precedence over other policy developments and "appears to have played a particular role in the initiation, development and reform of social policies" (Hall *et al.*, 1975, p.4%). Thus, programmes that are more long-term, for example programmes proposed by the present pilot co-ordination projects, are less likely to attract resources in a recessionary climate than are crisis interventions. However, it is important to note that crisis intervention will operate within the norms and limits as determined by the other factors affecting the policy-making process as set out above. The final and, perhaps, the most significant factor influencing the policy process, and, indeed, affecting the influence of all the other factors, is what can be termed the gatekeeping factor.

This refers to the presence throughout the policy making system of key gatekeepers, people with authority to make decisions or, as the case may be, to avoid making decisions. Such people can decide to allow an issue through or to block it or to slow down its progress. It is frequently the case that innovative developments occur because a particular individual happens to be in a particular role at a specific point in time.

In any given policy-making situation, and particularly in the context of inter-sectoral co-ordination, some or all of the above factors will be in operation with varying degrees of extent and impact. Because of the presence of this wide range of factors impinging on programme development, it is very likely that misunderstandings will arise and that these will be exacerbated by poor anticipation and communication and by a failure to address them constructively from the outset. In many instances the interplay between these factors is sufficiently dynamic and constructive to enable a satisfactory working consensus to emerge between all the parties and interests involved and to enable mutually acceptable adjustments to take place. Recognising and understanding the potential presence of the factors outlined above is an important element in ensuring that they do not become barriers to effective collaboration.

## **6.2 Voluntary-Statutory Forum**

One of the functions of the pilot projects set out in the *Terms of Reference* (National Council for the Aged, 1987) was to "provide a mechanism for the integration of services for elderly persons provided by the private sector and the voluntary sector" (p. 6). This provided the context for the concept of a voluntary-statutory forum which was established by one of the projects in April 1989.

The forum brief proposed the development of a tripartite system of co-operation between the health board, the local authority and voluntary agencies working with the elderly within a defined district. The district envisaged was one of 25,000-30,000 population and was based on the functional area for the district team for the elderly proposed in *The Years Ahead* report (Department of Health, 1988). The idea for a voluntary/statutory forum was proposed initially by a voluntary sector committee member who, with the assistance of the project development worker, drew up the brief for the forum.

The voluntary-statutory forum brief set out three core objectives:

- (i) the co-ordination of care packages for individual elderly persons and the appropriate mobilisation of services, voluntary and statutory;

- (ii) the establishment of a formal structure for co-operation between the health board, the local authority and all voluntary agencies involved locally in the care of elderly persons;
- (iii) the involvement of voluntary agencies as real partners with the statutory bodies in service provision for the elderly.

The structures proposed for achieving these objectives were:

- (i) the establishment of individual care co-ordination teams, consisting of:
  - a designated public health nurse supported by an area medical officer and/or the co-ordinator of services for the elderly
  - designated representatives of various services to be called upon on an *ad hoc* basis as required:
- (ii) the establishment of a district co-ordination team comprising:
  - the designated public health nurse      1 referred to in
  - the designated area medical officer      J 0) above
  - representatives of local community care services
  - representatives of local general hospital services
  - a general practitioner (nominated by the Irish College of General Practitioners)
  - an official of the local authority
  - representatives of voluntary organisations involved in the care of elderly persons
  - other personnel considered essential to the team.

The brief for the voluntary statutory forum contained three core stipulations:

- (i) that the voluntary sector have strong representation on and involvement in the teams;
- (ii) that the district co-ordination team be chaired by an independent person from the community;
- (iii) that the health board fully support and instigate the forum project and make staff available for its development.

The first task in establishing the voluntary-statutory forum envisaged in the brief was the identification and listing of all the voluntary agencies providing services for the elderly within a specific designated area. As part of this process it was stipulated that a key organiser be identified

in respect of each voluntary service. It was also envisaged that a study of each voluntary-based service would be carried out with a view to identifying:

- (i) the extent of the need for the service;
- (ii) the resource requirements for developing and maintaining a satisfactory service;
- (iii) the potential of the voluntary sector to provide services not currently available in the designated area.

The development and implementation of the voluntary-statutory forum concept, in accordance with the brief set out above, was undertaken by one of the project local committees who commenced the task in April 1989.

Following the identification by the project committee of the catchment area for the forum comprising a population of approximately 30,000 (4,600 elderly persons) the task of identifying and contacting the voluntary bodies involved with the elderly was undertaken by a voluntary sector member of the committee and the project development worker. Two health board officers who were members of the committee were also involved in this process. It consisted in the first instance of making contact with the clergy of all denominations involved in the designated catchment area. This was followed by meetings with some key voluntary service personnel identified through the initial contacts with clergy. This process was completed by October 1989 by which stage a number of voluntary organisations and personnel had been identified and a number of issues noted. As a result of this process, some individual elderly persons in need were also identified and appropriate interventions were set in motion.

The next stage in the process occurred in February 1990 when the committee implementing the forum concept organised a general meeting with representatives of all groups that had been contacted during the initial stage. The aims of this meeting were:

- (i) to create a more general awareness of the voluntary-statutory forum;
- (ii) to provide an opportunity for voluntary personnel to state their views on the forum and on related service-provision issues;
- (iii) to improve information exchange between voluntary and statutory agencies and between voluntary agencies themselves.

This meeting was attended by about fifty voluntary sector representatives from a variety of organisations. The meeting was addressed by the two

health board officers involved in the development of the forum. A number of issues of common concern to voluntary bodies and statutory bodies were identified and views on a range of issues were exchanged.

The intention at the time was that this meeting would act as a catalyst for progressing the voluntary-statutory forum concept. However, there was no systematic follow-up to this meeting and the voluntary-statutory forum as a concept and as a pilot project goal was in effect terminated at this juncture. Some of the specific issues identified during the process of contacting voluntary agencies were, however, given further consideration by the pilot project, *viz*:

- (i) the need for greater availability of information on services and entitlements for the elderly;
- (ii) the need for more effective transport for elderly persons, particularly to clinics and hospital appointments;
- (iii) the isolation and loneliness experienced by many elderly persons and the need for more visitation /social contact schemes;
- (iv) the need for a system to provide regular relief for family carers of elderly persons;
- (v) the need for a comprehensive information package for carers of elderly persons.

Partly as a result of needs identified during the forum process, the following schemes were set in motion by the project:

- the compilation of a series of information leaflets for family carers of elderly persons;
- an information package for elderly persons to be developed in conjunction with the local Citizen's Information Centre;
- a voluntary relief sitting service for family carers;
- a voluntary car pool to provide transport to specific services for selected elderly persons.

The first of these schemes, the information package for carers, was progressed during the course of the project. Five information leaflets were completed and a mechanism put in place for the completion of another ten. The general information system to be established in conjunction with the Citizen's Information Centre was progressed only to a limited extent due to difficulties in compiling the information. The relief sitting service for carers did not get off the ground because of difficulties in respect of insurance cover that were not resolved during the course of the project. The voluntary car pool was established on a

small scale but did not develop in any effective sense. Difficulties in respect of insurance cover also arose in respect of the voluntary car pool and were not resolved.

The voluntary-statutory forum concept fell through at a stage where:

- (i) only a limited amount of work had been done in respect of one of its key elements, *viz* the co-ordination of care packages for individual elderly persons; and
- (ii) only initial identification and contact work had been done in respect of its second element, *viz* the establishment of a formal structure for co-operation between voluntary bodies and the two statutory bodies in the area.

The reasons for the lack of progress of the voluntary-statutory forum are not altogether clear. However, a number of factors can be identified which contributed to its demise. Here it is important to note that no formal decision was taken to terminate the forum by either the committee responsible for its development or by the project steering committee. The demise of the voluntary-statutory forum co-incided with the implementation of new health board policy on service co-ordination. This involved the establishment of two structures:

- (i) a *care team* at community care area level which brought together representatives of various care-providing agencies and professions (including the voluntary sector) in order to plan services for the elderly;
- (ii) a *district team* to provide care services for selected incapacitated elderly persons in their own homes for a period of six to eight weeks.

The establishment of these teams in the area had major implications for some of the health board personnel involved in the development of the voluntary-statutory forum. Firstly, one of the officers who had been actively involved in the development of the forum was appointed to work on one of the two *district teams* in the area and was consequently not available to work on the forum. Secondly, the other health board officer became the key person in the organisation of both the district teams and the care team and, consequently, had less time to devote to the forum. It may also be of relevance that the chairperson of the committee that had responsibility for developing the forum, who was a voluntary sector representative and was the person who proposed and formulated the concept of the voluntary-statutory forum in the first instance, resigned from the chair in May 1990. He had been actively



involved in making the initial contacts with voluntary groups as part of the forum process.

Another factor relevant to the demise of the voluntary-statutory forum concept was that the project development worker did not continue to work in a developmental role in this regard after February 1990. Again, this does not appear to have been a conscious decision but rather the result of an extremely heavy workload where the development of the forum was not given priority. This points to a basic mismatch between the proposed programme and available resources.

In looking at the overall situation of the voluntary-statutory forum, a number of issues arise. Firstly, even though the concept was identified as a key project goal by the project steering committee this does not appear to have translated into health board policy at community care level. This resulted in a situation where health board personnel were not available to work on the forum concept at the level required. While it was envisaged that the voluntary-statutory forum would be taken up again under the auspices of the health board *care team*, this did not happen during the life-time of the pilot project. Secondly, the overall resource implications of developing a concept such as the forum were not addressed. Thirdly, the project steering committee did not pursue the concept or attempt to maintain its momentum when it lost direction at local committee level. All of those factors beg the question as to what extent there was seriousness of intent on the part of the project about the voluntary-statutory forum. This also raises another issue about the pilot project and its relationship with its parent statutory bodies and points to the situation where programmes undertaken by the project did not necessarily translate into action by statutory personnel on the ground. In a more general sense the experience of the voluntary-statutory forum points to the complexity and resource implications of integrating the voluntary sector in the overall planning and organisation of services.

### **6.3 Voluntary Sheltered Housing Scheme for the Elderly**

One of the tasks undertaken by pilot project committees during their first months of operation was an assessment of the housing needs of the elderly within their catchment areas. As part of this process one of the local committees identified an urgent need for additional houses for elderly persons. The establishment of a voluntary Association to provide such houses was mooted as the only workable option available in the short-term. While at the time there were severe restrictions in the local authority programme of housing, it was possible for voluntary bodies to provide houses for the elderly by availing of grant aid available from the

Department of the Environment. Under existing legislation, housing authorities were empowered to give fully subsidised loans to approved voluntary Housing Associations to meet 80 per cent of the cost of providing housing for the elderly and other disadvantaged groups, subject to a maximum of £20,000 per unit of accommodation. (Under this scheme of assistance the local authority is recouped fully by the Department of the Environment provided that 75 per cent of the houses continue to be allocated to specified categories of people). In recent years this type of voluntary housing provision has been actively promoted and encouraged by the Department of the Environment. Many voluntary schemes have been developed successfully in various parts of the country which involved high levels of co-operation between voluntary bodies and local authorities, including a number of schemes in both pilot project areas. The co-operation between SHARE (a voluntary body) and Cork Corporation in the provision of accommodation for the elderly in Cork City is a good example of successful collaboration in practice. It is estimated that since 1984 some 2,200 units of accommodation have been provided under the scheme to date.

In order to develop housing for the elderly and to avail of this funding scheme the project committee set about forming a voluntary Housing Association. An informal meeting was held in September 1988 with this intent. A number of people who were regarded as having a high profile and being in key positions in the community were invited to attend this meeting. The first formal meeting of the voluntary Housing Association was held in October 1988. The general aim of the Association agreed at this meeting was to provide and manage housing for the elderly and other disadvantaged groups. At this meeting it was decided that a local authority elected representative would be the chairperson *ex officio* of the Association. Two members of the pilot project local committee, the chairperson and secretary, were nominated to the committee. The latter, who was the local authority representative on the pilot project local committee, was also elected secretary of the Housing Association. A number of members of the Association were publicly elected representatives of the local authority while others were voluntary sector representatives. An honorary treasurer of the Association was appointed in February 1989.

Following the October meeting procedures were put in place for:

- (i) the incorporation of the Association as a limited company;
- (ii) seeking approval from the Minister for the Environment for grant purposes;
- (iii) acquiring sites for the proposed dwellings;

- (iv) designing the proposed dwellings;
- (v) raising funds to meet the Association's share of the cost (20 per cent of the total cost which was estimated at £50,000).

An architect and a solicitor were engaged to work with and on behalf of the Association.

The voluntary Housing Association was registered as a limited company in June 1989 and the Association was approved by the Minister for the Environment in 1989. Fund-raising schemes were put in place and by May 1990 the Association had some £30,000 in its fund. A scheme of 12 housing units for elderly persons was designed for a proposed site owned by the local authority which was expected to be made available to the Association (see below) and planning application was made to the local authority. Application was made to the Department of the Environment in January 1990 for a grant for the housing scheme and approval for the grant was received in April 1990.

The acquisition of a site for the proposed housing scheme proved to be a difficult and complex process. At the outset the Association identified a site in the town centre which was regarded as ideally suited to a small housing scheme for elderly persons. The site was owned by the local authority and designated for housing development. Informal negotiations commenced with the local authority in order to acquire the site. From these negotiations it emerged that the site would be available for purchase by the voluntary Housing Association at a cost of £67,000 with the possibility of a grant of 20 per cent of the purchase price being available from the local authority. A formal approach was made by the Association's solicitor to the local authority in December 1988 in order to progress the acquisition of the site. During the following months, however, negotiations continued at an informal level involving the Association's solicitor, the local authority solicitor and local authority officials but with little apparent progress. Ongoing negotiations on the issue during the ensuing months brought little progress in respect of the acquisition of the site.

As part of these negotiations questions were raised by the local authority in May 1990 concerning the Housing Association's ability to raise the money needed for (a) the purchase of the site, (b) the payment of the portion of the building costs not covered by the grant and (c) the ongoing running and maintenance of the housing scheme. In order to address this issue the Association set about establishing its fund-raising programme on a more systematic basis. It also emerged at this time that no grant would be available from the local authority towards the purchase of the site. Other options for the acquisition of the site considered —

leasing of the site to the Association, joint ownership of the site by the local authority and the Housing Association, sale of part of the site for a car park, payment of the purchase price over a period of years — seemed to have been either technically not feasible or unacceptable to the local authority. It would appear, however, that none of these options were fully investigated or explored. Further discussions took place during September and October 1990 regarding the acquisition of the site which involved members of the Association and key local authority officials but the issue still remained unresolved. By this stage the Housing Association had accepted provisionally a tender for the building of the houses on the site still under negotiation.

In November 1990 negotiations about the site took on a whole new perspective when it emerged that the local authority was not in a position to make the site available to the Housing Association because of a new major development plan that had been sanctioned for that part of the town. As part of this plan for urban renewal the local authority proposed to sell the site to a private property developer. An alternative site was offered to the Association by the local authority but this compromise was not acceptable to the Association. Firstly, the alternative site was regarded by the Association as quite unsatisfactory for dwellings for elderly persons. Secondly, and more significantly it would appear, the Association felt that it had a right morally and legally to acquire the original site. The Association had invested relatively large sums of money in designing and planning a scheme for the site on the understanding that the site was available to it once the technical and financial aspects of the acquisition had been dealt with. The Association was of the view that there was a binding and enforceable agreement for the sale of the site to the Association. This view was based on a number of facts:

- (i) that planning permission for the site had been applied for and granted by the local authority;
- (ii) that there were a series of negotiations in respect of the purchase price and other technical matters relating to the acquisition by the Association of the site;
- (iii) that the design specifications for the scheme on the site in question and the process of tendering for its building was carried out with the knowledge of the local authority and on the understanding by both parties that the actual purchase of the site by the Association would occur once the technical aspects of the sale had been dealt with.

The local authority on the other hand was of the view that the site was not allocated to the Housing Association and that it was entitled to

dispose of it to a third party, particularly when an alternative site was being offered for the voluntary housing scheme.

Various efforts were made to resolve the resultant *impasse*. A number of alternative sites were offered to the Housing Association, all of which were deemed unsatisfactory. A number of informal efforts were made to resolve the *impasse*, including contact between the pilot project steering committee and key officials in the local authority. The local authority offered alternative sites which were considered by the Association to be unsatisfactory. A compromise arrangement whereby the housing scheme would be included as part of the overall development plan for the area had the advantage of the site being made available free of charge to the Association. However, members of the Association considered that this arrangement would mean that the scheme would be located in a less desirable location than that proposed in the first instance.

The foregoing brief outline of the progress of the voluntary Housing Association suggests a serious malfunctioning in the relationship between the Association and the local authority in respect of the acquisition of the proposed site. These problems must be regarded as somewhat unfortunate in the context of the pilot co-ordination project which had, as one of its central aims, the improvement of co-ordination between the voluntary and statutory sectors and where there were a number of instances of successful joint working between the two sectors. The difficulties encountered in this instance would not appear to reflect the widespread successful development of voluntary housing schemes which has been referred to above or, indeed, the less problematic evolution of other voluntary housing schemes established under the auspices of the pilot project. In the case of the present voluntary Housing Association it should, of course, be noted that there was a strong indication at the time of writing (June 1992) that the difficulties in respect of the acquisition of a suitable site would be resolved and that the housing scheme would eventually come on stream. Here it should be noted that under the 1991 Social Housing Plan local authorities are now empowered to make sites available to voluntary housing associations at a nominal charge where 75 per cent of prospective tenants are being taken from the housing waiting list.

While all the factors pertaining to the delays in progressing the voluntary housing scheme are not easily identifiable, it is possible to suggest some. Central to the *impasse* in respect of the entitlement of the voluntary Housing Association to purchase the identified site was the fact that there was no written documentation in respect of the various discussions that took place about the acquisition and purchase of the site. Thus, while the Housing Association felt that they had in fact been offered the

site, this was not the perception of the local authority. While the informal nature of negotiations between the Association and the local authority may be attributed to the dual role performed by a number of Association members (who were also members of the local authority), it may also reflect a less than rigorous approach to negotiations between statutory bodies and voluntary bodies. The experience in this instance also raises questions about the appropriateness of officers of statutory bodies becoming members of the board or officers of voluntary housing associations. The question must also be raised as to whether the local authority personnel on the Housing Association presumed too much about the availability of the site at the outset without formally checking out the position and seeking confirmation from the relevant local authority officers. There would also appear to have been at all times a reluctance on the part of the local authority to enter into a contract arrangement with the Housing Association in respect of the disposal of the site, a factor which, perhaps, should have caused the Association to take greater stock of the actual situation. It could be thus argued that the Association was somewhat remiss in progressing the housing scheme without having formally acquired the site.

Another aspect is the difficult position of public representatives who quite properly support a major beneficial development for an area even though this cuts across a desirable social project which they also support. This problem may not be appreciated fully by other people involved, thus complicating negotiations.

As a general comment on the Housing Association's operation, it would appear that the Association was initially primarily concerned with the fund-raising and design aspects of the housing scheme. The Housing Association would appear to have somehow taken it for granted that the local authority would provide a site. It seemed to have been assumed by the Association that it was the responsibility of the local authority to provide the site as had happened in other local authority areas where voluntary housing schemes were being developed. It also appears that, while in the last analysis the Association was prepared to buy the site from the local authority, they felt that they should not have had to do this and that the local authority was exploiting their goodwill and commitment to the elderly. The reason for the establishment of the Association at the outset was that houses for the elderly were urgently required in the town and that the local authority was not in a position to provide them.

The foregoing case study suggests that the core issue was a breakdown in communication between the Housing Association and the local authority. It would appear that during the early stages of the voluntary

Housing Association's existence the urban renewal scheme and the housing scheme were considered separately and exclusively and that the voluntary Housing Association was not aware of the fact that other options for the site were being considered simultaneously by the local authority. This points to less than satisfactory channels of communication throughout the deliberations which probably contributed to the *impasse* which evolved. Had the Housing Association been aware of the urban development option at an earlier stage and before it was a *fait accompli*, a compromise might have been more easily attainable. The situation was complicated further by the inevitable conflict of loyalty for some of those involved between support for a major urban renewal scheme on the one hand and the desirability of providing much needed houses for the elderly in an attractive town centre location on the other hand.

## 6.4 Conclusion

The two case studies outlined above, while somewhat different in nature, illustrate some of the problems inherent in the policy-making process and, more specifically, in the development of joint working between the statutory and voluntary sectors. As stated at the outset, problems inherent in joint working must be resolved to the satisfaction of all parties involved if successful collaboration is to occur. Firstly, there is the process of non-decision making which operates in a somewhat subtle manner to keep certain issues on hold or to allow them go off the agenda by default. In the case of the voluntary Housing Association the non-decision making process appeared to function in a way which resulted in a situation where the voluntary Housing Association was not aware of the alternative local authority option for the site identified for the housing scheme. In the case of the voluntary-statutory forum the non-decision making process operated in a manner which resulted in its demise by default.

Secondly, both case studies illustrate how the administrative system can hinder the progress and development of policy. In the case of the voluntary-statutory forum the administrative system appeared to lack the capacity and the resources to deal with an innovative approach to voluntary sector involvement. In the case of the voluntary Housing Association the local authority administrative system for processing the disposal of the site did not keep pace with other aspects of the work of the Association with consequent difficulties for the co-ordinated approach being adopted.

Thirdly, the political factor was also present in both case studies. In the case of the voluntary housing scheme it was difficult in practice to achieve

a balance between a major programme for urban renewal which was likely to have a bearing on the population as a whole and a relatively small-scale housing project. These factors are less obvious in the case of the other case study, the voluntary-statutory forum. However, the breakdown of the forum may be an implicit indication of a reluctance on the part of statutory bodies to involve the voluntary sector in an equal partnership with the statutory sector. Fourthly, it is evident that neither of the case studies referred to a programme which could be said to be crisis intervention in the conventional understanding of the term. This meant that neither project was treated with any degree of urgency by the statutory bodies involved. Finally, both case studies raise the issue of the role played by gatekeepers in the system. In both cases key statutory personnel could conceivably have progressed and provided greater momentum for the projects in question and might, in different circumstances, have been able to progress them more purposefully. Indeed, it could also be argued that the successful implementation of a co-ordinated approach requires a strong pro-active approach by key statutory personnel.

The two case studies deal with voluntary-statutory co-ordination and point to the difficulties experienced in this regard. As such they should provide a useful learning experience and contribute to the ongoing deliberations on partnership between the voluntary and statutory sectors at all levels of the policy-making system.



## CHAPTER 7

# Key Aspects of the Pilot Projects Identified and Analysed

### 7.1 Introduction

Chapter Five presented the findings of interviews with project participants and Chapter Six set out two case studies which illustrated some problematic aspects of the pilot project experience. This chapter summarises the researcher's perspectives which are based on (i) an analysis of all documents pertaining to the projects, (ii) attendance at project committee meetings (the researchers attended all steering and local committee meetings during phase one and most steering committee meetings during phase two) and (iii) a process of negotiating realities with key participants which was described in 3.3 above. The chapter is organised under five main headings: the project *Terms of Reference* and the establishment of the pilot projects; the projects and the parent statutory bodies; the development and operation of the projects and the role of the National Council for the Elderly. Finally the key issues arising out of the pilot projects are identified and analysed.

### 7.2 Establishing the Pilot Projects and Implementing the *Terms of Reference*

As stated already in this report, the *Terms of Reference* (National Council for the Aged, 1987) for the pilot projects were drawn up by the National Council for the Aged and accepted in principle by the statutory bodies in the two project areas. In retrospect, it is clear that the *Terms of Reference* were accepted without a clear recognition of the level of resources and administrative back-up required to implement them. Major difficulties in implementing these *Terms of Reference* emerged at the outset. Firstly, the two health boards involved indicated clearly that they were not in a position to second a full-time officer to the project as stipulated in the *Terms of Reference*. This was to have important consequences for the establishment and development of the projects. (See Chapter Five). Secondly, the requirement in the *Terms of Reference*

that statutory personnel be made available for participation in and servicing the steering committees was only partially met in that personnel were not relieved of any of their existing responsibilities to enable them to participate in the pilot projects. Thirdly, the *Terms of Reference* did not stipulate any personnel requirement in respect of membership and servicing of the project local committees. While such a requirement might appear to have been self-evident in view of the proposed structure and membership of the local committees and because the local committees were an integral part of the project structures it should nevertheless have been clearly stated.

While there was definite goodwill towards the pilot projects on the part of the statutory bodies involved in both project areas, it would appear that there was a certain reluctance on their part to assume clear ownership of the projects from the beginning. The fact that the initiative for the pilot projects came from the National Council for the Aged led to a situation where there was a tendency to look to the Council to generate the initial momentum for the projects. This resulted in a delay in the local statutory agencies taking full responsibility for progressing the projects and a certain confusion about the role of the Council's evaluation team. In addition, the initial impetus for the projects may have been inadequate in that the National Council for the Aged did not have a developmental brief and, consequently, did not have funds for and could not take on that role. While the Department of Health supported the projects in principle, it did not take on a promotional, developmental or funding role in this respect. This resulted in a situation where at the outset the projects were perhaps viewed at somewhat marginal in the overall context of service provision by the statutory authorities concerned.

In the case of the Tipperary S.R. project there was a difficulty in that the project was negotiated locally in the first instance through the director of community care for Tipperary S.R. and, therefore, the South Eastern Health Board at senior management level was not centrally involved during phase one of its operation. It took considerable time before the project and its resource implications were accepted at health board level and before the project became an integral part of the health board agenda. There was a somewhat contrasting situation in the case of the Dun Laoghaire project where the initial negotiations took place at central health board level and where local Eastern Health Board personnel were made aware of the pilot project only after a decision had been taken to establish it.

The initial establishment of the pilot projects was problematic for a number of reasons. Firstly, as stated above, the resource requirements

recommended and implied in the the *Terms of Reference* were not met. The statutory bodies in both project areas took the decision to instigate the projects without seconding a full time officer. There was a strong feeling that, because of the severe climate of budgetary restraint that prevailed at the time, the secondment of such an officer was out of the question. The choice was seen as being between establishing the projects without a full-time officer or not establishing them at all and the perception was that a full-time officer was not absolutely necessary. In retrospect, this was regarded by statutory personnel as an error of judgement and procedures were put in place in both projects to deploy a project development worker operating on a full time basis. (This point is discussed further in 7.4 below). Secondly, the *Terms of Reference* implied an approach to needs assessment and goal-setting and set out committee functions that had considerable resource implications. These resource implications were not spelled out in the *Terms of Reference* and were not addressed by the statutory bodies in either project area. This gave rise to considerable difficulties in respect of the operation of the project committees which have been referred to in Chapter Five and will be elaborated further in 7.4 below.

Thirdly, many statutory personnel at local level considered that the pilot project was imposed on them without due consultation and that it compounded an already difficult work situation, particularly where no provision was made for reducing existing heavy workloads. It would appear that some of the statutory personnel involved in the projects in both areas were rather reluctant participants at the outset and that this influenced their initial attitudes and level of commitment to the projects. Fourthly, administrative and secretarial back-up provided for the pilot projects in both areas was minimal at the outset and quite inadequate for the range of work being undertaken. The level of health board secretarial and administrative support was specified as the equivalent of only one person for one day per week in the case of the Dun Laoghaire project and was not specified in the case of the Tipperary S.R. project.

Fifthly, the *Terms of Reference* did not set down a protocol for the establishment of the pilot projects and the actual procedures adopted in each project area were rather unsatisfactory. The implications in terms of resources and personnel were not addressed at the beginning and no additional resources were made available to any of the statutory bodies involved. In retrospect, it can be argued that greater efforts should have been made to involve the Departments of Health and the Environment in the instigation and funding of the pilot projects and that these Departments should have been involved in the initial approaches to the local statutory bodies in respect of establishing the pilot projects. Also,

more preparatory work should have been done in the project areas to address the resource and personnel implications of the project committee functions set out in the *Terms of Reference*. This is particularly the case in respect of the local committees which were established by both projects before their resource implications were fully understood, before the steering committees had worked out a clear understanding of the project objectives and committee functions and before the respective functions of steering committees and local committees were clarified and appropriate liaison mechanisms identified. It is important to note that these problems were considerably exacerbated by the non-availability of a full-time statutory officer to work on the establishment and development of the local committees. It is also reasonable to assume that some, at least, of the difficulties identified would not have arisen if more time was spent at the outset in a consideration and critique of the *Terms of Reference* by senior personnel in the health boards and local authorities involved in conjunction with representatives of the National Council for the Aged. It is also the case that some of the difficulties would have been anticipated if an induction/orientation programme had been organised for all project participants.

The researcher takes the view that the importance of the committee process as a key element of the pilot project structures was underestimated. Secretarial back-up for committees was inadequate and the need for training in committee procedures and skills was only partially addressed.

### **7.3 The Pilot Projects and the Parent Statutory Bodies**

While the initial goodwill and support of the statutory bodies involved towards the establishment of the projects continued throughout, the relationship was less than satisfactory in that the projects had no formal statutory base, no direct claim on resources and only a minimal secondment of staff. In addition, the projects had no clear identity within the existing service delivery system and no call upon the budget allocation for local care services. From the beginning the relationship between the project and the parent statutory bodies was affected by the general climate of budgetary constraint and cutbacks which prevailed, resulting in a situation where the project was afforded only minimal attention by the statutory personnel involved. This had a significant limiting effect on the project.

There was no involvement in the projects of elected representatives of the two statutory bodies which meant that the projects did not receive the publicity or the public profile that they might have. Such a profile

might have contributed towards the projects having a more central role in the service planning and delivery system in the pilot areas.

There were no clear formal authority and accountability structures built into the project structures. In practice the reporting/liaison procedures that operated in respect of the projects between statutory personnel involved and more senior management personnel in their respective agencies were of an informal nature.

A major problem which operated in respect of project committees was the difficulty statutory members had in making time available for committee work without impinging on their existing work. While the level of statutory representation on committees was adequate in theory, in practice great difficulty was experienced by statutory people in making time available for project work which frequently had to be carried out outside of normal work hours. It should be noted that within these constraints individuals on committees worked co-operatively and systematically for the most part.

There would appear to have been a general acknowledgement on the part of the statutory bodies instigating the projects that involvement in the project by officers of both the health board and local authority would, of necessity, be in addition to their existing duties and responsibilities. In essence, this meant that statutory personnel were expected to become involved in the pilot project almost on a voluntary basis. As in the case of the non-secondment of a full-time officer to the project at the outset the lack of time for project work by statutory personnel also turned out to be a key factor in the development of the project and the functioning of project committees.

In the case of the Dun Laoghaire project the local authority indicated at the outset that there were severe restrictions on the number of personnel it could make available for committee membership. This had a big influence on the decision to establish only two local committees as distinct from an ideal number of three such committees in the catchment area. In the case of the Tipperary S.R. project the local authority was unable to make personnel available to represent the rural parts of the local committee catchment areas.

As the projects evolved, the need for greater statutory support become more accepted. This was evidenced in the Dun Laoghaire project by the allocation of funds in June 1988 for the employment of a project development worker on a full-time contract basis. In addition, statutory personnel involved in the Dun Laoghaire project began to make time available for steering committee meetings during normal working time (initially meetings had been held during lunch-time) and undertook

some committee tasks. However, lunch-time meetings for the two local committees continued to be the norm.

The establishment by the Eastern Health Board in 1990 of structures for district care teams as recommended in *The Years Ahead* report (Department of Health, 1988) re-affirmed the concept of local co-ordination of services and thus provided a supportive context for the Dun Laoghaire project. It was also the case that some key members of the care team structure were also members of the pilot co-ordination project steering committee. The downside of this, however, was that the primary policy emphasis was on the development of the care team structures which had been formally established and not on the pilot co-ordination project which was short-term and somewhat marginal to overall health board policy in respect of the elderly.

In the case of the Tipperary S.R. project the relationship between the project and the health board also improved as the project developed. A significant factor in this respect was the fact that the director of community care for Tipperary S.R. acted as health board community care programme manager for a period during phase one of the project. Consequently, there was closer and more structured communication between the local project and health board management which enhanced the relationship between the two. The Health Board facilitated the project, where possible, by making sites available for projects such as sheltered housing schemes and day care centres initiated by the pilot project. Also, the board provided funds for the defraying of expenses incurred by a development worker operating on a part-time voluntary basis from February 1989 to July 1990 and employed a full-time development worker for the final year of the project.

In the case of both local authorities involved there was a very positive attitude toward the pilot projects on the part of local personnel. However, central Departmental directives and functional responsibilities tended to dichotomise housing services and health/welfare services with a consequent reluctance on the part of local authorities to become involved in what were primarily seen as health board responsibilities. Also, financial cutbacks may have contributed to a relatively small involvement in the project committees by local authority personnel. The overall contribution of local authority personnel to the local committees would appear to have been quite small even though there was an active involvement of the local authority representative in two instances. While there was definite support for the projects at manager and assistant manager level this support did not materialise into the provision of financial resources for the projects by either of the local authorities involved. However, the local authorities did facilitate the development

of certain schemes initiated by the pilot projects — the development of a day care centre in a sheltered housing complex was supported and part-funded by Dun Laoghaire Corporation and the development of a number of voluntary sheltered housing schemes for the elderly was facilitated by Tipperary S.R. County Council.

Despite the involvement of local authority personnel in the project committees in both areas and despite the fact that local authority officers acted as steering committee chairpersons for a time in both projects, it is not entirely clear how the pilot projects related to the local authorities. It could be argued that the pilot projects should have had a higher profile with the local authorities. Indeed, it would appear that this was the original intention in the Tipperary S.R. project when the county secretary was the local authority representative on the steering committee for the first six months of the project. While the local authority involvement was evident in respect of housing issues this involvement could not be said to have extended to joint or shared responsibility with the respective health boards for the projects. Here, however, it should be pointed out that both local authorities funded (with the two health boards) a joint project conference held during the final year of the project.

In general, the projects aimed to complement and to work in harmony with existing statutory services for the elderly in the area and were supported by the various existing services. For example, the public health nurses in Tipperary S.R. co-operated fully with the development of an *elderly at risk* register which was a key undertaking of the pilot project. Also, the existing geriatric liaison nurses in Tipperary became an integral part of the project structures. There were, as already stated, practical problems with statutory service personnel making time available for project work — attendance at meetings, reading documentation and carrying out committee tasks. Also, it was frequently unclear where and how the project fitted into the existing system of provision. Decisions continued to be made and plans drawn up without any reference to the project. Frequently the projects had to struggle to make their views heard and/or to be recognised by their own parent statutory agencies as a legitimate voice in the area of service provision and development. There were also significant gaps in the composition of both project steering committees in that there was no involvement of the health board general hospitals sector or of the psychiatric services.

It is difficult to assess what impact, if any, the projects had on statutory service development locally. In the case of the Dun Laoghaire project it is likely that the project did influence and inform the procedures for establishing the care team in the area. However, it should be noted that

in 1989 the Eastern Health Board policy document. *Services for the Elderly* (Eastern Health Board, 1989), which set out the basic structures for the care teams, was drawn up without any formal reference to or consultation with the pilot project. Deliberations by the Dun Laoghaire project committees on the urgent need for a community physiotherapy service coincided with negotiations for this service at central health board level and the subsequent putting in place of such a service. Also, the identification by the project of the need to develop and maintain an *elderly at risk* register coincided with central health board thinking along the same lines. The Tipperary S.R. project provided the focus for the development of a number of day care centres in addition to the putting in place of a mechanism for developing and maintaining an *elderly at risk* register in the area.

The involvement of key service providers from statutory authorities in the project areas most likely did result in project thinking being reflected in the general approach to service provision in those areas. The projects made recommendations on various issues and these recommendations are there for consideration by the health boards and the local authorities.

While the merits of a co-ordinated approach based on the principles underlying the pilot projects and endorsed in *The Years Ahead* report (Department of Health, 1988) were gradually being recognised by the statutory bodies involved in the pilot projects, this recognition did not translate into a major input of resources to the projects. This lack of access to budgets/resources effectively marginalised the projects throughout and their pilot nature placed them outside existing and proposed planning and service delivery mechanisms.

## **7.4 The Development and Functioning of the Pilot Projects**

The initial aims of the projects and the committee functions as set out in the *Terms of Reference* were very elaborate and the challenge facing the project committees to put a structure in place to meet these aims was a complex one. This proved extremely difficult during the first year of the projects. There was a general lack of clarity at the outset as to what the purpose and function of the projects was and it took time for committee members to realise the complexity of the task. This was particularly pertinent in the case of the steering committees which had great difficulty in (i) setting targets and goals and putting in place programmes of action for the projects and (ii) providing appropriate direction accordingly for the local committees.

The researcher takes the view that there was an absence of resources



and skills on the ground to carry out the assessment of needs in accordance with the approach envisaged in the project *Terms of Reference*. This was compounded by the fact that committee members had no time available outside of meetings to allocate to project work. As a result, the approach to developing an overall programme of action by each project was somewhat piecemeal and haphazard. Project committees became overwhelmed with the task of setting objectives and this resulted in a high degree of frustration with the projects on the part of some project personnel. This frustration was dysfunctional and took a long time to dissipate. By degrees both projects adopted a more *ad hoc* approach and identified specific tasks that were achievable within the resource and personnel constraints that operated. This approach would have been more realistic for the projects at the outset and would have resulted in specific tasks being undertaken at a much earlier stage than was the case. It would also have avoided some of the more negative attitudes toward the projects that emerged.

Neither project could be said to have developed an overall programme of action. What emerged in each case was the result of a pragmatic and *ad hoc* response rather than a programme based on systematic planning. It was, nevertheless, a useful and valuable contribution with important service tasks being undertaken and some key issues identified in this regard. For example, the development of a mechanism for drawing up and maintaining an *elderly at risk* register was a useful contribution made by the Tipperary project and the compilation of a Project Report<sup>1</sup> by the Dun Laoghaire project should be a very valuable contribution to policy development in the area.

The fact that for statutory personnel membership of project committees was additional to existing duties and responsibilities would appear to have had a major impact on the functioning of all project committees. This situation was compounded by the fact that the project *Terms of Reference* were vague and over-ambitious and that committees had great difficulty in interpreting and coming to grips with them. This resulted in a lack of clarity of purpose and function. Another major problem was that committee deliberations were frequently not processed or followed through. The question must be raised as to whether it was realistic for projects of this nature to function effectively on the basis of monthly committee meetings of two hours duration in the case of the steering committees and frequently less than one hour in the case of the local

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<sup>1</sup>The Dun Laoghaire Project steering committee were in the process of compiling a Project Report at the time of writing (June 1992).

committees. There was also the problem of key statutory officers frequently not being able to attend meetings or being present for only part of them. In addition, different committee members were accountable to separate agencies and heads of discipline or section and any co-ordination that occurred at committee level was not necessarily replicated at other levels of the system.

As a general observation it can be stated that the operation of the two pilot projects was severely affected by a mismatch between functions and resources. It is thus scarcely surprising that the projects did not regularly address or review the committee functions as set out in the *Terms of Reference*. Indeed, it is the case that many of the people who joined committees during the course of the project were not aware of the various committee functions.

There were a number of factors which impinged on the operation of the project steering committees. Firstly, during the early stages there was nobody in either project who was assigned clear responsibility on a full-time basis for focussing and directing the development of the projects. In addition, neither project steering committee had a person designated to act in an executive capacity in respect of the committee. This resulted in a situation where clearcut decisions were not always taken or conclusions drawn from the deliberations of the committees and where committee decisions were not always followed through or taken up at subsequent meetings. Issues identified at committee meetings were frequently not processed systematically due to lack of time and personnel and relevant data were often not compiled for the same reason. Also, committee members frequently did not have an opportunity to consider issues between meetings and planning meetings between the chairperson, secretary and development worker were not held in either project area. The committee process was also affected by a tendency for committee members to act rather defensively in relation to their own agency or discipline on occasions and a consequent absence of the type of open discussion required for an effective coordinated approach.

Similar factors operated in respect of the project local committees and were compounded by additional ones:

- the absence of clear direction from the steering committee;
- the lack of experience in or training in committee procedures on the part of many local committee members;
- the tendency for committee meetings to be "squeezed in" during lunch-time between other tasks or held in the evening time;
- the inadequacy of basic secretarial facilities at local level;

- the lack of autonomy of some statutory members who could not undertake committee tasks without approval from their heads of discipline.

While some of these problems lessened as the projects evolved and with the appointment of development workers, some significant vestiges remained throughout and affected the purposeful working of the committees. The committee procedures were not thorough enough for the reasons outlined above, and the approach to issues was on occasions lacking in specificity and without an appropriate knowledge base. In general, the executive function in respect of the project committees was rather weak and while the situation was improved through the presence of development workers it remained less than satisfactory throughout.

In the case of some of the project local committees responsibility for initiating and sustaining development was assigned to voluntary sector personnel. While this was a welcome development in some respects it was perceived as a derogation of responsibility on the part of the statutory bodies by some volunteers who felt that the initiative, momentum and direction for a co-ordinated approach should have come from the statutory sector. The local committee chairpersons were a key part of the project structures but the importance of their role was not recognised by either project. Special induction courses should have been organised for the local committee chairpersons and regular meetings of the local committee chairpersons in each project area should have been held in order to discuss issues of common interest.

The membership of project committees was less than satisfactory in a number of respects. Firstly, neither project resolved the issue of *voluntary sector representation* on committees. While some voluntary sector members made very useful contributions to the projects, for the most part voluntary personnel on committees were there on an individual basis. While some represented their particular organisations there was no mechanism for overall representation of the voluntary sector. Co-option of voluntary sector members occurred purely on an *ad hoc* basis and was not organically linked to the local communities. The issue of voluntary sector involvement in a co-ordinated approach is considered further in 7.6 below. Also, the number of voluntary sector members on a committee was at the discretion of the individual local committee. This resulted in a situation where the number of voluntary members ranged from seven on one committee to two on another committee.

Secondly, the issue of *general practitioner representation* on project committees was not resolved satisfactorily. Those who were involved did so purely on a personal basis. The pilot projects did not succeed in

overcoming the administrative problems associated with integrating the independent general practitioner service in a co-ordinated approach. Despite a number of efforts to deal with the problem, the projects failed to negotiate any mechanism for systematic representation with the local branches of the Irish College of General Practitioners. This is a significant issue for local service co-ordination and is also considered further in 7.6 below.

Thirdly, the involvement of the *private nursing home sector* in the projects was marginal. In the case of the Tipperary S.R. project there was no representative of the private nursing home sector involved despite some initial efforts to do so. The Dun Laoghaire project co-opted a representative of the Irish Private Hospitals and Nursing Homes Association to the steering committee. This method of participation was, however, unsatisfactory: (i) the Irish Private Hospitals and Nursing Homes Association represented only about one-third of all private nursing homes; and (ii) the nursing homes representative tended to act more as an observer than as an active participant in the committee process.

Fourthly, as already stated, the committee system in both projects did not include adequate representation of the *hospital sector*. Neither project had any involvement from the administrative side of general hospitals serving the catchment areas and the Tipperary S.R. project had no effective participation from the special hospitals programme despite efforts to do so. It was also the case that there was no involvement of the *psychiatric services* in either project. Fifthly, the relatively high number of health board community care personnel on the steering committee in both projects (see figures 4.1 and 4.3 above) tended to make it difficult for single representatives from other sectors to feel that they had a real input to the work of the committees.

Sixthly, the involvement of *family carers* of elderly persons in the project committee process was not entirely satisfactory. While it was envisaged that each local committee would have a family carer as a member this occurred successfully in only two of the local committees during the course of the projects. As in the case of the voluntary sector the effective participation of family carers in a co-ordinated approach and on a representative basis requires ongoing consideration. Finally, the projects offered possibilities for the *involvement of elderly persons in their own right* in structures in which they could have an input into the planning and delivery of services both of a preventative and curative nature. However, neither pilot project succeeded in purposefully or creatively involving elderly people in the project structures.

### *Liaison Between Project Committees*

Liaison between project steering committees and the local committees was an integral part of the project structures but, in the view of the researcher, presented considerable problems in both projects.

In the case of the Dun Laoghaire project, the steering committee secretary was nominated to both local committees and was to be the central liaison person. However, this did not work satisfactorily and a degree of confusion ensued. It would appear that the liaison person was not sufficiently well briefed on, or did not clearly understand the requirements of the role and that neither the steering committee or local committees were sufficiently clear or specific in their expectations. In the case of the Tipperary S.R. project, a steering committee representative was also nominated to the local committees to act as central liaison person. This arrangement broke down quite early on in the project and, while alternative arrangements were made in respect of liaison with two of the committees, no such arrangements were made in respect of the other committees. Liaison in both projects was improved considerably by the co-option of the local committee chairpersons to the steering committees and by the appointment of development workers who attended both steering committee and local committee meetings. The regular inclusion of updates from local or steering committee meetings as agenda items for respective meetings also helped the liaison process.

However, despite improved liaison mechanisms, many problems remained about the respective roles of the steering committee and the local committees in both projects and the relationship between the two continued to be rather uneasy throughout. In particular, as the projects evolved, the local committees in each project lost confidence in the steering committee. This was partly due to the fact that the local committees had high, and probably unrealistic expectations, of the steering committees in the first instance. Liaison between steering and local committees was also made more difficult by the fact that there was no inbuilt mechanism for representatives of the different sectors on the steering committee to liaise with their counterparts on the local committees. This was particularly the case in respect of voluntary sector representatives in the two projects and of the local authority representatives in the case of the Tipperary S.R. project. In addition, there was no mechanism for local committees in each project to meet and to pool ideas or to adopt a consensus approach to common issues. The only structured meetings for local committee members were the joint project meetings which were organised by the projects on four occasions during the course of the projects.

### *Project Development Workers*

As already stated, the project *Terms of Reference* stipulated that officers of the health boards be seconded to the pilot projects on a full-time basis. The Eastern Health Board employed a development worker for the Dun Laoghaire project on a contract basis from November 1988 onwards. The South Eastern Health Board provided funds for the deployment of a part-time voluntary development worker from February 1989 to July 1990 and employed a full-time development worker for the final year of the project. The deployment of a development worker was of key importance in both projects and made a considerable contribution to the work of the projects. In both instances the development worker helped to focus the work of the committees, particularly the local committees, and contributed to better liaison between the steering and local committees. The development worker in the Dun Laoghaire project made a very useful contribution to the project programme of work during phase two. In the case of the Tipperary S.R. project the full-time development worker provided a vital impetus for the project at a time when interest and motivation was very much on the wane.

It is difficult to draw inferences from the experience of the development worker in the Tipperary S.R. project because of the relatively short duration of the full-time appointment. However, the experience of the development worker in the Dun Laoghaire project provides valuable insights. In practice, much of the development worker's time was spent on the more technical sides of the work of the project committees — preparing, typing and circulating documentation. This work would have been more appropriately undertaken by secretarial/administrative personnel which would have allowed the development worker more time to devote to developmental work with voluntary groups and professional groups. This problem was compounded by the fact that there was effectively no secretarial assistance for the development worker and by an implicit expectation on the part of the steering committee that the development worker would act as its executive secretary. Another factor which arose was the relative isolation of the development worker who was not attached to any existing discipline, who was employed on a temporary contact basis (renewable on an annual basis) and whose office was located outside the project catchment area and away from other participants in the pilot project. There was also a divergence of views about the precise role of the development worker between key steering committee members and the development worker. In addition a steering committee sub-group constituted to advise on and help prioritise the work of the development worker did not function satisfactorily and only

met briefly on two occasions during the course of the project. In practice, there was no system of direction and supervision for the development worker. While the presence of the development worker contributed much to the Dun Laoghaire project, it is the view of the researcher that the full potential of the role was not realised because of the factors outlined above.

The more limited contribution of the role of the development worker in the Tipperary S. R. project also pointed to the absence of a mechanism for integrating the development worker into health board structures and, also, indicated a less than satisfactory system of secretarial assistance and thus bears out the experience of the Dun Laoghaire project. While the isolation of the development workers was partly addressed by the development workers themselves by arranging regular meeting between them, neither project developed a mechanism for integrating the development worker into the day to day system of health board administration. Also, an innovative pro-active developmental role would have required a level of support and direction for the development worker that was not available in either project area.

## **7.5 The Role of the National Council for the Elderly**

As already stated, the four statutory authorities involved, the Eastern Health Board, Dun Laoghaire Corporation, the South Eastern Health Board and Tipperary S. R. County Council established the pilot projects in 1987 on the suggestion of the National Council for the Aged. The Council undertook to evaluate the pilot project over a three-year period. This was subsequently extended to four years by agreement of all the parties involved. During phase one of the projects the Council's evaluation team adopted an action research approach to the evaluation which involved working in close harmony with the project committees in interpreting the project *Terms of Reference* and in drawing up programmes of action with defined goals and targets. This approach was adopted for two reasons, firstly, to assist in the identification of specific project goals and targets against which outcomes could be evaluated and, secondly, to assist project personnel in clarifying tasks and committee functions. As part of this process, the evaluation team prepared a number of briefing documents for the committees and provided critical comment and feedback on the process of establishing structures and setting goals for the projects. In retrospect, the role of the evaluation team during phase one had both positive and negative aspects. On the positive side, the evaluation team provided a necessary and useful focus for the project committees at a time when they were struggling to find a direction for themselves and when neither project had a development

worker. On the negative side, some of the documentation prepared by the evaluation team was vague and over-ambitious in terms of the skills and resources available to the project and compounded the initial shortcomings and lack of precision of the project *Terms of Reference*. Another shortcoming of the action research model of evaluation adopted during phase one was that a high proportion of the research time was used in a supportive/developmental role to the project committees. While this was a valuable contribution, it diffused somewhat the objective evaluation role of the researchers. During phase two of the project the evaluator (a part-time researcher) did not operate at all in the supportive/developmental role that existed during phase one. This may have been a significant loss to the project local committees, particularly in the case of the Tipperary S. R. project where a full-time development worker was not in post until January 1991.

It is very likely that ongoing regular and focussed inputs from the evaluator throughout the project would have helped, particularly if they were considered in the context of assessing progress in implementing the project committee functions which, as already stated, were not systematically referred to by any of the project committees. This did not occur for two reasons:

- (i) the resources available for the evaluation of the projects were limited and allowed for only a relatively small level of research involvement during phase two;
- (ii) such inputs were not at any time requested by the projects.

### ***Interim Evaluation Report***

As part of the evaluation process, an *Interim Evaluation Report* (Browne, 1989) was prepared which covered phase one of the projects (that is up to the end of 1988). The report had four principal objectives which were aimed at assisting the development of the projects:

- (i) to identify factors which impinged on the development and functioning of the projects during phase one;
- (ii) to provide demographic and other data which would assist the projects during phase two;
- (iii) to set out an agenda of tasks which needed to be addressed in order to enable the projects to function more effectively.

The Interim Report which was issued in April 1989 had relatively little impact on the projects and did not serve the function intended. A number of reasons for this lack of impact can be identified. Firstly, the report itself was a comprehensive and rather bulky document which did



not lend itself to easy consideration by project committees. Secondly, more work should have been done to summarise issues and tasks identified and to process these at committee level. Such work should ideally have been undertaken by project development workers in consultation with the researcher. This was difficult in practice, however, because one of the projects did not have a full-time development worker and because the part-time researcher evaluating the projects during phase two was unavailable for a period of six months following the compilation of the Interim Report. Thirdly, many of the issues identified as affecting the operation of the pilot projects were outside the immediate control of the projects and required to be addressed at higher administrative and policy-making levels. There appeared to have been little interest at these higher levels in examining the issues identified in the Interim Report. A fourth and related reason for the relatively small impact of the Interim Report is the fact that the National Council for the Aged, who were responsible for the evaluation of the report and to which body the Interim Report was submitted, ended their term of office in May 1989 immediately after the compilation of the Interim Report and a newly constituted National Council for the Elderly did not take up office until March 1990. While the outgoing Council did organise a workshop in May 1989 involving project participants and representatives of relevant agencies which discussed the findings of the Interim Report, there was no immediate follow-up to these issues and a proposed consultative committee on co-ordination to address such issues was not constituted until March 1990. There was also a problem in respect of the workshop organised by the Council in that it did not facilitate discussion and exchange of views between project personnel and, therefore, did not address their immediate requirements. The workshop was structured in such a way as to place the issues arising from phase one of the pilot projects within the broader context of developing local service co-ordination. In retrospect, a workshop should have been structured to address the immediate problems of project committees and project personnel on the ground.

While the Interim Report appears to have had little impact on the projects and while not all project personnel agreed with all of its findings, it nevertheless served some useful purposes. By identifying constraints that were outside the control of project committees it helped to dissipate some of the frustration being experienced by project personnel. It also helped to draw greater attention to the existence of the pilot projects and to give them a better profile with their parent statutory bodies.

### *Consultative Committee on Co-ordination*

As already stated, the National Council for the Elderly established a Consultative Committee on Co-ordination in March 1990 with the following aims:

- to assist the projects in clarifying their aims and objectives for the duration of phase two;
- to receive direct representation from the projects;
- to address itself to issues such as service overlaps or gaps in service provision that could not be resolved at project level without agreement at higher managerial, health board and departmental level;
- to make recommendations to the Council on issues raised by the projects, particularly (i) in relation to the flow of relevant information between the statutory and voluntary sectors and (ii) in putting co-ordination on the agenda at higher levels — i.e., at health board regional level and national level in the statutory sector, and at appropriate levels in the voluntary sector.

The committee was constituted as a sub-committee of the Council and its membership was comprised of representatives of the Departments of Health, the Environment and Social Welfare, a representative of each of the two pilot projects, a health board chief executive officer, a county manager, representatives of the National Council for the Elderly (including a general practitioner) and the project evaluator. The committee met on eight occasions between March 1990 and December 1991.

The committee addressed a number of issues arising out of the experience of the pilot projects and in particular focussed on issues which required discussion and resolution at higher level. On the basis of the deliberations of the consultative committee the Council made submissions to the Department of Health on (i) the issue of representation of the voluntary sector in a co-ordinated approach and (ii) difficulties in co-ordination between statutory agencies, particularly between health boards and local authorities and, to a lesser extent, between these bodies and the Department of Social Welfare. In order to address the issue of voluntary sector representation it was recommended that the Department of Health fund the appointment on a pilot basis of development workers in two selected health board community care areas to work with and develop the voluntary sector in these areas and in so doing to address the problem of representation. However, to date no arrangements were made for the deployment of such development workers, but the development of the voluntary sector was included as a specific part of the work brief of the development worker appointed to the Tipperary

S. R. project in January 1991. On the question of difficulties in co-ordination between statutory agencies it was submitted that there was an urgent need to implement the recommendation contained in *The Years Ahead* report that "*the Departments of Health, the Environment and Social Welfare agree administrative arrangements to ensure co-ordination of policy towards the elderly at national level and monitoring of progress towards the implementation of the recommendations of this (The Years Ahead) report*" (Department of Health, 1988. p. 51). At the time of writing (June 1992) this recommendation had not been implemented by the Departments concerned.

The impact of the consultative committee on the pilot projects would appear to the researcher to have been minimal. It was established too late in the life of the projects to be of assistance in the process of clarifying project aims and objectives for phase two. The two submissions made by the Council would appear to have had no impact on the functioning of the pilot projects and it is not clear whether or to what extent they will contribute to the process of policy development or service co-ordination in the long-term. The committee relied very much on the two projects to refer issues for consideration. While some issues affecting the working of the projects (for example, transport issues in respect of the elderly and problems of insurance cover in respect of volunteers) were referred, there was no regular flow of such issues and, consequently, the committee met on only two occasions during 1991.

A positive outcome of the establishment of the consultative committee was that it brought the pilot projects to the attention of the three key Government Departments — Health, the Environment, Social Welfare — dealing with services for the elderly. It also brought the pilot projects to the attention of the health board chief executive officers and the City and County Managers Association through the involvement on the committee of representatives of these bodies.

In the researcher's view, the consultative committee also provided a broader context for the projects and a forum through which the issues being experienced on the ground could be channelled. It provided a focus for the projects which enabled them to crystallize local difficulties and point to their regional or national implications. It also helped the projects to focus more clearly on co-ordination as the key organising concept of the pilot projects and to progress service development accordingly. However, the barriers to local co-ordination which arise from separate functional statutory responsibilities and from the absence of an ethos of co-ordination throughout the system were not addressed by the committee. Rather, representatives of the various agencies tended to articulate their own functional responsibilities, describe their own roles

in the system and present agency or departmental perspectives. While theoretically the consultative committee could have engaged in an open-ended and imaginative consideration of the co-ordination issue, in practice it tended to be hidebound by the *status quo* and limited in its deliberations by a preoccupation with defending the existing system of statutory functional responsibilities. It appears to the researcher that the experience of the consultative committee bore out the conclusion reached by Barrington (1980) that members of interdepartmental committees tend to concentrate on voicing the viewpoints of their own organisations and that because of this such committees tend to "produce solutions that are at the lowest level of agreement and that seldom or ever represent a creative solution to the problem" (Barrington, 1980, p. 113).

## **7.6 Components of Effective Co-ordination: The Pilot Projects Analysed**

The experience and outcomes of the pilot co-ordination projects need to be considered in the context of general factors which predispose towards effective co-ordination. Drawing on the literature on the issue of co-ordination as presented in Chapter Two, eight such factors are set out in Figure 7.1 — *the presence of an ethos of co-ordination; a shared understanding of the co-ordination task; favourable organisational arrangements; adequate resources; joint planning to facilitate joint working; partnership; an inter-disciplinary team approach; and the key worker concept*. Each of these factors is now considered with particular reference to the pilot co-ordination projects.

### *An Ethos of Co-ordination*

The co-ordination of service provision for the elderly at local level is a complex and challenging task which requires the presence of an ethos of co-ordination throughout the legal and administrative system. This ethos needs to be reflected at national, regional and local levels, beginning with Government itself and permeating through Government departments, regional authorities and local agencies. The concept of co-ordination as the cornerstone of service provision needs to be enshrined in administrative structures which enable agencies at all levels of the system to co-ordinate their efforts in the planning and financing of service provision. In order to bring about such an ethos it is necessary to overcome barriers created by administrative and political traditions and by separate methods of financing and separate budgetary processes (OECD, 1977). In the Irish situation, however, the existing administrative system which is divided according to broad functions and single

**FIGURE 7.1: Towards a model of effective co-ordination**

<i>Component</i>	<i>Elements of Component</i>
(i) An ethos of co-ordination	National and regional administrative and institutional arrangements favouring co-ordination.
(ii) A shared understanding of the co-ordination task	A belief in the value of co-ordination; emphasis is on interdependence rather than functional authority; acceptance of super-ordinate goals; a problem-solving rather than a bargaining approach to decision making.
(iii) Favourable organisational arrangements	Opportunities for one to one relationships on a regular basis; simplified administrative structure; rule of "primary responsibility".
(iv) Adequate resources	Financial investment needed to promote co-ordination.
(v) Joint planning to facilitate joint working	The capability to jointly plan a balance of health, welfare and housing services as opposed to joint discussion of separate plans; joint financial and budget arrangements.
(vi) Partnership	Shared responsibility for planning, policy-making and implementation; all partners vital to servicing the elderly involved — general practitioners, voluntary, private and informal sectors in addition to statutory bodies.
(vii) Inter-disciplinary team approach	Domain consensus; breakdown of status differences; physical proximity; continuity of team members; effective team leadership; ongoing training and education for co-ordination.
(viii) Key worker	Key worker to facilitate exploring of development options; promoting exchange of information.

departments at central Government level and which does not have any formal integrated administrative mechanism at local level (Barrington. 1980). tends to militate against an ethos of co-ordination. Our system of administration is highly centralised (Barrington, 1980) and allows for only minimal inputs by local bodies, whether statutory or voluntary, into the policy and decision-making process (OMahony. 1985).

The pilot co-ordination projects were thus working in an administrative context where a co-ordinated approach at central level was not the norm and where there was little scope for innovative development at local level because the major thrust of policy was already determined at central level. In attempting to co-ordinate services for the *elderly* at *local* level the pilot projects were in a real sense attempting to swim against the tide. In practice it proved very difficult to develop a co-ordinated approach in respect of services for the elderly in a policy context which lacked a generic approach to service co-ordination. Also, while the need for co-ordination at national level in respect of services for the elderly was identified in 1988 by the Department of Health Working Group on Services for the Elderly, no institutional arrangements were put in place to address this need. As stated above, a recommendation to this effect made in *The Years Ahead* report (Department of Health, 1988) that the Departments of Health, the Environment and Social Welfare agree administrative arrangements to ensure co-ordination of policy towards the elderly at national level was not implemented during the life-time of the pilot projects. This absence of an ethos of co-ordination, while outside the direct control of the projects and to a large extent also outside the control of their parent statutory bodies, had a major bearing on the work of the pilot projects.

### *A Shared Understanding of the Co-ordination Task*

In addition to the presence of an ethos of co-ordination, the implementation of a co-ordinated approach also requires a shared understanding of the co-ordination task based on a shared belief in the value of co-ordination. It requires an acknowledgement of the premise that single agency goals can be achieved most effectively with the assistance of other agencies (Gilbert and Specht, 1977). It further requires an appreciation of policy and planning issues from the perspective of other agencies and professions as well as one's own (Stringer, 1967). The acceptance of superordinate goals, that is the subordination of immediate agency or professional goals to longer-term and broader objectives, is also a pre-requisite for a co-ordinated approach (Bruce. 1980) and should facilitate the process of identifying and working towards agreed joint objectives in the short-term. This also entails an emphasis on the notion

of fostering interdependence between agencies as distinct from an approach which is aimed at maximising the functional autonomy of individual agencies (Gilbert and Specht, 1977). A problem-solving approach to joint decision-making as distinct from a bargaining approach (based on a premise of gaining or losing) is a further important element of a co-ordinated approach. Because of the absence of an ethos of co-ordination throughout the system the pilot projects experienced some difficulty in coming to terms with an approach to co-ordination which embraced notions of superordinate goals and interdependence and which challenged the traditional concept of functional autonomy and responsibility. It is not surprising that at the outset there was a strong tendency for issues to be approached primarily from the agency or discipline perspective and a certain amount of defensiveness on the part of project participants in respect of their agency, discipline or programme. While this defensiveness was a characteristic of statutory personnel in both projects, as already stated, it also appeared to be reflected in the working of the National Council for the Elderly Consultative Committee on Co-ordination as outlined in 7.5 above. As the projects evolved and as personnel on project committees came to know each other, some of this defensiveness dissipated. However, the project participants' approach to co-ordination continued to be hampered throughout by their functional and professional responsibilities which pertained outside the context of the pilot projects. While a shared understanding of the co-ordination task emerged gradually in the context of the projects, this understanding may not have gone beyond the individual project participants. Also, while participants gradually came to recognise and understand the perspectives of other sectors, existing policy and budgetary processes precluded the development of shared or superordinate goals in any planned or structured sense.

### *Favourable Organisational Arrangements*

The successful implementation of a co-ordinated approach requires the presence of favourable organisational arrangements (Wright *et al.*, 1988). Structures are needed where personnel from different agencies have opportunities for one-to-one meetings on a regular basis, thus allowing understanding and mutual trust to develop. It also requires a rationalisation and simplification of existing administrative structures and geographical boundaries. The establishment of clear criteria between professionals and agencies in respect of matters such as transfer and referral is also required so that all personnel involved are agreed as to who has primary responsibility for a particular situation.

In the case of the pilot co-ordination projects the researcher considers

that the organisational arrangements were less than satisfactory in a number of respects. Firstly, personnel from the various sectors involved continued working from their own agency offices so that there was a continued physical distancing of the personnel from different sectors. Secondly, the relatively high number of health board community care personnel involved in both project steering committees and based in the one office tended to make it difficult for individual representatives from other sectors to have effective participation. Thirdly, in the case of the Dun Laoghaire project, the personnel responsible for administering the project were located at central health board level and at a distance from the project catchment area. Also, in the Dun Laoghaire project the development worker's office was located both outside the project catchment area and away from central health board offices. Fourthly, in the case of both projects there was no administrative mechanism at local level to facilitate day to day contact between local committee personnel. Fifthly, there was a problem in respect of the administrative catchment area for each project. In the case of Dun Laoghaire project the local authority functional area which was the project catchment area catered for less than half of the population of the relevant functional health board community care area. In the case of the Tipperary S. R. project there was a part of the functional health board community care area which was outside the relevant local authority functional area. In addition, there was the situation that while the boundaries of the catchment areas for the local committees in the Dun Laoghaire project were identified at the outset, in practice these boundaries had little bearing on committee work or membership. A sixth organisational factor which presented difficulties for the projects was the absence of any framework for integrating the various health board programmes at local level and the consequent difficulty of involving the hospital sector and the psychiatric services in the projects. The pilot projects did not develop or propose any new organisational structures to deal with the problematic interface between hospitals and community care in respect of the elderly. Another significant aspect of the pilot project structures already stated was that they were based on a committee system which was rather unsatisfactory in practice because many committee members lacked training or experience in committee procedures.

A final and centrally important point in relation to the organisation of the pilot projects was that they had no formal basis within the existing statutory framework and were purely advisory in nature. In practice, the pilot project committees were not consulted by parent statutory bodies about policies and programmes that were being put in place. This contributed significantly to the fact that the projects remained outside the mainstream of service provision.



### *Adequate Resources for a Co-ordinated Approach*

Experience has shown that a co-ordinated approach is costly in organisational terms and financial incentives need to be provided if innovative joint developments are to emerge (Dant *et al.*, 1989). Effective co-ordination is not necessarily a cheap option. It is also the case that co-ordination is likely to work best where services already have sufficient resources and confidence in themselves to allow 'give and take' to occur (Wright *et al.*, 1988). In general, co-ordination cannot be seen as a substitute for inadequate resources (Holman, 1978). The pilot projects operated in a climate of severe budgetary constraint. No additional funding was made available for the projects. Also, as has already been stated, most statutory personnel involved in the projects were not relieved of any of their existing responsibilities in order to undertake project work. The absence of additional resources for developing an innovative approach to co-ordination was exacerbated by the lack of funds to deal with service gaps identified and needs identified. Also, the work of the local committees in each project area was severely restricted by the fact that they had no direct access to resources of any kind and, consequently, no basis on which to engage in programmes of work on their own initiative.

### *Joint Planning to Facilitate Joint Working*

Joint planning is central to the concept of service co-ordination and joint working. What is required is jointly prepared plans as distinct from an exchange of views on separately prepared plans (DHSS, 1973). Joint planning involves the acceptance of a longer-term agenda in respect of an appropriate balance of provision in housing, health and welfare services — statutory, voluntary and private (Chant, 1986). This requires that obstacles created by separate budgetary provision and separate prioritisation of needs by different agencies be overcome. In this context the provision of joint finance provides an incentive to agencies to work together on the basis that the money allocated cannot be spent unless all parties agree (Glennerster *et al.*, 1982) and provides a totally new context for joint planning and collaboration (Booth, 1983).

There was little scope for joint planning in the pilot projects in that the planning processes of the statutory agencies involved continued to operate without any formal involvement from the project. While it is likely that individual personnel involved in the projects represented the project experience in their own inputs into planning and policy in their respective agencies, this was something quite different from joint planning. Also, while there was some co-operation and sharing of

resources between the statutory and voluntary sectors and between the health and housing authorities in respect of specific schemes, for example, day care centres and sheltered housing schemes, this operated on an *ad hoc* basis rather than on the basis of systematic joint planning and joint financing. However, there was a positive approach to joint financing when the four statutory bodies involved financed a workshop for all project participants.

### *Partnership*

The concept of partnership is crucial to a co-ordinated approach and involves the integration of the non-statutory sectors into the planning, policy-making and policy-implementation processes of the state. It requires a clear definition of the role of the private sector within the context of a mixed economy of welfare provision and appropriate planning mechanisms to involve this sector in a manner which is complementary to the statutory welfare system. Partnership also requires that the voluntary sector be involved in the policy-making and planning arenas (Brenton, 1985) in a manner which goes beyond mere rhetoric (Leat *et al.*, 1981). This requires that strategies be developed to facilitate appropriate representative mechanisms for a fragmented and diverse voluntary sector (Wolfenden, 1978). Partnership also entails the incorporation of independent professional groups and, in particular, the general practitioner service into the policy-making and planning processes of the state (Hunter *et al.*, 1988). As in the case of joint planning, there is an important distinction between groups or agencies submitting views and being actively involved as partners in the decision-making process.

While partnership between statutory and non-statutory sectors was an important underlying principle of the pilot co-ordination projects, it proved a very difficult concept to implement in practice. The involvement of the private sector, the voluntary sector and the general practitioner service was less than satisfactory in both projects. As already stated, the voluntary sector was involved in both projects on an individual rather than a representative basis and the limited general practitioner involvement in the projects was also on an individual basis. The private nursing home sector had a marginal involvement in the Dun Laoghaire project and no involvement at all in the Tipperary S. R. project. In addition, because the projects were outside the mainstream of service planning and because the budgetary system precluded local initiatives by the projects, there was little scope for effective partnership in the context of the pilot projects.

### *An Inter-Disciplinary Team Approach*

Effective co-ordination requires teamwork and collaboration between professionals and administrators. Such teamwork is facilitated by an acceptance of the concept of domain consensus, an area of activity over which all are agreed a particular profession, discipline or administrative unit has legitimate authority (Bruce, 1980). Inter-disciplinary teamwork is also facilitated by the breaking down of conventional status differences between professions which frequently results from face to face contact between the professions (Bruce, 1980). Continuity of team members also promotes the development of close links and understanding as does effective team leadership (Wright *et al.*, 1988). Basic and ongoing education and training in inter-disciplinary working is also an important aspect of teamwork.

The pilot projects were the first opportunity that many of the participants had for inter-disciplinary working. During the course of the projects many barriers were broken down and a new openness and trust between members developed as a result of the project experience. Also, there were some good examples of inter-professional working as in the case of the group of professionals who prepared and compiled an information package for family carers under the auspices of the Dun Laoghaire project. However, it would appear that issues such as confidentiality, domain consensus and statutory responsibility affected the work of the projects. For example, the issue of confidentiality operated in respect of how much information could be divulged to voluntary sector personnel. The issue of domain consensus operated somewhat in the reverse with some local authority personnel taking the view that they had no brief to become involved in health matters. Another issue which arose in the Dun Laoghaire project was a difficulty that some professionals had with non-professional personnel having key roles on co-ordination committees. The issue of education and training in inter-disciplinary working was also one which was not adequately addressed by either project. While some training in committee procedures was provided for local committee members in the Dun Laoghaire project during its final year of operation, this training was not designed to address the complexity of inter-disciplinary working. A final issue in respect of inter-disciplinary working was that neither project designated any person as a full-time team leader.

#### *Key Worker*

The need for a key worker to bring together the various elements in a co-ordinated approach is widely recognised (Bulmer, 1987). The presence of a key worker facilitates exchange of information and communication

between participants. S/he also provides the crucial link between participants on a day-to-day basis and thus can keep abreast of changing problem situations. The key worker is also in a position to put forward solutions which will enable mutually acceptable adjustments to take place between the personnel and the agencies involved (Power, 1971). The issue of project development worker has already been discussed in 7.4 above and its implications for the pilot projects have been considered. The employment of development workers in the two projects contributed much to their operation and development in terms of focus and information exchange. However, the absence of development workers during phase one was a considerable shortcoming at that time and had an effect on the ongoing development and functioning of the projects throughout.

## 7.7 Summary

This chapter has presented the researcher's perspectives in respect of the establishment, development, operation and outcomes of the pilot projects. It has considered issues relating to the establishment of the pilot projects and their *Terms of Reference*. It has also discussed the relationship between the pilot projects and their parent statutory bodies. A number of aspects of the development and operation of the pilot projects have been highlighted and the role of the National Council for the Elderly, on whose suggestion the pilot projects were instigated in the first instance, has been considered. In the final section of the chapter the experience and outcomes of the pilot projects has been analysed in the context of a series of factors which, according to the literature, are likely to constitute a model of effective co-ordination.

The general conclusion which emerges from the analysis is that the pilot projects were operating largely in a policy vacuum. There is at present a general absence of an ethos of co-ordination throughout the Irish administrative system. Also, the organisational structures put in place by the projects were not a formal part of the main statutory organisational framework for service planning and provision. The difficulties in implementing a co-ordinated approach in such circumstances was further compounded by the climate of severe budgetary restraint that prevailed. The *Terms of Reference* for the projects were over-ambitious both in terms of the resources available to the projects and in terms of the prevailing absence of an ethos of co-ordination. The inadequacy of the *Terms of Reference* was exacerbated by the failure of the projects to deploy full-time officers as stipulated. In addition, the findings of the *Interim Evaluation Report* and its recommendations were not adequately considered or implemented. The involvement of the non-statutory sectors in the pilot projects was primarily on an individual and somewhat

*ad hoc* basis and the projects did not in practice carry out a planning function. As the projects evolved there was a greater recognition and understanding of the co-ordination task and its complexity and a greater appreciation of the concept of inter-disciplinary teamwork. While the projects operated under substantial institutional and structural constraints, the dedication and commitment to the co-ordination task of many of the personnel involved contributed much to the building of a necessary platform on which future approaches to co-ordination can be built.

## CHAPTER 8

# Summary, Policy Implications and Conclusion

### 8.1 Introduction

This report deals with the evaluation of two pilot projects which were established in order to improve service co-ordination for the elderly at local level. The rationale underlying the projects was that service provision for the elderly would be improved through the establishment of structures to facilitate teamwork, liaison and collaboration between the various sectors and programmes involved in the planning and delivery of such services. The pilot projects were the first attempt in the Republic of Ireland to bring together in a systematic manner the various parties, statutory and non-statutory, involved in the provision at local level of health, housing and welfare services for the elderly. Since tried and tested models of local service co-ordination did not exist, the task of operationalising the pilot project concept presented a considerable entrepreneurial challenge. This chapter summarises the experience of the two pilot projects in responding to this challenge. It also presents a summary analysis of the principal issues which affected the establishment, development and programme of work of the pilot projects. The chapter sets out a number of policy issues which are regarded as likely to have a bearing on service co-ordination for the elderly at local level. Finally, some general conclusions are drawn from the project experience and from the analysis of the various factors which impinged on their operation.

### 8.2 Summary Analysis of the Pilot Projects

There was a high level of goodwill, commitment and generosity of time on the part of many of the pilot project participants, both voluntary and statutory. The existing good *ad hoc* relationship between health board and local authority personnel on the ground in both project areas was an important positive factor, particularly during the early stages of the projects. Both of these contributed to the continuation of the projects

over a four year period despite considerable institutional, structural, budgetary and organisational difficulties. It is a tribute to the commitment and goodwill of the people involved that the projects continued for four years, that some new services were put in place, that important gaps in service provision were identified and that useful information exchange and improvements in inter-agency and inter-sectoral working relationships occurred at local level over the period. In a general sense, the projects, by applying the theoretical concept of local service co-ordination, made a significant step forward. Difficulties that were encountered in respect of co-ordination, local and institutional/structural, were identified and brought to the attention of the relevant bodies. The concept of co-ordination became more clearly understood by the participants who had first-hand experience of both the potential and difficulties of teamwork and collaboration. The projects provided a useful forum for the breaking down of barriers and for improving information exchange between local authority and health board personnel, between statutory and voluntary personnel, between professionals and between service professionals and administrators.

The projects contributed significantly to better communication and liaison between professionals working with the elderly and between statutory and voluntary sector personnel and paved the way for a more effective team approach in the future. Individual working relationships were strengthened and there was a growing awareness of the difficulties facing the management of statutory bodies in implementing a co-ordinated approach to service provision. Individual personnel were exposed to a wide range of issues and information through the projects which should enhance their skills and knowledge-base not alone in dealing with elderly clients but also with other staff and other client groups.

The projects facilitated the use of a co-ordinated approach in the assessment of various services by affording an opportunity to all groups and agencies to make comments on each service from their own particular perspective. Recommendations in respect of a number of service issues based on such an approach were submitted to the appropriate authorities. The experience of the pilot projects also provided an important complementary perspective to the new emphasis on developing and co-ordinating services for the elderly that emerged as a result of *The Years Ahead* report (Department of Health, 1988). The project experience should be a most useful one in the process of implementing the recommendations on service co-ordination contained in the latter report.

The projects contributed much to a greater awareness of the range of needs of the elderly and of the substantial difficulties to be overcome if these needs were to be addressed in a comprehensive and co-ordinated

manner. However, the projects did not explore a more preventative approach to illness and dependency in old age or explore the concept of older people as a resource in the community.

In practice, considerable difficulties were experienced in respect of the establishment and development of the pilot projects. This is hardly surprising since the projects had no prior model to guide them. The project *Terms of Reference* set out elaborate project tasks and committee functions which were over-ambitious and generally beyond the scope of the personnel and resources made available to the projects. The projects did not systematically carry out the project functions as stipulated and, in particular, the project steering committees did not carry out the primary planning function assigned. In terms of work programmes, both pilot projects adopted an *ad hoc* approach to goal-setting. Such an approach differed from the more systematic and rational approach to needs assessment and goal-setting envisaged in the project *Terms of Reference*. It was, however, the only approach that was practicable within the resources available to the pilot projects. It resulted in the instigation of a number of schemes in respect of day care, sheltered housing and support for family carers under the auspices of the projects and in the identification of a range of co-ordination and service issues in respect of elderly persons and their carers which should form the agenda for future action in the two project areas.

The projects were established at a time of severe budgetary constraint and staff cutbacks in statutory services. Undoubtedly this was a major obstacle to the work of the projects and made service development and innovation extremely difficult. The lack of adequate resources was particularly pertinent to the project local committees who had no direct access to any resources. Also, the pilot co-ordination project structures were somewhat less than satisfactory in that they were conceived and applied from the top down rather than having been developed through a process of discussion and reflection with personnel on the ground. In this sense the project structures were not sufficiently organic and for this reason may have lacked a sense of reality.

The concepts of co-ordination, collaboration and teamwork in service delivery were relatively new in the Irish context when the projects were instigated and it took considerable time for project personnel to come to terms with the complexity and inherent difficulties of operationalising such concepts.

The pilot project process in both areas was less than satisfactory because participation in the projects by statutory personnel was additional to their existing duties and responsibilities. It was also the case that project



development workers were not available during the first year of the projects, a crucial period in their development.

Project committees functioned less than satisfactorily, particularly during the early stages of the projects. The lack of training/experience in committee procedures coupled with the absence of basic introductory/orientation programmes at the outset was a definite drawback. In addition, the project local committees were established before the steering committees had processed or come to grips with the project *Terms of Reference* and before the specific roles of respective committees were clarified. Liaison between the steering committees and local committees in both project areas was less than satisfactory throughout and neither project steering committee could be said to have assumed overall leadership or direction for their own project.

The *Terms of Reference* proposed committee structures for the projects which would involve the statutory and non-statutory sectors — health board, local authority, the voluntary sector, the private sector, the general practitioner service and the family caring network. In practice, the projects were unsuccessful in integrating the voluntary sector, the general practitioner service, the private sector and the family caring network. While there was some involvement in the projects of all these sectors it was on an individual rather than on a representative basis. The involvement of health board programmes other than the community care programme in the projects was also less than satisfactory. There was no effective involvement of the psychiatric services or of the general hospitals in either project. This was a significant shortcoming of the pilot projects in that it would have been reasonable to expect that co-ordination projects of this nature would have been able to address the problems arising from a lack of adequate co-ordination between the three health board programmes, all of which have involvement with the elderly.

The pilot projects were established in a predominantly urban area and a predominantly rural area on the basis that there might be differences in the outcomes of the two projects. In practice, the experience in both project areas appeared to be broadly similar. Issues of inadequate resources, less than satisfactory committee functioning, difficulty in formulating a programme of action, problems in integrating the non-statutory sectors (voluntary, private and general practitioner) and difficulties in involving the health board psychiatric services and hospitals programmes were common to both projects. In addition, there was a certain lack of clarity in both projects concerning the role of the local authorities and specifically a lack of understanding about the local authorities' joint responsibility (with the health boards) for the projects.

The Tipperary S. R. rural-based project experienced some difficulty in incorporating the rural parts of its catchment area in its committee structure due mainly to lack of personnel and the absence of a development worker for much of the project's life-span. However, it is also the case that there were many parts of the Dun Laoghaire project catchment area that were not involved though this omission was less apparent than in the case of the rural project.

As indicated in Chapter Seven, there were a number of general factors which had a bearing on the pilot projects. The absence of an ethos of co-ordination throughout the Irish administrative system meant that the general climate conducive to a co-ordinated approach at local level was lacking. This absence of an ethos of co-ordination also meant that the statutory bodies who instigated the projects and the personnel responsible for their establishment and development at local level considerably underestimated the complexity of the co-ordination task, as did the National Council for the Aged who drew up the project *Terms of Reference*. In practice, the subordination of immediate agency and professional goals to more long-term and broader co-ordination objectives proved to be a difficult process. There was a strong prevalence of agency defensiveness and professional protectionism on the part of many of the key participants in the projects and a pre-occupation with statutory functional responsibilities. This defensiveness was particularly noticeable in respect of 'grey areas' such as the welfare aspects of sheltered housing and responsibility for mentally infirm elderly persons.

The project *Terms of Reference* implied a potential for the establishment of organisational structures for inter-agency working which was not possible in practice. Existing administrative divisions, planning mechanisms and reporting arrangements were already formally established and not amenable to change in the short-term to facilitate pilot projects. This resulted in a situation where the projects, which were established without a formal statutory base, were effectively operating in a policy vacuum, outside the mainstream of service planning and provision and having at best an advisory role in respect of their parent statutory bodies. In addition, there were no administrative offices or mechanisms at local committee level which would have facilitated the work of local committees.

In such a context it was almost impossible to apply concepts such as partnership and joint planning which are essential components of a co-ordinated approach. Since the pilot projects were outside the policy planning process the best that could be hoped for was an opportunity to submit views on plans already prepared. However, there were no formal procedures established in either project to facilitate such consultation.

While project personnel and the agencies involved co-operated in respect of a number of schemes instigated by the pilot projects, this fell very much short of the shared responsibility for planning and policy-implementation implied in the notion of partnership.

There were three factors which are commonly regarded as being necessary for innovative development in the area of service co-ordination, all of which were absent or present only in part in the case of the pilot co-ordination projects — *resources for joint working, induction and training in inter-disciplinary teamwork* and a *key worker*. The pilot projects had no specific resources for joint working and were totally dependent on allocations from already overstretched statutory budgets. It is reasonable to assume that the availability of specific resources for joint working would have facilitated a co-ordinated approach and acted as an incentive on the basis that the money could not be spent unless all parties involved were in agreement. It is also reasonable to assume that the provision of education and training courses in inter-disciplinary and inter-agency working, particularly induction courses with a long lead-in process at the beginning of the projects, would have helped project participants in the difficult tasks of teamwork and collaboration, especially since this was their first experience of such a process. The training courses provided, while beneficial for the participants, were too little and came too late to have any effective impact on the programme of work of the projects. As stated throughout this report, the absence of project development workers during phase one was a major disadvantage which affected the functioning and development of the projects throughout.

It is important to point out here that many of these general factors which are identified here as impinging on the work of the pilot projects were already identified in the *Interim Evaluation Report* (Browne, 1989) and that an agenda of tasks was set out in order to address these issues. As already stated, this report had little impact on the projects, an outcome which raises serious questions about the potential for learning from the experience of pilot projects of this nature. Here it should be noted that many of the agenda tasks identified were outside the immediate control of the pilot projects themselves and required interventions from the senior management of the parent statutory bodies and from relevant Government Departments.

The main achievement of the pilot projects was that they facilitated improved communication, better understanding and a sense of mutual trust among participants in the respective project areas. The project committee process provided valuable opportunities for people working with the elderly to meet and get to know each other, and to develop communication links and a sense of cohesiveness between them. The

breaking down of barriers and the building up of trust between service personnel is a basic pre-requisite for the development of a co-ordinated approach. In this context the experience of the pilot projects was most useful and established a platform on which future service co-ordination in the project areas can be built. While the pilot projects achieved a lot according to criteria of improved communication, understanding and informal teamwork in the catchment areas, the achievements were rather minimal when other criteria of integrated planning and service co-ordination between the health boards and local authorities, between health board programmes and between the statutory and voluntary sectors are applied. However, important and necessary beginnings have been made for the ongoing development of a co-ordinated approach based on such criteria.

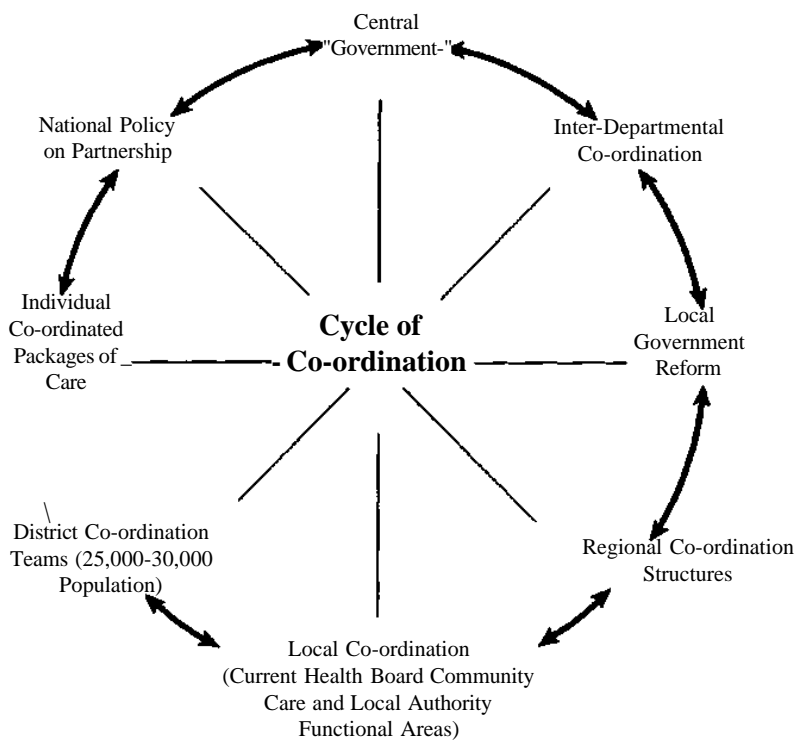
### **8.3 Policy Implications**

There are a number of policy issues which arise out of the experience of the pilot co-ordination projects and from the analysis of that experience. These issues are presented here in the context of the dimensions of service co-ordination which are set out in Figure 8.1. They range from the need to provide co-ordinated packages of care for specific individuals to the need for an articulation of a national policy on co-ordination and partnership. The articulation of a national policy on co-ordination would inevitably have to include a review of the current system of local government so as to facilitate the provision of structures for co-ordination at regional and local levels between health authorities and local authorities.

The promotion of an ethos of co-ordination throughout the system is of paramount importance. The key Government Departments concerned with the elderly should instigate mechanisms to develop such an ethos and should, perhaps, consider sponsoring further pilot projects in the area of service co-ordination so as to develop workable co-ordination structures and procedures. It is also necessary that comprehensive education and training programmes in multi-sectoral and inter-disciplinary working should be developed. Guidelines for the representative and effective participation of the non-statutory sectors (voluntary, private and general practitioner) in a planned co-ordinated approach to service delivery are also required with particular emphasis on how these sectors can be integrated with the statutory sector at local level.

In the case of co-ordination between health boards and local authorities, some additional formal mechanisms are required to ensure that there is

**FIGURE 8.1**  
**Dimensions of service co-ordination**



a regular interchange of views and information, a review of existing co-ordination procedures and an ongoing identification of potential areas for collaboration between the two authorities. In the case of the health boards, structures are required to surmount the difficulties in respect of comprehensive service provision for the elderly arising out of the current programme division of services. In particular, difficulties in relation to the interface between hospital-based services and community-based services across existing programmes need to be addressed and the concept of overall planning and provision for the elderly by geographical area needs to be developed. It is also important that health boards address the need for administrative structures and resources at district level (25.000 — 30.000 population) so as to (i) ensure the optimum level of teamwork and co-ordination at this level and (ii) develop mechanisms for effective liaison between services in such areas and more centralised hospital and community care services. In the foregoing context the integration of the voluntary sector is crucial and, therefore, statutory staff need to be deployed in order to work with and develop the voluntary sector so as to ensure its effective and satisfactory involvement in a co-ordinated approach.

As has been already suggested, co-ordinated development at local level is a complex and challenging task which requires an innovative approach. Crucial to such an approach are (i) adequate resources for inter-sectoral initiatives on co-ordination; (ii) the deployment of development workers to facilitate innovative programmes; and (iii) comprehensive induction and education programmes for participants in innovative projects.

## **8.4 Conclusion**

The pilot co-ordination projects were the first attempt at developing a structured co-ordinated approach to service provision for the elderly within an Irish context. The statutory bodies involved, the Eastern and South-Eastern Health Boards, Dun Laoghaire Corporation and Tipperary South Riding County Council are to be commended for making the effort at a time of severe budgetary constraints in the public services. However, looking at the situation objectively, the question must be asked if projects, which were theoretically innovative, could ever have been effectively such in the recessionary climate in which they were established. It must also be recognised, however, that if the ideal time for testing new approaches was to be awaited, such projects would be unlikely ever to get off the ground.

The pilot projects did not identify any substantial gaps in service provision but rather a system strained and under pressure and engaging in

a high level of crisis intervention. The experience of the projects bore out the premise that co-ordination is not a substitute for inadequate resources or for poorly focussed policies and plans on the part of the co-ordinating agencies. It is inevitable that co-ordination will fail if seen as the panacea for problems and service gaps whose root cause lies elsewhere. An essential pre-requisite of co-ordination would appear to be an acceptance that co-ordinated approaches are unlikely to translate directly into savings. Rather co-ordination must be seen as an extension of existing care provision and funded as such, rather than as part of a cost-cutting exercise. This perspective on co-ordination presents a major challenge to its proponents at a time when financial stringency in the statutory sector continues to be the norm.

Service co-ordination is essentially a long-term developmental process and should be considered as such both in terms of resources required and expectation of outcomes. Participating agencies and professions need time not only to come to terms with a different approach to service planning and provision but also, and more importantly, perhaps, to appreciate the barriers to co-ordination that arise from traditional practices and a pre-occupation with defending and protecting existing functional responsibilities. The development of effective co-ordinating mechanisms within the existing administrative system is a task of considerable complexity and should be resourced as such.

As already stated, the pilot projects highlighted an absence of an ethos of co-ordination throughout the Irish administrative system which has obvious implications for service co-ordination for the elderly at local level. This raises the crucial question as to whether services for the *elderly at local* level can ever be effectively co-ordinated within an administrative system where a co-ordinated approach is not the norm. This is an issue which requires to be addressed both at Departmental and inter-Departmental levels with a view to formulating a national policy on co-ordination.

The pilot projects also pointed to difficulties in integrating the non-statutory sectors in a co-ordinated approach. This is another key aspect of the co-ordination issue which requires to be addressed at the highest levels of policy-making. The question of the precise role for non-statutory bodies within a mixed economy of welfare must be addressed as must the organisational structures required for developing health, housing and welfare policies based on partnership between the statutory and non-statutory sectors.

The challenge of coming to terms with the considerable complexity of the co-ordination task is a difficult one which requires an openness

and new vision on the part of policy planners, administrators and professionals. It requires an acknowledgement of the fact that the reality of service co-ordination, teamwork and partnership is very much different from the rhetorical and aspirational language which is sometimes used to describe it. The pilot projects have contributed to mapping the beginnings of a new approach and it is to be hoped that their experience and the analysis of that experience will both generate and contribute to a comprehensive policy debate on local service co-ordination in the Republic of Ireland.



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## APPENDIX

# *Terms of Reference* Drawn up by the National Council for the Aged and Adopted by Pilot Projects on Coordination of Services for the Elderly

### 1. Provision of Services at Local Level

The increasing numbers of elderly people in the community and particularly the growing numbers of those aged 75 years and over with increased levels of dependency represents a major social challenge and presents a major test to the health and social services in Ireland. If this challenge is to be met, there is a need for a much greater level of flexibility and co-ordination in the provision of services for the elderly at local level — housing, social and medical — than is currently the case.

There is a need for varying policy responses to meet the needs of the elderly in various parts of the country depending on factors such as:

- (i) the current and projected proportion of elderly persons in the community with particular reference to those aged 75 years and over;
- (ii) the percentage of the population in the 'dependant' age groups (i.e. 0-14 years and 65 years and over);
- (iii) the tenure, location and facilities of households occupied by elderly persons;
- (iv) the potential for family and voluntary care of elderly persons in the community;
- (v) the urban/rural mix in the distribution of population and the related distance from service centres;
- (vi) the traditional and cultural 'styles' of caring, if any, in the particular community;
- (vii) the actual and potential sources of income of the elderly;

- (viii) the type of facilities and services available in the area;
- (ix) the number of people living alone.

There is a need to adapt and 'fine tune' general and national policies of care provision for the elderly in accordance with local conditions and requirements. For example, it is likely that very rural areas which are distant from service centres will require many more services provided 'on wheels' than urban/town areas. Even within regions (e.g. health board regions) distinctive forms of provision will be required from area to area depending on local demographic and social factors and on the level and type of housing and of health services and facilities already available in the area.

The needs of the elderly persons are catered for by a variety of responses and services which vary from area to area. It is important in any given area to assess the contribution that each particular service is making to the care of the elderly in the area. The contribution of each particular service will obviously vary from area to area.

The role of the family in the provision of care to elderly persons is also a vitally important consideration. The presence or absence of family care for the elderly person and the actual and potential level of such care has a significant bearing on the level and type of other services and facilities required.

## **2. Developing an Appropriate Structure for Local Co-ordination**

The role of a statutory body, whether local authority or health board, should be more than that of provider of services for the elderly. Its role as planner, initiator, enabler and co-ordinator is all important if families are to get the type of support they require and if the voluntary caring potential in a community is to be tapped and realised. Currently, voluntary organisations in Ireland operate in a policy vacuum. Yet their involvement, particularly in times of economic stringency, is a key element in the provision of an adequate level of 'community care' for elderly persons. The greater involvement of neighbours and of voluntary groups requires a planned approach on the part of the statutory bodies.

The emphasis on maintaining old people in the community and in their own homes rather than in hospital or institutions requires that different agencies, voluntary and statutory, co-operate at local level towards this end. The starting point for such co-operation is an acceptance of the idea that the needs and conditions of each local area should determine the way services are organised in the area. The next stage is the availability of

a forum where all the people who provide services or dispose of resources can meet together to ensure that:

- (i) the right mix of services is provided;
- (ii) different services by different agencies are not duplicating each other;
- (iii) agencies and their personnel are offering each other the kind of expertise they have got.

The appropriate mix of services for elderly people at local level can best be achieved if health and social policy for the elderly is governed by the following considerations:

- 1. that it be seen as a comprehensive, that is to say, based on informed and up-to-date demographic information, which would be the basis for adequate provision at every level and which would ensure that all elderly persons in need are reached, rather than just those who are referred for care;
- 2. that it be seen as an integrated range of services from the provision of simple supports for mainly comfort or preventative reasons to acute hospital care and continuing nursing care for those who require specialist medical or nursing attention;
- 3. that it be seen as the responsibility of a number of parties including the family, the community, the housing and health authorities as well as the medical, para-medical and nursing professions.

This requires an integrated and co-ordinated approach both at the level of provision and the level of planning between:

- (i) families, voluntary groups and statutory services;
- (ii) hospitals and community care services;
- (iii) housing and health authorities.

The needs of elderly persons rarely fall into watertight compartments to be met by one authority or one service only. An elderly person may be enabled to remain living in the community not only through the support of his/her family and friends, but also through

- (a) the efforts of the housing authority (in facilitating housing adaptations, improvements, extensions and in providing group/sheltered housing schemes);
- (b) the efforts of the voluntary and neighbourhood caring network;

- (c) the provision of domiciliary help and nursing care by the community care services;
- (d) the availability of effective assessment, rehabilitation and other hospital services on a day and in-patient basis;
- (e) the availability of intermittent in-patient facilities for both planned and crisis admissions;
- (f) the availability of adequate transport services and communication facilities.

The purposeful and smooth functioning of all these elements requires co-ordination of services at local level. This co-ordination can only effectively occur if it is based on the following considerations:

- (i) The commitment of each health board to promote and facilitate the development of a co-ordinated range of services for elderly persons involving the hospital and community care programmes is essential. In order to achieve this, resources may have to be redistributed; the hospital programme may have to become more community conscious and both programmes will need to ensure that a mechanism is established for co-ordinating their information and activities.
- (ii) Appropriate and adequate housing accommodation is fundamental to the care of the elderly in the community. The local authority must, therefore, be involved in any co-ordinating mechanism established in a local community to promote improved community care provision for the elderly.
- (iii) Though it may not always be adverted to, community care, by definition, implies that the people being cared for continue to live at home or in a surrogate 'home'. Care in the community is, therefore, founded on informal care, whether that be the care provided by families, by friends and neighbours or by members of voluntary organisations. These sectors must necessarily be included in any mechanism designed to improve the co-ordination of services for the elderly.
- (iv) The private and voluntary nursing home sectors play an important role in the provision of care services to elderly persons catering for some one-third of all elderly persons in long-term institutional care. It is important that these sectors be integrated into the overall system of care provision for elderly persons.
- (v) Geriatric medicine, while an important speciality in its own right, cannot operate in isolation from other hospital specialities.

- (ii) identify the needs of the elderly in the area and the local resources with a view to informing the planning process in the designated area;
  - (iii) maintain an up to date inventory of elderly persons likely to be 'at risk' in the area and carry out a regular assessment of their needs;
  - (iv) evaluate regularly the contribution of existing systems of service provision both voluntary and statutory;
  - (v) provide an advocacy role for individual elderly persons with relevant service agencies, (e.g. in relation to an application for a local authority dwelling or an application for a home help service);
  - (vi) maintain close contact with institutional facilities both private/voluntary and statutory in the area;
  - (vii) make recommendations to the steering committee as to how services should be developed in the particular local area;
  - (viii) act in a consultative capacity to agencies/individual professionals/volunteers working with individual elderly persons or with groups of elderly persons in the area.
6. It will be the responsibility of the steering committee to engage in regular and ongoing consultation with these local committees in order to ensure adequate planning and appropriate allocations of resources.
7. The success of these projects will depend among other factors on the commitment of the two agencies involved, the health board and the local authority to:
- (i) support in principle, and in practice, the concept of co-ordination of services at local level;
  - (ii) make available the personnel for participation in the steering committee and for servicing the committee.

It will also depend on the goodwill of all professional and voluntary personnel on the ground.

8. The effective development of the projects requires that an officer of the health board be seconded on a full-time basis to promote the project in various sub-areas during the first year at least. Terms of reference for this promotional role would be drawn up.

9. It is essential that the projects have an evaluation dimension built in from the outset. Ideally there should be provision for an independent evaluator for each of the projects which would facilitate a more comprehensive and objective evaluation than would otherwise be feasible. The National Council for the Aged would be willing to provide this independent evaluation for the projects if funding for such evaluation were available to the Council.
10. The evaluation referred to in 9 would be an important consideration in the context of a more general application of principles of local co-ordination throughout the country. Of particular relevance in this context would be the evaluation of the existing framework and the various responsibilities of health boards and local authorities in relation to elderly persons.
11. The two pilot projects would be established for a specified period of time (two years minimum).
12. The National Council for the Aged would have a role in disseminating information on the rationale of two co-ordination projects to relevant personnel in areas that showed an interest in setting up the projects.







## **NATIONAL COUNCIL FOR THE ELDERLY REPORTS:**

1. *Day Hospital Care*, April 1982.
2. *Retirement: A General Review*, December 1982.
3. *First Annual Report*, December 1982.
4. *Community Services for the Elderly*, September 1983.
5. *Retirement Age: Fixed or Flexible* (Seminar Proceedings), October 1983.
6. *The World of the Elderly: The Rural Experience*, May 1984.
7. *Incomes of the Elderly in Ireland: And an Analysis of the State's Contribution*, May 1984.
8. *Report on its Three Year Term of Office*, June 1984.
9. *Home from Home? Report on Boarding Out Schemes for Older People in Ireland*, November 1985.
10. *Housing of the Elderly in Ireland*, December 1985.
11. *Institutional Care of the Elderly in Ireland*, December 1985.
12. *This is Our World: Perspectives of Some Elderly People on Life in Suburban Dublin*, September 1986.
13. *Nursing Homes in the Republic of Ireland: A Study of the Private and Voluntary Sector*, September 1986.
14. *"It's Our Home": The Quality of Life in Private and Voluntary Nursing Homes*, September 1986.
15. *The Elderly in the Community: Transport and Access to Services in Rural Areas*, September 1986.
16. *Attitudes of Young People to Ageing and the Elderly*, March 1987.
17. *Choices in Community Care: Day Centres for the Elderly in the Eastern Health Board*, September 1987.
18. *Caring for the Elderly. Part I. A Study of Carers at Home and in the Community*, June 1988.
19. *Caring for the Elderly. Part II. The Caring Process: A Study of Carers in the Home*, November 1988.
20. *Sheltered Housing in Ireland: Its Role and Contribution in the Care of Elderly*, May 1989.
21. *Report on its Second Term of Office*, May 1989.
22. *The Role and Future Development of Nursing Homes in Ireland*, September 1991.
23. *Co-ordinating Services for the Elderly at Local Level: Swimming Against the Tide*, September, 1992.

## **NATIONAL COUNCIL FOR THE ELDERLY FACT SHEETS:**

Fact Sheet 1 — Caring for the Elderly at Home.

Fact Sheet 2 — Carers: You Matter Too!

A price list for the above publications is available on request from the National Council for the Elderly, Corrigan House, Fenian Street, Dublin 2.

\*Please note that Reports 12, 13, 14, 17, 18, 19 and 20 may be purchased through any bookseller or directly from:

GOVERNMENT PUBLICATIONS SALES OFFICE  
SUN ALLIANCE HOUSE  
MOLESWORTH STREET  
DUBLIN 2.

The front cover shows  
the 'Tao' symbol for long life.  
The symbol is signed by  
the eighty five year old artist  
Yen Chih.



National Council for the Elderly.